



Health and Social Services Scrutiny Panel

Quarterly Hearing

Witness: The Minister for Health and Social Services

Wednesday, 23rd September 2026

Panel:

Deputy B.B. de S.V.M. Porée of St. Helier South (Chair)

Deputy L.D. Carpenter of St. Helier Central (Vice-Chair)

Deputy G.A. Raimondo of St. Brelade

Deputy C.D. Leck of St. Saviour

Witnesses:

Senator T.J.A. Binet, The Minister for Health and Social Services

Connétable A. Howell of Trinity, Assistant Minister for Health and Social Services

Ms. R. Johnson, Director of Health Policy, Health and Care Jersey

Mr. A. Weir, Managing Director, Health and Care Services

Mr. R. Silva, Head of Product, Digital Health

[14:01]

Deputy B.B. de S.V.M. Porée of St. Helier South (Chair):

Good afternoon, everyone, and welcome to the public hearing of the Health and Social Security Scrutiny Panel. Today is Wednesday, 23rd September 2026, and this is our quarterly hearing with the Minister for Health and Social Services. I would like to draw everyone's attention to the following. We have 1½ hours for this hearing. The hearing will be filmed and streamed live. The recording and transcript will be published afterwards on the States Assembly website, and I ask everyone to check on your personal devices to make sure they are turned off. If we are all okay, we will start

with introductions and that will start with me. My name is Beatriz Porée, and I am the chair for this Scrutiny Panel. To my right is ...

Deputy L.D. Carpenter of St. Helier Central (Vice-Chair):

Deputy Lee Carpenter, vice-chair of the panel.

Deputy C.D. Leck of St. Saviour:

I am Deputy Chris Leck.

Deputy G.A. Raimondo of St. Brelade

I am Deputy Gabriel Raimondo.

The Minister for Health and Social Services:

Senator Tom Binet, Minister for Health and Social Services.

Assistant Minister for Health and Social Services:

Connétable Andy Howell of Trinity, Assistant Minister for Health and Social Services.

Director of Health Policy, Health and Care Jersey:

Ruth Johnson, Director of Health Policy for Health and Care Jersey.

Managing Director, Health and Care Services:

I am Andy Weir. I am Managing Director for Health and Care Services for Health and Care Jersey.

Head of Product, Digital Health:

I am Ricardo Silva. I am the Head of Product for Digital Health, Health and Care Jersey.

Deputy B.B. de S.V.M. Porée:

Thank you, everyone. So we will start with the questions now. I will be addressing the Minister directly, and I am going to ask you, before we move into any specific questions, the panel would welcome that you give us an overview of your priorities for this term of office, if you can. In particular, it would be helpful if you could outline the key challenges facing health and care in Jersey, the areas where you believe the greatest improvements can be achieved, as well as the principal outcomes you hope to deliver for the Islanders over this time.

The Minister for Health and Social Services:

Okay. I will start from the top about the overall ambition. As everybody knows, we are spending hundreds of thousands of pounds on the new hospital and it has always struck me as important that

if we are going to have a first-rate hospital, you have to put a ... by the time we get to moving in, we need a first-rate health service otherwise there seems very little point in building the building in the first place. So the overall ambition is very, very clear. We want to take the health service from where it is, to make it the operational equivalent of the building that it is going to move into. Bear in mind that that is one building and there are more buildings to come. In terms of the issues that I think we need to attend to in the short to medium term, we have introduced a Health Partnership Board. We got that over the line just in time for the election, but I have to say it was not in a mature form. So we just got it through in time, and the work in the next 6 months particularly is going to be to bed that in. We have some subgroups already, but we want to make sure we have got subgroups that reflect all of the major areas of health. The subgroups is where the work will get done on shortening patient journeys and making sure that everybody along that patient journey knows what the other one is doing and they can work together to try and make sure that we are more efficient and more effective. Then once that is all settled, it is the major issues that will come up to the actual board itself; the ones that are common to all of the others. I think that is central to the operation. Fundamental to making that work is digital services. I have made it plain publicly before that we started a very long way back. We are now 9 months into the funded programme, and we will be hearing more about that, but there have been some glitches. It is year one, and as I say, quite a low starting point, and there have been some establishing problems, but most of those have been overcome. Hopefully, going forward, we can see some real progress. Another area that I am very keen to see progressed is health prevention. I have to say health prevention; it is a misnomer, really. It is preventative measures for health to try and move us away from being constantly reactive, to try and stop people becoming ill in the first place. A lot of areas to work on. As I say, we are 9 months into the programme. I think I can already see areas where we could refine that, going into year 2. But I think there is some good progress being made in both of those areas. The thing that is bothering me at the moment is waiting lists. I think that between now and Christmas, we are going to do some real work to make sure that we can hit the ground running in 2027, to make sure we can get those down. I am of the opinion we could do with some more money for that, but that is something I will not be raising here. But I have been making some points in the Budget discussions. Watch this space because unless we get on top of waiting lists ... as I say it is pointless ... the other thing is developing a health strategy but it is pointless having a health strategy if you are constantly dragging the waiting list up to 18 months for critical services. You just will not have a health strategy, so the 2 things have got to go in tandem: have the health strategy but make sure you are producing something that is workable and it can only be workable if we get our waiting list down to ... well, we want good levels of waiting lists, not bad.

Deputy B.B. de S.V.M. Porée:

We will be asking you a few questions about the waiting list.

The Minister for Health and Social Services:

I am sure you will. I am ready for it, do not worry.

Deputy B.B. de S.V.M. Porée:

But please carry on.

The Minister for Health and Social Services:

At the moment I am limited as to what I can tell you, but I can tell you that we are planning on it and I am certainly happy to update you as those plans come to fruition. As I say, money is important in that regard and I am sure I can look to you for support in the Assembly if we need some more because you know how important it is. Basically, I hope that gives you an overview of what is going on at the moment and the things that we are trying to focus on to take things forward.

Deputy B.B. de S.V.M. Porée:

Thank you, Minister, for sharing your priorities with the panel. We really appreciate that. I am going to just be asking some questions around the sustainability healthcare funding and about the Jersey Audit Office. My first question to you with the intro is that in the July reports, the Comptroller and Auditor General concluded that the financial recovery programme alone will not deliver sustainable healthcare funding, as you briefly mentioned. What measures are being developed to address the long-term funding gap, and when does the Minister expect to bring funding proposals to the Assembly for discussion?

The Minister for Health and Social Services:

Okay. There is some detailed work going on. I think it is quite advanced. I will at some point hand over to Ruth to talk about that. But I think it is safe to say that for the time being we have got to do the best with the resources that we have got. It is probably a good opportunity for Ruth to talk in some detail about where we are. You can update them, that detail will be helpful.

Director of Health Policy, Health and Care Jersey:

What we have focused on to date in terms of the actions we are taking is we have developed a model that allows us to forecast our future health and care costs across the whole of the Jersey health and care system. That is not just the costs that Government incurs, for example, in the delivery of hospital services. It also looks at what is the future growing impact on G.P.s (general practitioners), on dentists, on the out-of-pocket payments that people make. So we have undertaken a complex modelling exercise, which was referenced in the auditor's report, in order to take the current expenditure and forecast it forward. Forecasting it forward has included looking at the impact of the changing demographics as our population changes and we get older, also disease prevalence and trends in disease prevalence. It is often assumed that we have more disease just because

people are older. That is actually incorrect. Younger cohorts of people are also exhibiting with more diseases and more kind of dual diseases, comorbidities, so we have taken account of that. We have taken account of trends in what is called healthcare seeking demand; so as more treatments and more drugs come onstream and more and more people demand more healthcare and usually and invariably more expensive forms of healthcare. We have looked at all these things that will put pressure on our current expenditure and, as a result of that modelling work, we estimate that the year-on-year increase in health and care costs across the whole system is just shy of 3 per cent every year over and above R.P.I. (retail price index). Between now and 2045, that has a very significant increase in the total amount of money that would be needed to invest in our health and care services if we do not change what we are doing. We are currently finalising those figures and once they are finalised we can absolutely share them with the panel. Having forecast what our costs look like, we are now going through an exercise of developing options to manage that growing expenditure. That happens in 4 key ways. The first way is the Government of Jersey in consultation with the public needs to determine whether or not we are going to invest more public monies in health and care services and, if we are, how are we going to raise those monies. Ultimately, it does not matter what option you take, whether you say we are going to put more tax money in it, more social security contributions, more pay as you go or more private healthcare premiums. It is citizens ultimately who are paying for these services. We need to think about how much more new money we need to invest and what is the best way to invest those new monies. Alongside that, we need to think about how we are delivering efficiencies; so we make sure that we are using the money we have as effectively as we can do. That talks partly to the financial recovery process that H.C.J. (Health and Care Jersey) has been delivering and delivering very successfully for the last few years. But we also need to think about what further measures are. Earlier this year, we introduced a new policy which was called the Treatments and Interventions Prioritisation Policy, which is a process via which the healthcare department determines the clinical effectiveness and the cost-effectiveness of new treatments, that we are actively using that policy as new treatments come onstream. What we also need to do is we need to think about applying the principles of that policy across existing treatments and drugs to make sure that we are using the ones that are clinically effective and the most cost-effective within our system. Alongside that, we also need to think about how we are commissioning the services that we provide. That includes when we commission services from third-party providers in Jersey, whether that is our G.P.s, (general practitioners) whether that is our charities, when we are commissioning services from U.K. (United Kingdom) providers, so when we are sending acute referrals to the U.K. for treatment. But also, as part of that process, we need to look at the services that we are currently providing in Health and Care Jersey and make sure that those services are clinically effective and cost-effective and are organised in the best way. As a piece of work it is never-ending because you always have to be evaluating your services and how effective they are. But alongside that never-ending cycle of evaluation and making sure that you have got the right tools and techniques to evaluate, we do need to address the issue of are we going

to be investing more money in our healthcare system and how best are we going to raise that money? There is a live and active conversation going on with the Minister at the moment, and we would envisage that in early 2027 or thereabouts we will start to engage our community in a conversation about what that might look like.

Deputy B.B. de S.V.M. Porée:

Thank you. That is very good, a very precise answer.

[14:15]

Deputy C.D. Leck:

Can I just understand in relation to next year's Budget then with the increased costs, which you are trying to mitigate with other activities, and you mentioned earlier that you need money for the waiting lists, has that not been incorporated into the Budget for next year or are you still fighting?

The Minister for Health and Social Services:

We are in those very last minute discussions now. It is only a day or 2 to go. I am hoping that what we will come out with will be sufficient to see us through the next 12 months. That is the hope.

Deputy C.D. Leck:

Thank you.

Deputy B.B. de S.V.M. Porée:

The C. and A.G. (Comptroller and Auditor General) recommended that the development of a clinical service strategy and integrated health and social care strategy is needed. Has any consideration been given to that?

The Minister for Health and Social Services:

My understanding is we have a clinical strategy already. Perhaps you could give the detail on that.

Deputy B.B. de S.V.M. Porée:

Could you tell us a little bit about it, please?

Managing Director, Health and Care Services:

We have completed a clinical strategy for acute services. That has been completed and published. We have a mental health strategy that was completed and published. I think the next step now, we recognise we have to think about health and social care as a system, and a lot of that is not things that we do, it is things that other people do; third sector providers, other providers, et cetera. This

is where the Partnership Board becomes important, I think, because the Partnership Board allows us to think about the whole picture, not just about the Health and Care Jersey picture. The best example of that is we have recently had a conversation in the Partnership Board about a workforce strategy. We can do a workforce strategy for the new hospital, for example, but given the growing rates of dementia, growing rates of social care need, requirements to keep people out of hospital wherever we can, one of the biggest places that we face a real challenge around workforce growth is domiciliary care and social care in the community, the majority of which we do not provide. We need to think about that with providers that do provide that. We think about how are we going to develop a workforce strategy for the whole workforce, not just for Health and Care Jersey. I think it is a work in progress. We have got the foundation blocks from a Health and Care Jersey perspective, but I think what we now need to do is think about the whole picture, and the Partnership Board is exactly the vehicle to do that.

Deputy B.B. de S.V.M. Porée:

Thank you for that. The C. and A.G. also identified fragmentation in the healthcare funding. Has the Minister given any consideration in creating a single Ministerial accountability for all the health and social care funding? Has it been something that you considered?

The Minister for Health and Social Services:

I have taken the C. and A.G. ... it is a little while since I have read the report, but I take it that is referring to the Health Insurance Fund and long-term care narrators, yes. I had a meeting with the Minister for Social Security only 2 days ago, and she did say that in her view the whole of the Health Insurance Fund should move over to Health, and that would be a consolidated funding within the health service, which I think makes sense. I did make the point to her that I think there needs to be a discussion about the way long-term care, that is the L.T.C., planning ... it sits in 2 places, levels 1 to 4 with Social Security, and everything above that comes and hits the Health budget. That seems to be growing exponentially. I think we need to sit down and have a serious look at where that belongs and how that should be handled going forward. There are discussions going on to try and consolidate those 2 things.

Deputy B.B. de S.V.M. Porée:

Do you, Minister, feel that, at the moment, you can see that you have got any support from the Council of Ministers to transfer those responsibilities into your portfolio? Is that something that you are discussing with the wider membership, or is it just a direct communication with the Minister for Social Security?

The Minister for Health and Social Services:

It has been mentioned at the Council of Ministers. It has not been taken there for a formal decision, I am not entirely sure whether it would need to. Would it need to? Presumably it would, Ruth?

Director of Health Policy, Health and Care Jersey:

It would.

The Minister for Health and Social Services:

It would need to go to the Council Ministers. But they are aware of it, they are aware of the discussions going on. I think there are a lot of practical things that need to be decided before that happens, and those things are being analysed now. I think that will come back on to the agenda hopefully before too long.

Director of Health Policy, Health and Care Jersey:

Yes, and just to say ultimately it would be a decision of the Assembly because both those funds are set up in law and transfer of Ministerial responsibility would require a legislation change, which would require the Assembly's agreement.

Deputy B.B. de S.V.M. Porée:

Thank you. I think I will stop for now and pass on to Deputy Carpenter.

Deputy L.D. Carpenter:

Thank you, Chair. Minister, how is the department addressing delayed discharges and insufficient community care capacity? What impacts do you expect that to have on the hospital demand and costs around that?

The Minister for Health and Social Services:

That is a more complicated one, I am going to hand it straight over to Andy for that.

Managing Director, Health and Care Services:

We have a weekly delayed discharge meeting, so we look at this data every week in terms of granular individual patient activity, and then of course we collate it and we look at what the themes are and trends over time. Delayed discharges have reduced slightly in the last year, but the look of those have changed significantly. Probably 3 years ago, one of our biggest delays was obtaining community care packages; so people would wait for quite a long time to get a package of care outside of hospital. That has really changed. Because of changes that have been made through how social care procure those packages and working with providers, that happens much more quickly now on the whole. The biggest problem that we have by far is people waiting for nursing care. If you come into hospital and you did not come from a nursing home and you need to go to a

nursing home, you are going to be delayed. If you come into hospital with dementia and you need to go into a nursing home, you will probably wait about 3 months in hospital when you do not need to be there. Of course the consequence of that is that people deteriorate in hospital. It is not a neutral thing, just staying in hospital when you do not need to be there. It causes people to become unwell. So we are doing a huge piece of work at the moment. Firstly, we are implementing the dementia strategy, which has got a whole tranche of work in relation to this, and that is particularly around improving community models and looking at additional capacity. But we are also looking at, again, under the auspices of the Partnership Board, at what does the future nursing care provision need to look like. I have said to the Minister on numerous occasions, if we do not sort this out we are going to end up with the most expensive nursing home in the world up on the hill because it will just be full of people that do not need to be in hospital. There is a shift here, we have to make a shift from hospital care to out-of-hospital care. A good example of one of the things that we are looking at doing is we have a limited breadth of supported community models around accommodation, for example. In other jurisdictions, you might go to warden-controlled accommodation where there is someone available to help you but you have still got your own front door, et cetera. There are some community aspects of that. We do not have that here and so the breadth of things that we can offer to people needs to be expanded, but we also really need to look at volume and how do we ... we have had a number of occasions about do we need to increase the state-provided nursing home provision? We only provide one nursing home at the moment and everything else is done privately. Of course the problem with that is that the private provider very reasonably can pick who they take and do, and so they should because it is business. You could say we cannot complain about that. If that is the model that we choose to operate that is what is going to happen, but it has impact. It keeps people waiting in hospital. So overall granularity, looking at it every week in detail trying to move people through individually as quickly as possible but really also looking at the trends, the patterns, and what do we need to do at a system level to change that.

Deputy L.D. Carpenter:

Thank you. Minister, you mentioned at the outset prevention among your priorities or things you will be focusing on. Can you speak a little bit more around what you see the role of prevention and public health investment in improving health outcomes and reducing future healthcare costs?

The Minister for Health and Social Services:

I think it spreads across the piece. One example you may or may not have seen, there has been a recent TV advert about putting on suncream to avoid skin cancer. I think I am correct in saying we have got one of the highest levels of skin cancer anywhere, certainly in the U.K. So those are the sort of initiatives that we are funding to try and raise awareness, to get people. Another thing we are very keen on is children's diets. That is an area that I do not think we are giving sufficient focus to.

Assistant Minister for Health and Social Services:

I think there is quite a lot of obesity in Jersey, and we are trying to work as Health and also with Education so we can increase exercise, get the right messages across about healthy eating.

The Minister for Health and Social Services:

Address dietary situations from childhood onwards, trying to get the job right at the beginning so children's palates are adjusting to eating healthy for the whole of their lives. It is a long-term thing because you put the money in and you are quite a while before you see any benefits, but when you see those benefits they could be lifelong. As I say, we have come back to the point that Ruth was making about this exponential rise in cost. In my view, the only way to bring those down is to chuck some extra money at it now, get ahead of the game, so that you reduce those costs for the future, which is a dilemma because we have a budget and every department needs more money, and there is never really enough. It is an awkward situation, but we always do try and make the point that it is important to put your money here, because if not the health service will inevitably eat up a whole economy. Either that or you start to draw a line and say to people: "Well, these new treatments you are not going to get because the money is not there." There is no easy solution to it. But, as I say, I think the importance of ... we have got £4 million that we are working with at the moment. It sounds a lot, but when you get around to spending it, it goes very quickly. But, as I say, if we can keep that ... I think the arrangement was to have that £4 million for 5 years, and if we can prove over the course of time ... if that formula gets maintained, if we can prove over that time that we are having an effect, then hopefully that money will be sustainable even in the longer term.

Assistant Minister for Health and Social Services:

I think some of the money has gone towards diabetes prevention. A small amount has gone towards children's dental care, so that there is a programme going into the nurseries, going into the schools trying to get young children not to be eating lots of sweets in between meals and cleaning their teeth and eating all the right things.

Deputy L.D. Carpenter:

So these are initiatives that are already being deployed?

Assistant Minister for Health and Social Services:

We are doing the work.

The Minister for Health and Social Services:

Do you have anything further on that?

Director of Health Policy, Health and Care Jersey:

The States Assembly in the 2026 Government Plan approved a programme of work called Prevention First and, as the Minister has said, it is £4 million annual investment in initiatives which focus on preventing ill health in the first place or supporting early detection of potential disease. So there is a significant programme of work which we are rolling out. Not everything will happen in year one, as you can imagine. There are a vast array of initiatives within that. So we are doing quite a lot around screening, particularly around improved breast cancer screening, bowel screening, and then we will move on to lung cancer screening. We are doing a lot of activity, as Andy has mentioned, around skin cancer because that is, in most cases, entirely avoidable, or in many cases entirely avoidable. So there are screening initiatives. We are currently working and developing a package of health checks, which will be community-based health checks, which will help some members of our community understand whether or not they have got issues with their weight, their blood pressure, et cetera, and will help us support people to take action before any of those early indicators turn into disease. We are doing some work around children's dental within that. There are a range of initiatives which will roll out over the next few years, which will hopefully, over a period of time, start to change the dial on some of the key 5 preventable diseases, which ... and I am not going to remember them all, but they are cancer, dementia, heart disease, and 2 others; sorry. But we can certainly come and do a briefing for the panel on the Prevention First programme and the work that we are doing around that. Prevention First is really important because it is about health and well-being of Islanders. It is really important because dampening down the prevalence of disease keeps the costs down, and jurisdictions the whole world over are thinking and talking very actively and seriously about prevention.

Deputy B.B. de S.V.M. Porée:

Thanks for the offer to come and have a briefing.

Deputy L.D. Carpenter:

Minister, to what extent are contributions from those who can afford to pay being considered and how would equitable access to treatment be protected were you to introduce anything like that?

The Minister for Health and Social Services:

I hope we all accept the fact that with private provision we do get money in which helps to contribute towards running the remainder of the system. I am led to believe - I stand to be corrected, Ruth - but I think there are more people that are insured than actually use their insurance.

Director of Health Policy, Health and Care Jersey:

Yes.

The Minister for Health and Social Services:

One of the key jobs for us is to try and make sure that if people are insured they use their insurance in the proper way, because that is a very good way of taking pressure off and putting money back into the system. In terms of health equity, as I say, I know people have got different views about how they see this, about the provision of private care, but I would rather see more of it than less, as I say, so the more money can go back in and we can raise the bar for everybody. We come back to the overall funding requirement at the end of it to make sure we have got a system that works for everybody, but I would assume that there will always be a faster response for private than there will be for the public provision. But it is making sure that the public provision is good enough to actually get the job done properly without anybody having to suffer.

[14:30]

As I say, it is a delicate balance but we are trying to hit ... well, you can see that everything we are doing is trying to take us in that direction.

Deputy L.D. Carpenter:

Thank you, Minister.

Deputy C.D. Leck:

Can I turn to some questions now on the new hospital up at Overdale? Now that you have signed that contract ...

The Minister for Health and Social Services:

Do not talk about the contract. I am not allowed.

Deputy C.D. Leck:

We will not talk about the contract, but can you explain the governance, reporting and assurance arrangements you have got in place to make sure that the hospital will be delivered on time and how you are mitigating any risk associated with such a hefty construction?

The Minister for Health and Social Services:

You said you would not talk about the contract. We are going to have to; that is not a problem. I think you had seen that it had become a bit controversial, and it was quite unfortunate. The only reason it became controversial was because we had an election coming up, so we were all under an extraordinary amount of pressure. What became apparent to me late in the day was that there was further due diligence work to be done and, as I say, that came to me at the very last minute. I

then reacted to that because the due diligence, I have to say, has been very good. So the assurance work ...

Deputy C.D. Leck:

I was going to say, so I think we are all “happy” and understand how you do it, I suppose.

The Minister for Health and Social Services:

Okay, that is fine, good.

Deputy C.D. Leck:

But my question is more directed to the future, and in terms of what reporting assurance, risk mitigation factors we are having in place to ensure the hospital is delivered on time and to spec?

The Minister for Health and Social Services:

Going forward, if we use the same due diligence and assurance measures as we have done so far, I think we would be in very comfortable territory. I have been very impressed by the amount of assurance work that has been done, the amount of oversight that there has been throughout the whole project. I think the C. and A.G. is carrying out a report. I am fairly comfortable. I mean, you always find some fault with everything when you look at it, but I do not think there would be anything substantive at all. I certainly hope not. I think the assurance framework that we have got in place for the project should see its way through without too much problem. That said, the only reason there was any nervousness about this was because we had an election coming up and I did not deem it ... politically, I did not think it was sensible to not sign that contract and take a chance. Because I could see it coming: “Oh well, we have got to wait for the new Council of Ministers to be formulated. We do not know who is going to be elected.” It might have been that there were people there that says: “Oh, we are not sure about this, the world has changed, it is an awful lot of money.” We could have been back to square one. So I think the only reason that the whole issue of due diligence in assurance came up is because there was a requirement to do it. Just for the record, just in case anybody is listening that was not aware, we managed to find a contractual mechanism by which we signed the contract but had a withdrawal clause that lasted another 2 weeks. We assured the contractor that we did not think we were going to find anything adverse. They had been running with it and I think they knew that was fairly safe territory, so they were very good. They agreed to run with that. The 2 weeks elapsed, the assurance work was done. It all came out clean, as we expected it would, and on we go. So that contract is now live.

Assistant Minister for Health and Social Services:

I think there is a really good project team who are very confident and very dedicated.

Deputy C.D. Leck:

We understand, and correct me if I am wrong, but there is going to be a sort of political oversight group which might include the Minister for Treasury and Resources and the Chief Minister in terms of helping you to maintain, I suppose, oversight and manage the risks associated with the project.

The Minister for Health and Social Services:

There has been political oversight all the way through with the Minister for Treasury and Resources and the Chief Minister. So that is, I think, a continuation. I do not know how that has been reported, but that is ...

Deputy C.D. Leck:

I suppose I was wondering whether you were going to task a specific group which would comprise those 2 Ministers. I can see that they were perhaps ...

The Minister for Health and Social Services:

Well, they are part of the assurance process. Unfortunately, I have not got a chart that shows it all laid out. It is quite complex, but if you wanted that, I think you are due to have a presentation from the new hospital facilities team, are you not, at some point? But I will make sure that we include a couple of slides on governance so that we can put your mind at rest. As I say, I have been very impressed by it and I think it has done a good job.

Deputy C.D. Leck:

Okay. Then looking outside the new hospital, you have got Kensington Place and the possibility of developing things. You have got the St Saviour's Hospital. How do you see that programme developing? What is the current status of that?

The Minister for Health and Social Services:

That is very topical, and I know we are being recorded in the media, so once again I need to be a little bit careful. When we finalised the contract we had various sums of money in the contract, but it all formed one budgetary figure. In the event, 3 years after the decision to go down this route, the actual contract itself stayed within the overall budget, but it absorbed more money than we wanted to that we were hoping to be able to hold back for those other 2 sites. So we are now in a position where we cannot move as quickly and as comprehensively on those 2 sites as we were hoping. This has been raised in our recent discussions, and I would say that is work in progress. I am very keen that we move ahead as quickly as we can with those other 2 sites, especially the health village, and Andy has already made the point, we have got people with dementia sitting in hospital beds deteriorating. We have got one facility of our own which is full and it is ageing, and we desperately need those facilities. So what we need to do is plan the whole site so we know where everything is

going, and at that point in time we can then cherry pick and say we one piece at a time. We do not have to do the whole thing at once, but we can then do it on a needs-must basis, and that is the first thing we need to do. Once we have identified where it goes, we need to get on and build that in a big hurry. Because the thing is, a lot of people have got their own departments, they are concentrating on that. They are not aware of the subtle changes that happen and what our requirements are. So it is our job to make sure. So these hearings are very good because it gets the message out there.

Deputy C.D. Leck:

What do you see the timetable as being for those developments so that you might see things coming in place for dementia waiting lists and suchlike?

The Minister for Health and Social Services:

I think we share the same view. I would like to see a facility there heavily under construction or finished by the end of this political term. I think that is the degree of urgency there, and we are very much aligned on that.

Assistant Minister for Health and Social Services:

Because while we have got 25 people who are delayed discharges in hospital, that stops. That is another contributing factor to the waiting list.

The Minister for Health and Social Services:

This is the problem, it is a chicken and egg.

Assistant Minister for Health and Social Services:

Because if we have not got the beds, if it is not a day case, then you need a bed for someone to be in. It is so complex.

Deputy C.D. Leck:

I come back to you wanting to do the community care.

The Minister for Health and Social Services:

If you got the proper facilities, people can be treated properly and they can have exercise. They can have all the things that they need, and when they are stuck in a hospital bed, 6 in a ward, they are going to deteriorate. So we are on a downward spiral and we need to break that spiral, and that is the message that we are really trying to get over, because that is widely important.

Deputy B.B. de S.V.M. Porée:

Can I just ask a question, Minister? In your view, what is the main practical issue with running the 2 sides alongside to keep the work going on both sides? Is it more due to managing the patients, moving them from A to B, or what is it, in your view?

The Minister for Health and Social Services:

Andy can talk a little bit in more detail, but the fact is we have got the new hospital that is for acute; that is overnight stays. There should not really be very much transferring of patients at all. The stuff in town will be for day cases and the stuff at Overdale will be for either emergency or planned operations that require overnight stays. So they are relatively separate. The hospital in town, well, once the acute has moved out, that will shut down at night. So it becomes a different facility and, as I say, what we all consider to be a hospital, hospital will be happening at the top of the road. Andy, you might want to provide a little bit more detail.

Deputy B.B. de S.V.M. Porée:

In terms of the practical issue, that is really what I want to understand.

Managing Director, Health and Care Services:

No, you are right. So of course, there will be the need to decant areas.

Deputy B.B. de S.V.M. Porée:

Decant is the word.

Managing Director, Health and Care Services:

I would use the example of the refurb of the mental health services up at Clinique Pinel. We ran that as an operational mental health unit while doing the work. There were terrible difficulties with that, and not least noise, disruption, all of the things that you would expect if you were doing a large scale refurbishment with a ward in the middle of it essentially, which is what we were doing. So there has to be a set of staged steps, does there not, that work out what can we do there with minimal impact? Not no impact, minimal impact to direct patient care. I think that is the work that the project team is starting to do now. I have certainly been involved in meetings recently where they have been thinking about the detail of the Kensington Place site. What needs to be there? What goes where? How can we consolidate? Because there is certainly a consolidation opportunity around this site. We have got lots of services scattered around town at the moment. You can think about bringing those together in a way that is different. But all of that needs really quite detailed planning.

The Minister for Health and Social Services:

It is a consolidation requirement, because it would not really be feasible to run everything if we got everything dotted. Half a service dotted around all of those buildings, you would end up picking up all of the running costs of the whole interest, which we do not want to do. So we need that money to be able to plan properly so that when the acute moves out, we have worked out long before where everything is going to go and how it is going to operate.

Deputy C.D. Leck:

Okay. Well, I think that covers the questions I was going to ask then. Thanks.

Deputy L.D. Carpenter:

Sorry, Chair, can I just ask one final question on the hospital, if I may? Just around construction, it is estimated that the peak onsite workforce will be around 800 people and a meaningful share of those will likely be imported. Has any consideration been given to how they will be accommodated and moved around the Island?

The Minister for Health and Social Services:

A huge amount. It is a shame we have not got Jessica, the project manager here, because she has got all of those details, but currently they are working with Andy and landlords and so on. We have got a number of voids in the health service where we have got staff accommodation. You are probably closer to the detail of that, are you, Andy?

Managing Director, Health and Care Services:

Not particularly, no.

The Minister for Health and Social Services:

The principle is that we want to make sure we have utilised every single available unoccupied units or staff accommodation that we possibly can. So believe me, there is a lot of work gone into this and they have made great strides, and I think they are going to deal with it very well, to be fair.

Deputy G.A. Raimondo:

A slight shift now. Adult Mental Health Services, and more specifically focusing on the Jersey mental health strategy. In it, it states that people can experience gaps, delays, difficulties navigating the mental health services you guys offer. Could you tell me a little bit about which plans you have in the works developing to deal with these issues?

Managing Director, Health and Care Services:

Absolutely. So the mental health strategy was an all age strategy and was an integrated strategy, so it involved a lot of input from service users, carers, third sector providers, partners, et cetera. So

again, this is not just a Health and Care Jersey strategy, this is a much wider piece. We have an implementation steering group, which I chair, which looks at each one of these. It is a 4-year strategy, so we are not going to do everything in a year, and there are 4 sets of 4 priorities. So it sets out what we are going to do. There is a detailed implementation plan underneath that, that says this is the order in which we are going to do things. These are the things that we are going to do first. It is worth noting there were some other strategies which sit alongside this. So we have a suicide prevention strategy that has got its own plan, we have the dementia strategy that has got its own plan, and we have got the neurodiversity strategy that has got its own plan. So all of this comes together. At the moment, the work that we are doing, we are looking particularly at children's mental health, and there is a piece of work being led by the C.A.M.H.S. (Child and Adolescent Mental Health Service) team looking at what do we provide into schools? Does it work? What are we going to do around social media and the impact that we know that social media has on young people's mental health? That is becoming increasingly evident. So that is one of the pieces of work. One of the big priorities is around crisis and access. How do people get access to mental health services when they need it? The good news here is that we see approximately 90 per cent of people within 4 hours if they are in a crisis, and I have said repeatedly publicly, as a director of a mental health trust in the N.H.S. (National Health Service), I would have cut my arm off for that achievement. We were nowhere near it. However, the problem is that demand on the crisis service has grown since the first quarter of last year by 49 per cent. So it is ever growing. Today, we have not increased capacity in that service. So it is stretched, it is overstretched, and that is creating some problems for us. So we are currently looking at that in terms of how do we make the crisis service different? Alongside that, we have the planned development of the La Motte Street site. That will give us, for the first time here, a walk-in crisis centre. At the moment, we are one of the only jurisdictions now where if you have a mental health crisis, we often say: "Go to A. and E. (Accident and Emergency)." A. and E. is the last place for you to be if you are having a mental health crisis unless you have a physical reason to be there as well. But at the moment that is what we have got. Either that or see someone at home, and sometimes that is neither appropriate nor what people want frankly. We do do that. So the development of a mental health hub on that site will allow us a 24/7 crisis place for people to come, and it will allow us a much broader breadth of mental health day provision for people and services. This is an integrated offer between charities and health, not just something that we are going to be doing. Also, for the first time, we are looking to provide respite care, because we do not have that again for mental health. So if someone is assessed and in need of urgent mental health care but they cannot go home, they have to come into hospital, and sometimes that is not necessary. We could look after people in different ways. So we need somewhere for people to go, and this has worked very well in other places, and these places are often called crisis houses. So that is a priority. Then mostly, and I think the most important bit, is to focus on the culture of our services and making sure they are recovery focused. This is about understanding what matters to people. How do they understand becoming well?

[14:45]

How do they understand? So if someone has schizophrenia, for example, they may never become symptom free, but there are lots of things that they will aspire to that they can still achieve, and that is what we should be working towards. So the way that we deliver our services, and I think the best example of that that I can give is the Recovery Hub which has been up and running now for 18 months here. I just cannot commend it enough to the panel. The work is superb. They are incrementally doing more and more and more with people, but crucially half of the people delivering that activity use our services. They have mental health problems, but we are engaging them in running groups and delivering activities, and our aspiration around that is huge. We now employ peer workers. We employ 5 people in our services who have lived experience of serious mental illness and still use our services. All of this stuff is cultural shift and it is so terribly important. The mental health services used to be a very medical model here and really needed some movement. So the strategy is going to take some time to do everything that is in it, but we have got a set of priorities. They are realistic. We have got partners around the table working with us. The police are a good example. The work that we do with the police around mental health is bearing such significant improvement for people's experience of being in a mental health crisis and also reduced demand on the police when they are not needed. So I am really confident that we are driving it forward and it will get us to where we need to be.

Deputy B.B. de S.V.M. Porée:

Can I just jump in very quickly? You did mention that you are developing a provision of the mental health crisis centre; it is still ongoing I take.

Managing Director, Health and Care Services:

That is right.

Deputy B.B. de S.V.M. Porée:

So could you tell us what is the difference between this new crisis centre in terms of service provision in comparison to say, for instance, the Y.E.S. (Youth Enquiry Service) Project or the Listening Lounge, they are in place, what is this going to offer to people?

Managing Director, Health and Care Services:

Of course I can. So the Y.E.S. Project and the Listening Lounge are for what you would describe as lower level mental health problems. So if people that perhaps are a bit depressed, people are a bit anxious, people who are not going to perhaps develop a longer term mental health need or do not have significant symptoms that create risk. Secondary mental health care is much more about

working with people that have longer-term serious mental illness, acute mental illness and potentially risk, and that might be risk to self, much more likely to be risk to self, but may also sometimes be around risk to others. So that is the clientele that we work with. The difficulties that people experience are more pervasive and often multitudinal. So people do not just become unwell and have symptoms. Very often they lose their social skills, their relationship breaks down, they lose their job, there are issues around housing. So there is this whole complexity around long-term mental illness. The Recovery Hub then does a number of things. Firstly, you can come and have a crisis assessment. You can be seen, but it is more than that. It is also a place that when people are really feeling not great and feel like they just need a bit of support, they can come. The model that we are hoping to use is a café. So the building lends itself really nicely to that, and we would like to replicate the Beresford Street Kitchen approach, where also the public come in and can get a sandwich and a cup of coffee, and all of that stuff. Because that reduces stigma, and stigma is still a real problem here around mental illness. People that use our services tell us that all of the time. The other advantage of that model is that you can utilise that to train people in skills. So we would have people that use services running the café and working in the café, and you can do N.V.Q. (National Vocational Qualification) type training with people so they get a qualification, and that then of course boosts people's confidence. It boosts their ability to go out and get work. So all of that stuff. Alongside that, we have multi space. So we are intending to utilise those rooms for groups, individual activities with people, but as I said earlier, charities as well should utilise that space. So you may have a room where on a Monday morning Dementia Jersey might be doing a carers' group, and on Monday afternoon we might be doing an art group for people with severe injury, mental illness, et cetera. So really, creating a bit of a one-stop-shop, I think, for people with longer-term mental health needs. Then, as I say, the last bit of that, we have a service now called The Diner, which is a day provision. It is used by about 70 people. People come and they do activities in the morning, they have lunch, and then they do activities in the afternoon. Some people just come and have lunch. Some people come once a week. Some people come every day. For some of those people, it is the only social activity that they have. I was there at Christmastime last year and sat with a man who said to me: "Other than when I go to the shop at the end of my road, this is the only time in my week that I ever speak to anyone."

Deputy B.B. de S.V.M. Porée:

It would be worth to let us know where this facility is.

Managing Director, Health and Care Services:

We would love for you to come, please. We would be delighted to go through this with you in more detail.

Deputy B.B. de S.V.M. Porée:

Can you tell us where it is? Maybe members of the public would benefit from it.

Managing Director, Health and Care Services

Yes, absolutely. So it is at the back of the La Motte Street building. It is St John's Road ... I may have got that wrong, but I will provide details and we can publicise it. So people come there, they have to have contact with mental health services currently. That is one of the other things that we are going to change when the building is bigger. We would not want a large influx of people at The Diner, because the people that come that are anxious would not like that. They may not come anymore. So we have to manage that quite carefully. But when the building is bigger and we have the large café, et cetera, we want people to come and engage with us.

Deputy G.A. Raimondo:

So, obviously, there are some Islanders that are not receiving the support they need quite yet. Do you roughly know where that current level of unmet need is within the mental health services at the moment?

Managing Director, Health and Care Services:

Yes, so it is variable. Obviously we do not know about the people that we never see. We did a health needs assessment as part of the mental health strategy. So we know indicatively how many people we would expect to see in different parts of our service. But we know that there are parts of the service where there is much more work to be done. The eating disorders pathway is a good example of that. At the moment our offer is quite limited, it is separated between children and adults, and there are always going to be some things we cannot do here. So we have to be really explicit about that. We are never going to provide specialist inpatient eating disorder services, for example. They are highly specialised services. In England, they are provided regionally. You would not even have one in every big city perhaps. So there are some things, secure psychiatric care, we are never going to be able to do that here. We do not have enough demand to build and manage a secure psychiatric unit. But certainly, in parts of our community pathway, so eating disorders. Clearly, the biggest issue for us is A.D.H.D. (Attention Deficit Hyperactivity Disorder) and autism. That is the place we have most challenge currently, and I can talk about that. We have some quality improvement work to do in our inpatient mental health services. The feedback that we get around our inpatient services is significantly variant. So some people describe them as being really good, and some people describe them as being not so. I think the truth is it is sometimes in the middle, and I think if there is one thing that we want to do from a quality perspective around that is about making that more consistent. So I think we have got a pretty good idea of where the gaps are. Of course, there is a reality about resourcing, and that is about money, but it is also about staff. As you know, it is hard to get mental health professionals currently. It is particularly hard to get psychiatrists,

and the more specialised the area, the harder it is to get them. So we also have to be realistic about what can we deliver here?

Deputy G.A. Raimondo:

Yes , you brought up A.D.H.D. and autism. Which paths at the moment are you going down to support people with it ... well, possible A.D.H.D. and autism through diagnosis and especially within schools, that age group?

Managing Director, Health and Care Services:

Okay. So we did a large piece of work on this previously, and we have talked a lot about the challenges around ... I will stick with A.D.H.D. for the moment. The challenges around A.D.H.D. diagnosis, which you know there has been a lot of controversy about that. There are lots of different views around this. But also, everywhere, demand hugely exceeds capacity to the extent that in some services in England they have had to close the services, they have closed the waiting list because they simply cannot manage anymore. That has been an ongoing issue for a very long period of time. The difficulty that we have here is exactly that, is that demand has hugely exceeded capacity. The number of people on our waiting list has gone up, the rate has declined, but it is still rising. So we have got 1,254 people today waiting for a diagnostic assessment, and that is just adults. Under 18, the Children's Service deal with those. We have one psychiatrist who specialises in A.D.H.D. Because of our prescribing rules here, A.D.H.D. prescribing is done by that specialist. So in other places, A.D.H.D. prescribing is done in primary care, it is done by G.P.s (general practitioners), it is done as part of a shared care arrangement. We do not have that here at all for a variety of reasons. So the problem that we have is that every time we diagnose someone and want to treat them, we are reducing our diagnostic capacity because we are increasing the amount of prescribing that has to be done, medical reviews, and all of that stuff. Your predecessors, the previous group and the panel, did a full review of this with us and made a series of recommendations, some of which we have progressed. We have particularly looked at if people are waiting what can we do. Because medicines are not the answer to everything. There are other things that you can do for people with a diagnosis of A.D.H.D. So we established psychological groups, and people come to those and we get good feedback, and that is helpful for people that are waiting. But of course, people really want a diagnosis most of the time and they want treatment, if that is appropriate. So we are currently working on a piece of work to say: "What are we going to do about this problem?" It is not going away, it is not getting any better, and we do not have clinicians to come and do this work frankly. So either we are going to have to outsource or we are going to have to move some resource from another part of mental health services to fund this, and of course that creates significant concern for me. The idea of reducing expenditure in the crisis team, for example, when we know that the work has doubled, makes no sense, so we are back to the finite resource challenge. But the Minister has asked for, very correctly, a set of options around what could we do

to help manage this? We are still talking to primary care about prescribing. We are still talking about is there a different way of doing this? We have changed our skill mix. We have recruited a specialist nurse into the service who is able to do some of those things, but fundamentally this is a problem that we need to try and crack, but it is difficult.

Deputy G.A. Raimondo:

So you have spoken about some of those different services, mental health, primary care, social care, third sector providers, and obviously there are going to be people that have more complex needs, that are going to fall between those services, and often they end up getting passed around those services. What do you have in place at the moment, or what are you working on to make sure those people are supported?

Managing Director, Health and Care Services:

Yes, so there are a few things. At point of entry, we now have an integrated entry point so people can be referred into a team when there is a concern about them, and that team comprises someone from mental health, someone from social care particularly and, if necessary, someone from safeguarding, and that team will look together at the referral and say: "Who is the best person to do this initial assessment?" It might be 2 of us, and they can go out and do that work. There is a lot of cross working between particularly social care and mental health, but also community services. On an individual patient basis, we have a model, a framework for care that mental health services call the C.A.R.F. (Care and Recovery Framework), which says that you will have an assessment, you will have a care plan, you will have a key worker, and the job of that key worker is to co-ordinate. It is the conductor of the orchestra. They do not play all the instruments, they cannot do everything, but what they can do is say: "Okay, social care, you need to do that. We could buy in a package of care from a community provider. Mental health services will do this." The care co-ordinator oversees all of that and makes sure that it works. Every 6 months we sit down with the person and their families, if appropriate, and say: "What is working? What is not? Is the plan delivering what is needed?" So we have introduced formal structures to manage that. You are right, there are still examples of people being passed around the system, and in fact I was at a meeting only this morning where we were talking about that, and talking about is there a model that we could introduce where essentially if someone lands with you they stay with you until you have agreed what the next place is? But one of the difficulties at the moment is people can say: "No, it is not us", and that is the end of that. That is what allows people to be passed around. There are models in other places where people have piloted, saying: "Well, it is a bit like who is holding the baby? Someone has to be." So you cannot just pass this off and say: "It is not me." You have to agree with the next person who it is, and they have to take responsibility. We are thinking about that.

Deputy G.A. Raimondo:

Sure. Thank you. Right, I think that is ...

Deputy B.B. de S.V.M. Porée:

Are you happy with that? Okay.

Deputy L.D. Carpenter:

Thank you, Chair. Minister, the States Assembly adopted the prior panel's budget amendment requiring a women's health strategy to be published this year. Could you provide an update on the progress and confirm when you think the strategy will be published?

The Minister for Health and Social Services:

If you are happy, I am going to hand directly over to the Assistant Minister, who is responsible for this.

Assistant Minister for Health and Social Services:

So we did agree that it would be published by the end of the year, and it will be published by the end of the year. We had officers working on it throughout this year. We have involved the G.P.s, obstetric and gynae consultants, sexual health group, adult and children's mental health, and then we have worked using the Joint Strategic Needs Assessment, which is we undertook a women's health survey and published that at the end of 2024, I think. So that forms the basis of it, and then this year we have also involved government-provided services - primary care, and the third sector, the charity sector - and we have had a multi-sector workshop in May of this year to work out the priorities.

[15:00]

Deputy L.D. Carpenter:

Thank you. So in terms of the priorities, are you able to give some information around any established priorities or outcome measures for the strategy?

Assistant Minister for Health and Social Services:

I think probably the most important thing is that we want women to be listened to and not to be dismissed, and have welfare saying "addressed". I think that is probably the most important thing. We want women to know and girls to know that we really care about them and that they know that they can be offered compassionate, safe, clean care.

Deputy L.D. Carpenter:

Thank you. Are you able to give any information on how it would be funded?

Assistant Minister for Health and Social Services:

I think we are probably going to use mostly money that is already in the system, but we may be able to use some of the prevention budget going forward.

Deputy L.D. Carpenter:

How will the Minister or Assistant Minister ensure that publication of the strategy is followed up by implementation, and that it will be implemented?

Assistant Minister for Health and Social Services:

I think that would be our responsibility to make sure that ...

The Minister for Health and Social Services:

We usually have an implementation plan that runs alongside the strategy. That is something that we decided some time ago. You will normally find when a strategy comes out there is an implementation plan that goes with it, because we defined quite early on that it is pointless having a strategy if you are not going to explain what the plan was to implement. That should be running parallel.

Assistant Minister for Health and Social Services:

During the last couple of years we have had a women's action plan and we have been focusing on women's health throughout their whole lives, so before being born to when you are 103. We have been prioritising as we have gone and doing things to improve.

The Minister for Health and Social Services:

The truth is that a lot of the services are being delivered by existing services, so it is a case of making sure that there is the right focus and the right resource within all of those areas to make sure that women's health gets the priority that it requires. It would be nice if there was a printing machine and we could have some more money especially for women's health. That would be great. But at the moment - as we do in so many other areas - we have to make do with the funding that we have got.

Assistant Minister for Health and Social Services:

We have improved the maternity services over the last few years; we want them to be as good as they possibly can. We have improved the screening services for breast and cervical screening, and then we are trying to improve bowel screening. There are lots of bits that are going to fit in.

The Minister for Health and Social Services:

But as you rightly say, if it is preventative issues for women's health then that prevention money is there to be taken for those purposes. Ruth, you look keen to add something. I am sure you have got lots more to say than we have.

Director of Health Policy, Health and Care Jersey:

I was wondering if it might be helpful if I give you a practical example of some of the things that we will be looking at achieving. As the Assistant Minister says, we will produce a strategy and publish a strategy before the end of the year. We have been through a consultation process. That strategy will set out a range of changes that we want to deliver in order to improve women's health. There is no additional money so what we have to do is think about how we can deliver those changes within our existing resources. An example of that would be that in Jersey at the moment women up to the age of 21 can receive free contraception through what used to be called Brook Jersey and is now called S.A.Y.J. (Sexual Health Advice for Young People in Jersey). One of the things that we think we should probably be doing - and this will be set out in the women's health strategy - is extending access to free contraception to women at a later age. We need to decide what that age is. Lots of other jurisdictions provide free contraception up to the age of 25 because they work on the principle that when women start to reach the age of 25 they start to be more economically independent, they tend to have finished university, so they have got more available money to spend on contraception. Some other jurisdictions go beyond that. The U.K. provides free contraception to everybody of all ages. It is very expensive. Also interesting to note that while the U.K. provides free contraception to everybody it also has quite high termination rates, so there is not necessarily a correlation between those things. We are looking at the potential to offer an extended range of access to free contraception, but as we have no new additional monies we cannot just pay for more free contraception. What we will be doing is undertaking a wholesale review of all the contraception services at the moment, how we are investing in spending that money at the moment, and seeing if we arrange and organise our services differently if we can create the efficiencies that will allow us to extend that contraception offer. There will be a strategy published, that strategy will set out what we want to achieve, but achieving it will require us to think and work hard about how we do that.

Deputy B.B. de S.V.M. Porée:

You did mention the setting up of the new strategy board to look at women's health. Who do you anticipate will be the people who will contribute to the conversation within this board?

Director of Health Policy, Health and Care Jersey:

There is a steering group that is currently overseeing the development of the strategy and that has sitting on it a G.P., someone from children's mental health because it is a women and girls strategy, someone from adult's mental health, someone from our sexual health services, and also people who work in our obs and gynae services. So a steering group of clinicians and service providers

overseeing the development of the strategy. We have then gone out to consult various different providers of women's health services. We have a first draft of the strategy; you have multiple iterations of these things and we are working on that first draft at the moment. We are envisaging that in October we will be going back out to the people who we have already spoken to about the strategy to say: "This is our draft, what do you think are the priorities within that?" ahead of publication in December.

Deputy B.B. de S.V.M. Porée:

I was more trying to understand within that strategy board what is the percentage of women sitting there. That is where I was looking, sorry.

Director of Health Policy, Health and Care Jersey:

There are lots of women providers who happen to be sitting ...

Deputy B.B. de S.V.M. Porée:

It is really important if we are going to talk about women's health.

Director of Health Policy, Health and Care Jersey:

... there are also some men as well. What we have done in terms of consulting women, we have done that in multiple different ways. As the Assistant Minister mentioned, the work that informs the strategy was based on the Jersey strategic needs analysis of women's health. That was developed in 2023 and 2024, and that involved a survey that was sent out to women, to which we had thousands of women who responded to that and also a whole group of face-to-face meetings and focus groups with different groups of women to talk to them about their health priorities, so we have that as a source of information. We also undertook a review of our contraception services which, once again, we did by a direct survey with women responding to that, so we have that as a source of information. Also when we did the work on the Termination of Pregnancy Law we had women who responded to that, and while the subject was termination of pregnancy they obviously talked about other gynaecological, reproductive matters that were important to them in the feedback. Then in addition to that, as part of the development of this strategy, the steering group held an event back in May, to which we had service providers invited, and they also brought to that event women who were users of their services. Women's voices are echoed within the strategy as it is being developed. Women, like all group of people, do not necessarily speak with one single voice though, so we have to acknowledge that.

The Minister for Health and Social Services:

Rarely.

Deputy B.B. de S.V.M. Porée:

Thank you.

Deputy G.A. Raimondo:

Okay, fun one now; cannabis. We will start with medicinal cannabis. The number of medicinal cannabis prescriptions has increased significantly in recent years and, in fact, is significantly higher compared to comparable regions. Has the department undertaken any review of the prescribing patterns, the patient outcomes, and the clinical governance arrangements surrounding it?

The Minister for Health and Social Services:

I am happy for you to take that, Ruth, because it is very complicated territory.

Director of Health Policy, Health and Care Jersey:

You are absolutely right; levels of medicinal cannabis prescribing in Jersey are high. We have known that for quite a period of time. They are higher than lots of other jurisdictions, although it is important to note that other jurisdictions over a period of time are also seeing an increase in their medicinal cannabis prescribing. For example, there has been quite an exponential rise in the U.K. as well, to the extent that the U.K. Advisory Council on the Misuse of Drugs is undertaking a review of medicinal cannabis prescribing in the U.K. We may have seen the rise in Jersey earlier than some other jurisdictions but it is a trend that is also happening in other jurisdictions. One of the reasons why our prescribing rates may be higher in Jersey is that in lots of other jurisdictions they have very strict controls on who can prescribe medicinal cannabis. In the U.K. medicinal cannabis at this point in time can only be prescribed by a medical consultant; it cannot be prescribed by a G.P. or by another doctor. In Jersey our law permits medicinal cannabis to be prescribed by anyone who is a prescriber; so they may be a consultant, they may be a doctor, they could be a nurse. Potentially they could even be a dentist or a vet, but that does not happen in practice, okay. In practice, the people who are prescribing medicinal cannabis in Jersey are doctors rather than consultants, except for when you have a consultant in the hospital who is prescribing licensed medicinal cannabis as opposed to unlicensed medicinal cannabis, for something like someone who has multiple sclerosis. There are a very few and small number of circumstances in which medicinal cannabis is a licensed medicine rather than an unlicensed medicine, which basically means that someone says: "You take this amount this often, because we can evidence that it has an effect on this particular condition." Most of the cannabis prescribed in Jersey is unlicensed, so there is no evidence that: "You should take this amount for this condition to have this effect." What we have done is we have looked at a number of options for how we ensure that we have better controls around our medicinal cannabis prescribing. We have gone out to consult with medicinal cannabis prescribers in Jersey about some new legislative controls that we are going to bring into place. Those legislative controls still allow a doctor to prescribe medicinal cannabis, but that doctor has to

have a responsible officer in Jersey. A responsible officer is a G.M.C. (General Medical Council) doctor who holds other doctors to account. Most of the doctors at the moment who are prescribing medicinal cannabis in Jersey do not have a Jersey-based responsible officer, which means that Jersey cannot intervene in their prescribing practice. So we are looking at doing that as part of our new controls.

[15:15]

We are also looking at how we place requirements on those prescribing doctors. For example, we are looking at saying: "If you are going to prescribe to someone you have to have a face-to-face appointment with them." A lot of the appointments at the moment are remote because the doctors are in the U.K. prescribing to Jersey patients, and there is a lot of remote prescribing going on. We are looking at that. We are looking at the maximum period of prescription time a person can have without there being a face-to-face. We have developed a range of proposed controls, we have consulted with medicinal cannabis providers around that. Most of them are really supportive because they recognise that it is really important to protect the interest of patients. We will be starting to consult patients, so people who use medicinal cannabis, next month on those controls, and then we will be bringing them forward as legislation. So that is phase one of the work we are doing. Phase 2 of the work will be about potentially - subject to consultation - setting up a register of prescribers in Jersey. Then you can place standards on those prescribers' practice and you can deregister them if they do not adhere to that practice. That is a much more complicated legislative solution, which is why we are doing 2 phases. Phase one is easier and quicker to deliver, it deals with some of the immediate issues. Phase 2 is longer term but has potentially more stringent controls around it.

Deputy G.A. Raimondo:

Phase one, including the reviews, has that started? Is that taking place at the moment?

Director of Health Policy, Health and Care Jersey:

Yes. As I said, we have consulted the medicinal cannabis prescribers. Next month, October, we will be consulting medicinal cannabis users, and we would probably see those controls introduced within the first quarter of 2027.

Deputy G.A. Raimondo:

Okay, I just wanted to confirm whereabouts in the timeline. Looking more at monitoring then, is there any monitoring going on to assess the benefits, adverse effects, and then the long-term outcomes for patients accessing medicinal cannabis?

Director of Health Policy, Health and Care Jersey:

As part of the proposed controls in phase one that I was just talking about, what we are proposing is introduced is a requirement on all the doctors who prescribe that cannabis to keep a record of adverse effects. That record of adverse effects can then be interrogated by the Minister so we will understand what adverse effects look like for patients in Jersey, because we do not currently have insight and intelligence on that. What we do know is we know from what is happening in other jurisdictions quite a bit about the impact - both the benefits and the adverse effects - of cannabis use on different cohorts of people. That is complicated scientific and epidemiological studies that we do not have the resources to do, so like lots of our activity we have to sit back and rely on international evidence, which we do. For example, when it comes to the impact/potential impact of cannabis use on people with mental health problems we look at what international evidence tells us about that, but obviously we also - through the work that Andy is doing - look at what we see happening in our services. But that only gives us a small insight into the people who come into those services.

Managing Director, Health and Care Services:

That is right. We read reports now and monitor every admission into Adult Mental Health Services where someone has become so unwell that they have needed to go into hospital. We make a note if someone is using cannabis as part of that admission. There is a reporting system for when someone is prescribed a medicine and it appears to create an adverse effect. You can internationally report it using what is called the yellow card system. We do that. If someone is presenting, for example, with a significant deterioration in their mental health unusually, as the result of cannabis use, we report that so there is an oversight of the potential impacts that cannabis may or may not be having. The Alcohol and Drugs Service collects some information around diversion, so we know that we have some issues around medicinal cannabis being prescribed and then sold, and the people that are buying it then experience significant difficulties. We particularly hear about that anecdotally through our Alcohol and Drugs Service, so they keep some information around that as well. But Ruth is right, the small local information is just part of a much bigger picture.

Deputy G.A. Raimondo:

I want to go back and touch on the selling of it in a second, but first of all going back to mental health. On the other side of that, is there any way for a prescriber - which I guess now could include a vet - to know if the person that they are prescribing has accessed any sort of mental health care at all?

Managing Director, Health and Care Services:

They ask the person currently. There are ways, and there have been lots of conversation about the cannabis prescribers having access to G.P. records, and that is one of the things that I would very much encourage. You cannot just rely on what someone says to you; if you are going to safely

prescribe it is advisable to check. We have had deaths here where the Viscount has made a recommendation in relation to the use of cannabis contributing to that death in the context of someone with serious mental illness who was known to have had adverse responses to cannabis previously. So, yes, there are ways in which it can be done, and that is one of the conversations. I have just completed an incident investigation into another death where cannabis was involved and one of the recommendations that I have made is that we need to bring together primary care, secondary mental health services, and the cannabis clinics to have a conversation about how we can improve our governance collectively, because at the moment people are sliding through some of those cracks with impact.

Director of Health Policy, Health and Care Jersey:

I wonder if it might be helpful as part of the phase one controls that we are bringing forward, there will be a legal requirement on doctors to check the person's medical record.

Managing Director, Health and Care Services:

Excellent.

Director of Health Policy, Health and Care Jersey:

We are introducing that as part of the phase one controls. It is not in place at the moment. Most doctors do - and that is the thing to understand - most doctors do already do that but we will be bringing forward that as a legal requirement.

Deputy B.B. de S.V.M. Porée:

That is quite interesting; I thought this was already in place, that there would have to be a communication taking place between the cannabis provider and the G.P. of the person requiring that.

Managing Director, Health and Care Services:

There is no requirement.

Assistant Minister for Health and Social Services:

Nothing.

Deputy B.B. de S.V.M. Porée:

So it is still the kind of willingness to do so or not. So some of the cannabis providers could be more due diligent in making those connections rather than others?

Director of Health Policy, Health and Care Jersey:

Yes. So it is absolutely the case that some of them do - probably the majority of them do - but it is not required by law. What we are doing is we are requiring it by law, which means that if it does not happen we can take action against it. There are also some very practical things, which is about accessing the patient's record because of course that data - the patient's record - sits with the G.P. and it belongs to the G.P. A medicinal cannabis prescriber does not have access; they cannot go on a computer and look up that person's record. Working with our colleagues in primary care we are developing a system that allows for the easier exchange of information where there is something on that person's medical health record that the cannabis prescriber really needs to know about before making a prescription.

Deputy B.B. de S.V.M. Porée:

You would say that is really necessary.

Assistant Minister for Health and Social Services:

I think perhaps a States Assembly or 2 ago brought in the fact that lots of people could prescribe cannabis without the regulation. Unfortunately that was passed before we had the regulation and I think that was a mistake.

Deputy B.B. de S.V.M. Porée:

Thank you for that.

Deputy G.A. Raimondo:

Going back then and looking more towards people that are accessing prescriptions and then selling that onwards - and I know it happens because I have seen it, I am of the age group where that happens quite a lot - what is being done there with law enforcement agencies, G.P.s, specialists, prescribers to ensure that does not happen?

Director of Health Policy, Health and Care Jersey:

We know anecdotally that there is a diversion of medicinal cannabis; we cannot tell you what those amounts are. In terms of what action the police are taking, that is something that the Minister for Health and Social Services cannot respond to. That is a question that you would need to go and ask the police force about, but through the work of the Advisory Council on the Misuse of Drugs, which we have in Jersey, we do know that it is an active conversation and a matter of concern. A lot of that goes back to us having really good prescribing practice in the first place, so the people who are being prescribing medicinal cannabis are being prescribed it for a medical reason, not for the purposes of a diversion.

Deputy G.A. Raimondo:

Moving slightly then to personal cannabis use. There was a proposition that was put forward and then withdrawn, the Future Approach to Personal Cannabis Use. It obviously had options relating to the personal cannabis possession, cultivation, potential regulated market, and obviously was withdrawn. Can the Minister provide details as to why the proposition was withdrawn and whether any of the aspects of it still remain under review at all?

The Minister for Health and Social Services:

Once again, complicated territory and Ruth will give you a much more comprehensive answer than I can.

Director of Health Policy, Health and Care Jersey:

When the report and proposition was lodged, one of the things that was set out in the report was the fact that we were in discussion with the U.K. Home Office about the options set out. The reason why we were in discussion with the U.K. Home Office is that there are international conventions that control cannabis, they control narcotic drugs and cannabis falls within that. So with all international conventions the U.K. is the signatory to those conventions and it is extended to Jersey. That means that if Jersey, as a matter of its public policy, is doing anything that has a bearing on those international conventions we need to consult and work with the U.K. Government because the U.N. (United Nations) holds the U.K. Government to account for compliance with those conventions; not Jersey to account for the compliance of those conventions. So the Minister, on behalf of the Council of Ministers, lodged that report and proposition. We then withdrew it because we realised post-lodging that one of the 3 options that was set out in that report and proposition was causing confusion. The report was not as clear as it could have been or it should have been, so we withdrew it in order for us to do a bit more work and relodge it. What has happened is subsequently we have had an ongoing dialogue with the Home Office and, as a result of that ongoing dialogue, the Minister will be meeting with the original proposer of the recreational cannabis work, Tom Coles, and with the Council of Ministers, to determine how to proceed. We are midway through the process of sorting out what that looks like, but I would imagine that the Minister will be in a position to confirm how he is going to progress within the next month or so.

Deputy B.B. de S.V.M. Porée:

Thank you. Can I just stop everyone because I need to make us all aware that we are coming very close to 3.30 p.m. I would at this moment ask if you would be prepared to stay a bit longer so we can finish the set of questions, but otherwise the other option, if some of you have got other commitments, is to send you the rest of the questions we have proposed and hopefully you can reply to us in writing. There is still a bit but I am just very aware that time is running short now.

The Minister for Health and Social Services:

Under normal circumstances I would be very happy to stay but I know I am supposed to be somewhere sharp at 3.30 p.m. Are you happy that we do in that writing, if that is okay?

Deputy B.B. de S.V.M. Porée:

That is fine. I would be ...

The Minister for Health and Social Services:

Thank you. Sorry about that but, as I say, it is quite an important ...

[15:30]

Deputy B.B. de S.V.M. Porée:

No, that is perfectly fine. It is the time we have had allocated, we have run over and, therefore, as a panel we may have to tweak the time because 1½ is not enough. My next set of questions was going to be on discharge letters and the issues involving all that, so maybe sending that reply to us in writing will give us a better opportunity to collect that data and let the wider public understand what the issues are. I am sorry you came here and you are probably all prepared to give us the good answers, and we still need those good answers, but it may have to follow.

Deputy C.D. Leck:

Sorry, I do not know the answer but if we ask a question in writing and then you write back, is that then available as public record as if it is part of ...

Deputy B.B. de S.V.M. Porée:

The same way as if it would be ...

Deputy C.D. Leck:

Okay, so, Minister, you should be aware of that, that is all.

Deputy B.B. de S.V.M. Porée:

... a face to face, and hopefully the Minister and your team will be able to reply to us at earliest convenience so we can put it out there, okay.

The Minister for Health and Social Services:

Yes. What I would say is we normally would have a little bit of time over and I will try and make sure next time we will all leave ourselves available for potentially another half hour if we need it.

Deputy G.A. Raimondo:

Next time we will have to try and focus for 2 hours instead and book out 2 hours so it is easier than you guys having to mess around with your schedules.

The Minister for Health and Social Services:

Well, 1½ is fine, we will just allow for an overlap if you need it.

Deputy B.B. de S.V.M. Porée:

It is our first quarterly with the Minister and the new team so obviously we can always adapt and adjust things a bit better. We are just very thankful to all of you for your time, and your answers have been quite generously explained, and we do appreciate that. We will send you the rest of the questions and we will look forward to your answers.

The Minister for Health and Social Services:

If I could thank you for your wonderful chairing and the friendly atmosphere that has been created, and I thank the team because, as you know, these guys come up with some very detailed answers, so I am very grateful to them.

Deputy B.B. de S.V.M. Porée:

I did hear, yes, so thank you, much appreciated.

[15:32]