ST HELENA LEGISLATIVE COUNCIL

Select Committee 1 of Legislative Council
Fourth Live Evidence Hearing

Monday 19th May 2025 at 10am
At the Council Chambers

H&SC: Provision of Facilities and Services

The inquiry will focus primarily on the following:

- ***Hospital (including Palliative care)***
- ***Community Care Centre, Sheltered Accommodation and Domiciliary Care***
- ***Safe Haven and Children's Home.***

SESSION 2

Address by Chairman, the Hon Robert Midwinter

The Hon Robert Midwinter
Okay, thank you. We now return to our program of business for today and in this second session the Select Committee will focus on the main activities, main areas of policy and procedures, within the areas of Health and Social Care that we are reviewing. We are not focusing on the EHRC response here. This is the original questions that the Select Committee were looking at, there may well be overlaps, unfortunately, but this is the main focus of questioning that we had intended. I would hope that, because we had such a long session this morning, that this session would pass a little bit quicker, but we will, we will see how we go, and I have built in the possibility of a further break, should we need to do so. So without further ado, I would like to just raise two areas that regularly come up during the constituency meetings. Actually, no, I'm not going to, because we covered that off earlier today. So that did come up this morning. I'm going to take that out. I have one other, one other that regularly comes up, and that is

just about the quality of food at the hospital. So, and I'm aware that work has been done to address those concerns. So, could you just give me a very quick response on what has been done to address concerns about food?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
I think we're going to ask Ros to answer this question, but in summary, we have centralized the cooking of the food to ensure that we don't have two kitchens running at all times, because that's not necessary and proportionate, and it doesn't make a good use of our recurrent budget. But what we wanted to do also is make sure that the quality of food was consistent across Health and Social Care. So not only does the CCC cater for the hospital. It also caters for other care settings, across social care, and it also caters for individuals within the community where absolutely necessary. So, I'm going to pass over to Ros, because she's been instrumental in improving the offer in terms of hot and quality food at the hospital, but I also wanted to add that it was reviewed continuously by the dietitian that was on island previously, and now we have a specialist diabetic nurse who also has a dietetics background. She will continue to support the quality of food being provided to the people in hospital and across the island from a social care perspective. So, if I can come to Ros to answer the rest of the question.

Rosalie Brown - Head of Service, Social Care, Adults and Children
Yes, we have, I know there's been a couple of concerns raised previously, and we have tried to improve things just to add, it's the menu, what, what is sent down to the hospital is the same menu, what is provided at the CCC. It's a menu, what has been done in line with previous dietitian when she was on island, and that's constantly reviewed. We do take on board people's concerns if they don't like something, and that is not only at the hospital, the CCC, and also sheltered accommodation, because we provide and deliver, deliver meals out there. So, if somebody doesn't like a certain thing, we can re look at it daily. There's a choice, so that there's a choice for lunch and there's a choice for the evening meal. And again, if somebody doesn't want that choice, then we will provide an alternative. We do. There's been a lot of concerns and radio on about the hotness of the food and that it's cold that has been looked at. We've now provided another hot trolley down, down at the hospital. So, when food is brought down in the insulator box, it's put straight away in the in the trolley down there and served from the up trolley. I think on us doing that, we've not had as many as many complaints to what I'm aware of. I do go in on a regular basis and quality check the food. And also, we do have a patient's complementary slip. We hardly get any. And they are given at the end of a discharge by the nursing staff. And most of them, what do come back they come back not even completed. So, we have, we have introduced that, introduced that as well. But hopefully the standard of food is constantly checked, it's constantly looked at. We've always, there's always room for improvement. And I think it also depends on what age group you've got in as well. And sometimes, if it's probably younger people, they don't always like what, what the menu is for an older person, because predominantly, we're serving like Saint food and casseroles and choices. But in between, in between the menu is what goes down. Then they have afternoon tea, where the sandwiches and cakes sent down. There’s fruit, there's jellies, the soup sent down twice a day, and that's in an hot tureen . So, if some somebody doesn't feel like a meal at supper time, but would like some soup at eight o'clock and a sandwich, there is the provision there for him to get that.

Tim McDermott - Head of Governance and Safeguarding Lead
So I just want to add the thing about food has come around a number of times, and I know people have raised in that in the House here as well. I think the figures of complaints that formal complaints that we receive relating to food is negligible. In the last year, we had one specific complaint, and that was to do with the temperature of the food and but amendments, like Ros said, changes were made to ensure that

the food was hot at the point is served at the hospital. We haven't had any complaints at all about the quality of the food or the menu or anything like that, directly to us. But then, after the fact, we will occasionally hear in the community somebody moaning or complaining about the food, but that's not coming back to us formally, and we need to get that information in of what the issues potentially are, but formally, we haven't really been notified of any real concerns.

Rosalie Brown - Head of Service, Social Care, Adults and Children
Likewise, nothing's coming forward formally. And as I said, we do, we do, we do, make the regular checks.

The Hon Minister Martin Henry
Thank you for that, Tim. And I think just to add to what Tim just finished saying, I think this is a really important element to add, because I feel sure, yourselves experience similar elements to which I do, which is I will receive, sometimes multiple complaints about the food, but it isn't from the person who has the complaint, it is from someone else who has handed it on. Hence my comment earlier. And then, as per usual, sometimes on St Helena that escalates to you know, 100 people had an issue with the food, but we only have one complaint for this year. So first and foremost, that might the most important thing I would ask patients to do is fill in that form that we provided. And secondly, is to if that's not the case, then, then to make a complaint. But don't just say the food was, but make a complaint on what you thought was wrong with the food. In particular. Let's remember, I mean, that is a struggle here sometimes to get the ingredients we require. There's also the cost element involved. And we are providing a basic supplement food for the potential stay in hospital and the variety that goes with it for when, like residents of the CCC, etc., receive so, so a lot of input goes into providing, providing a food service. However, it is, once again, limited by these criteria. We can't provide gourmet food. We're not a restaurant. It's an environment which is catered for needs, rather than an overabundance of expectations. I think it's just important to put that into context in terms of, what do you require the service for? Especially when you go into hospital, it isn't the food. It is. It is for the medical service, and the food is provided needs to be provided at a standard, not at a gourmet quality.

Tim McDermott - Head of Governance and Safeguarding Lead
Sorry, I just pointed out. I mean, when the Minister makes comment around the resource heaviness of this, when a patient stay at the hospital for one day is charged out at about 13 pounds, I believe, and within that, you will have like, you will have your breakfast, your lunch, your evening meal, your sandwiches, your coffees, your teas, your you know, your soups. You know this isn't this, this is not that we're slimming down and, on a budget, or anything like that. You know, the amount that we provide is what, is what we can do within, within the money we have available.

The Hon Robert Midwinter
Okay. Thank you very much.

Rosalie Brown - Head of Service, Social Care, Adults and Children
Can I just add further? We have had instances as well where it's very difficult for portion control, particularly when people's being discharged or people's coming in, and we have had times where patients have not wanted the food, either due to having sufficient or being unwell, and that food has been taken home by a family member. So, I just wanted, just wanted to raise that that's so yeah, and that and that, that has happened on a number of occasions.

The Hon Robert Midwinter
Okay, thank you. Just going back, and I know we did touch on, Councillor Ronald Coleman did touch on booking of appointments this morning. Can you, can you say what the current waiting times are, and also what constraints currently consist in this area, and in particular, I'm interested, do you hold statistics regarding failed appointments, basically when somebody fails to turn up for an appointment? And can you say how many of these are currently occurring on a weekly or monthly basis, and the impact that this has on waiting times for appointments?

Tim McDermott - Head of Governance and Safeguarding Lead
Yeah, I think I'm quite well placed to answer this. So, we do track appointment times, specifically in Jamestown, but in other areas, in the outer clinics as well, the current wait time for a GP appointment on average is less than two weeks. The average appointment time is, I think it comes in at about six or seven days for a routine appointment. Obviously, we have our outpatient nurse triage system, wherein people will often get seen in the same day. If they need to, they will be seen, you know, shortly after being seen by the nurse. So routine appointments are within two weeks currently. We started tracking the failed appointments rate towards the tail end of last year, noticing that there was a significant number of do not attends. Unfortunately, with our appointment system at the moment, it's a very manual job to do, to physically count how many people didn't attend, and it's a bit we're missing because I don't have the figures to hand, but we did, the Minister and I did an in scope on this recently, and the number of failed appointments is significant. And in certain key areas, it's as upwards as much as 20% of all appointments have failed. I think gynaecology is probably one of the key areas where we get a significant number of do not attends that that one, I think, on the last check round, was, was about 25% and the GP appointments then are anything between 15 and 25% in any given week. What we did realize, when we did the first-time round of this, we realized in a six-week period, no in a one. Month period. Sorry, we lost an entire week of GP clinic appointments by people who didn't attend. What we would ask people to do is, if you no longer need the appointment, is to let us know. You know that that courtesy means we can, we can then go to our list of people who need appointments, or on who got appointment booked in a couple of weeks' time, but would like to be seen earlier, and we can contact them and ask them if they'd like to come in. It makes our life considerably easier, and it frees up some of the time for the, you know, to make sure that people can get seen much quicker. And the other area I would like to point out is dentistry. We have a significant number of people who don't turn up for dentistry, and dentistry appointments can be anything up to an hour, hour and a half, or kind of more complex treatment that really, really can affect the turnover of patients through the dental clinic. One cancellation could have been as many as, you know, five check-ups that we could have done. So it is a significant problem for us.

The Hon Minister Martin Henry
Thank you, Chair and I, great that you raise such an important point around appointments, because this was the first thing I think we started with when we came four years ago, and it's something that I spent nearly the first part of this tenure trying to address. I just want to make a couple of things quite clear, which is that there is a limit on how much you can effectively reduce the waiting time on an appointment. So, for instance, reducing the waiting time on an appointment to 10 days or two weeks, as we speak, would be exceptional anywhere else in the world, especially for a service like this. And I mean exceptional. The UK is struggling to get its appointments down to such levels, so is many other European countries. I think the best one I have seen in some latest research, I think, was either Germany or France, which was down to about the same as ours. That's the leading nation in terms of time. So, I just want to make that point absolutely clear, there is no, and I don't want it to ever be an

expectation that someone can pop up on the same day and get a GP appointment just for a routine check. We do have areas which we are still working with in resolving. In terms of the trials, there are sometimes a little bit of misunderstanding in between, but those are individual areas that we address as and when. But in general, I am happy with, very happy with the waiting time on appointments, given the global circumstances, given what we're trying to achieve here, and also given the request for appointments, which I can remember, given to the Council at some stage being about, we are providing over 500 appointments per month just for GPs, which is exceptional for a population of 4000 people.

The Hon Robert Midwinter
Thank you. Okay, thank you, in which case I will now hand over to my colleague, the Honourable Ronald Coleman.

The Hon Ronald Coleman
Thank you, Mr. Chair. I'm going to ask a few questions around the hospital. So, with the recent refurbishing of the hospital, how many bed spaces were lost? That's my first question to whoever

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
The refurbishment of the hospital predates myself. Councillor Coleman, we have 20 beds in the hospital and then four oncology beds. So, if it was previously a 28 bedded Hospital. My assumption is that we lost four.

The Hon Minister Martin Henry
Can I just respond on the developer needs of the population as well? Because that's an important point. So currently, some of the spaces are being taken up by sophisticated pieces of equipment now, which you know we will come to now expect to be able to use, but they are relatively new. So, for instance, there was a whole ward review. We now got the CT scanner, and because, as there was a whole ward we now got the cancer unit. So, these are really important in hospital elements that needs to be addressed. So, the last of the bits wasn't wards, it is significant, but only significant because we are being held by the other element we mentioned earlier, which is sometimes we have social care patients that overstay. So that if the social care element was taking being taken care of right now, the hospital is still absolutely fit for purpose, for in terms of bed space, for the current population.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Can I just add that we monitor capacity at the hospital on a weekly basis? So, meet every Monday morning and look at how many people we have in hospital. And during the time that I've been employed within health, which is three and a half years. I don't think we've ever been over capacity. I don't think we've ever been at a point where we've had to add beds, per se. So, I think we've managed it quite well, regardless of the fact at times we've had 10 or 11 people waiting for social care.

The Hon Ronald Coleman
Yeah, thank you. I was going to ask about the loss of space and what's been used for. And you've also answered the other question that will be adequate for now in the future, can I just ask how many private wards are there in hospital, or single wards?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Single beds, single wards?

The Hon Ronald Coleman
Right?
Tracy Poole-Nandy - Portfolio Director for Health & Social Care
So, well, there's no there's no private wards, but there are single bedded rooms. So there's two of those in the hospital, and then you've had the mental health bed as well.

The Hon Ronald Coleman
Thank you. Do you have a children's award?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
No, we don't have a children's ward, but what we do have is we have an obstetrics ward for people that are in labour, so we can utilize that Ward more effectively. But generally, what we do use is a single room so that parents can remain with their children, and that is an expectation that they'll remain with their children for their duration of their stay in hospital.

The Hon Ronald Coleman
Thank you. The other question leading on from that was, do you have adequate incubation units to manage premature babies?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
We do not have adequate incubation units. Councillor Coleman, we have two incubators, both of which require work. So, we do not have, we do not have adequate incubation units. But that said, we've managed, very recently, managed to premature birth successfully with the use of the permanent with the incubator unit that we have. That doesn't work very well, but we've managed that successfully. Baby was then transferred to South Africa and is doing incredibly well.

The Hon Ronald Coleman
So in regards to how you support babies that are born prematurely, you would benefit greatly from a new incubator?

The Hon Minister Martin Henry
I would just like to remind the team at this point that, as you all know, as a Government organization, in budgets, etc., we do not have access to an OPAC or an operate a Capex funding. So, there isn't, every year a submission that we can we can make, particularly on its own, that we can get capital equipment from. In recent years, we have had access to what is considered the essential equipment funding. And the equipment that you are talking about now was put on that funding list, but there is a huge number of other pieces equipment, and it will go on a new funding list. If that funding becomes available, we understand and see the need for it, but however, this particular area does have a specialist doctor in that area, and we have in recent years, used the South African service because we won't take a chance with mothers and babies. It's something that we tend to do because of how quickly things can develop. The service is very keen to ensure that we operate as safe as possible within our means?

The Hon Ronald Coleman
Can I just ask how much one incubator would cost?

The Hon Minister Martin Henry

I am unsure of that cost, but we did. We did put a new request.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Yeah, I think, I think they're in the average of about 10 to 15,000 pounds.

The Hon Ronald Coleman
Yes, why I asked that? Because there are also outside donors who might want to donate for 10 to 15 pounds, not a lot of money.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Absolutely, we do always welcome a donation.

The Hon Ronald Coleman
Thank you for that. So, we do have a paediatrician, you said, or is it?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
No, we have a, we don't have a paediatrician. We have a specialist anaesthetist consultant. So ordinarily, babies that are born, we have an ops and Gynae consultant, and we have a specialist anaesthetist on island. So, between the two consultants, they would successfully support the delivery of a premature baby, or did support the delivery of the premature baby and then the safe transfer? Well, we don't have paediatrician on an island because we have to, we have to, again, manage within our resources. And the demand placed upon a resource of a paediatrician is not high enough to have a full-time paediatrician. What we do have is we have a constant we have access to consultant paediatricians, both in South Africa and the UK. And this is, these leads on to some issues that we have in regards to children that have complex health needs, and how their health needs probably would be best met, not on island, if you will. So, if you have a child that's got a long, complex health need and will require lifelong treatment, we have the support from the UK and South Africa, but primarily the UK.

The Hon Ronald Coleman
Thank you. You mentioned earlier about the residential care patients, patients waiting for residential care being accommodated at the hospital. How many of those patients you can accommodate at any one time?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
We'd rather not accommodate any Councillor Coleman, but we've accommodated up to 10 at one point, I think on the, in the main the female Ward has a majority of the people awaiting discharge for social care beds. So, a preference would be to keep it down to one to five, if at all possible, and even less, we try to make sure that we have plans in place with the support of the heads of service in social care in regards to safe discharges for those people. So, we don't want to have anybody in hospital for any length of time because it's not in their best interest. They become very socially isolated. They become institutionalized because it's not a natural environment. So, if you're entirely honest, from a social care perspective, we don't want anybody in hospital unless they need to be there.

The Hon Ronald Coleman
So, moving on. Then. How does this affect the running of the hospital when there's serious bed blocking?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Well, it's the same with any other hospital across the world. Everywhere is the same. I think when the Speaker of the House, Lindsay Hoyle came to visit us on the Island, we did make reference to the fact that we had a quite high number of people with delayed discharges, and he just saw us as same as everywhere else, and it impacts the day to day running the same as it would with any other service. So, for example, we have to have additional staffing on to meet that need. We would have, it would impact us in the event that we have a specialist visiting. So, we probably have to reduce the numbers of people that were treated by the specialist visitors, or hopefully get them in and out as a day patient, because everybody has to recover from the anaesthetic. So, it just impacts the practical arrangements around that and the demand. You see, you can't just leave people in a bed. You have to make sure that they need to wake, that they're clean, they're dressed, and they're fed. You know, you have to have that interaction with people. So, it has a day-to-day demand.

Rosalie Brown - Head of Service, Social Care, Adults and Children
Thank you. If I could just add as well, then Councillor Coleman, when we have had people in hospital, waiting for a bed with one of our services, what we try to do is encourage them to get out of the hospital because of the social side of it, and we do bring them into day-care at the CCC to try and like ensure that they are, that some of the needs are met socially because they can become socially isolated.

The Hon Ronald Coleman
Thank you. So, I don't know if you'd be able to answer this, or you might be, who would be responsible for redesigning things like the hospital and was expert advice brought in for what you've got now,

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
I think, I think again, it's, exactly the same as the CCC. I think its specialist architects that have been brought in. But generally speaking, the funding is given to us by the UK Government. So, the lead would be in conjunction with FCDO and UKG, if it's the money that they're supporting us with, also it would be informed by whoever at the time that the hospital was reconfigured, the Director that was in post at the time in regards to clinical demand and need.

The Hon Ronald Coleman
Yes, so you wouldn't have known if the front steps were considered to be taken out.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
No, I don't. I'm sorry. It predates, I think even myself being on island.

The Hon Ronald Coleman
Thank you. Can you say what types of care are offered in the hospital, the different types of care now?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Now, so everything really, so you've got primary and secondary care. So your primary is your GP appointments. Occupational therapist is your specialist, in terms of keeping, you know, making people safe within their own environments, physio therapy. We've got mental health support. We've got Ops and Gynae, you've got your general day to day care, your emergency care. We've got planned operations, because we've got general surgeon on island. So anything that's planned or in place, and even emergency surgeries in place. Anything that's specialist in Tertiaries would have to go off to South Africa or the UK. Obviously, we've got oncology on site as well. We deliver chemotherapy. We've got our

screening on island, or we've got screening schemes in place for all of the island. Does, but you've got oncology in place for chemotherapy. You've got radiology so you can have your CT scan, your mammogram scans and X rays, as is required with an emergency service or a planned day to day hospital service. You've got community nursing. You've also got the nought to 19 team, which used to be the school nursing team, and we're trying to grow that into a Health Visiting team, opposites. It's not only just your hair visiting team, it also it takes you on to, you know, your later years, adolescence, etc. We've also got midwifery we've also got sexual health service within the, within the service gynaecology. Does that answer the question?

The Hon Ronald Coleman
Yes, it does. Thank you very much. Quite extensive.

The Hon Minister Martin Henry
Can I just add a particular element here? Because it has been raised before, and our team have looked and discussed that before, but obviously money is the one thing, but which is the fact that is it absolutely, is it possible to actually split that service and look at a front because it has been discussed by previous Governments, and it still makes sense to some degree today, which is to look at a potential primary care setting away from the medicine itself, because we are, as we move into an era where we're trying to push forward more preventative techniques in terms of screening, scanning, etc., you will probably take note to the UK Government doing something very similar now, where they're putting a lot of these interventions on the high street so that you don't enter a hospital facility to get them done. It pretty much makes sense that, that if the funding was available, that these sort of techniques could be implemented on Saint Helena, because, as the Director has just mentioned, we are trying to capture about 15 to 20 different really important elements all under one setting, and it was never built to maintain that particular cocktail of different things, and it is only potentially going to increase as we move into a scenario with an aging population and different elements coming through. So, the need now to look at a separate building for primary care is back on the table quite significantly.

The Hon Ronald Coleman
Thank you. And I know that you have problems with staffing, but to run a hospital adequately, how many nurses would you require, roughly?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
It depends on the size of the hospital. So, if we're talking about our hospital, so we have over 30 nurses just for them at the hospital, I think it's in the region of about 38 which, which, which we're given, that the level of capacity in a 20 bedded unit is quite good ratio. So, we have some vacancies that have naturally arisen. People have retired. People have moved to the Falklands or Ascension, for example, so we have had some vacancies in the nursing cohort, but that's to be expected. And you know, I talk about this all the time. If you train to be a nurse anywhere else in the world, you have a choice, don't you, where you want to work. You can go and work at the hospital there, or the hospital in the next town, those are options. And you know, you can grow and develop in terms of your career pathway, which is quite limited on Saint Helena. So, there is a natural expectation that people are going to want to move on at some point. So, to answer your question, I think we're in the region of about thirty eight just in the hospital alone. But I think it's adequate. If you think about a ward in the UK, 20 beds have probably been divided into two nurses, so a couple of health care assistants. So, as we speak, we've got, we've got quite a good cohort of staff, if we had all of our vacancies filled, and if we didn't have social care discharges on hospital, social care patients on in hospital as well, I think we'd be okay.

The Hon Ronald Coleman
So, when you talk about 38 cohort that include other disciplines or just nurses?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
That's nurses and HCA. If I'm honest, Councillor Coleman, we probably benefit from more HCA, and then the nurses can concentrate on the specialist element of their roles. But because HCA is, you know, they offer their very basic care needs. They're also trained to take blood, etc., etc., and we need to make sure. I don't know if you recall when Professor Cummings came to the island and he spoke about increasing people's skill set to the ceiling, rather than reducing it in line with other areas of the world. And that's what most medium income countries do, and that's what we need to strive to achieve, is upskilling our HCA, so that they're doing all of the, all of the care, including taking blood, catheterization, etc., that other healthcare systems undertake in the rest of the world, I think, and that's what our aim is, by introducing the care certificate, upskilling people to get to a good standard, so that we don't have that over reliance of qualified nursing staff all of the time, but we've got a good cohort of experienced and reasonably qualified healthcare assistants.

The Hon Ronald Coleman
Thank you very much. Can I just ask who makes the decision for an admission into hospital, or also for a discharge? What are the procedures following a discharge?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
So, an admission and a discharge would be Dr led, so it would be based on clinical need, the presentation at the time, whether or not they're absolutely required to be in hospital, because nobody really wants to be in hospitals either. So, it's Doctor led based on clinical need. The discharge if it's a complex discharge, so it should be subject to a discharge planning meeting prior to discharge, if it's a day-to-day discharge, or it's you and I being discharged after a period of illness. Again, its Dr led, you're fit for discharge, and then you go home. So, the discharge planning meeting, when I talk about complex case, would be somebody even returning to social care's care, somebody who's had a significant health event and was returning home and required a package of care. So that's what a complex discharge would look and feel. Next, we make sure that we have a multi-agency plan in place, that patient is individually assessed to ensure that there is a safe discharge for them to go home. Now, quite often people want to go home sooner than they really are ready, and they'll push for that, and you don't want to keep anybody in hospital longer than absolutely necessary. So sometimes people do get discharged, and then they'll come back because they weren't actually ready. So, you know, it's a little bit of responsibility on everybody's part, and I'm guilty of that every day of the week. I would much rather be out of hospital than in. So, I can understand why this happens, but that's generally the process. There's always going to be an anomaly where it doesn't work out well, everybody thinks that person's fit for discharge and has a clear plan around them, but actually they come back in because they weren't quite 100% ready. But that's always going to happen, especially with a more complex health dynamic and an aging dynamic on island.

Rosalie Brown - Head of Service, Social Care, Adults and Children
If I could just add to that as well, weekly, social care are involved in the doctors meeting at the hospital, and that's doctors, nurses and ourselves included, and then every week, we have an MDT meeting what discusses all discharge, discharges, and that's to ensure that packages of care are put in place and that it's the discharges are safe, and everybody has got what that what their assess needs are being met.

The Hon Ronald Coleman
Thank you. My next question is on palliative care service that is provided at the hospital, and is there the appropriate facilities available for this?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Yeah? Yes, I can respond to this. Generally speaking, somebody that's palliative is in a single unit, so they're in one of the side rooms, as you spoke about, private room, so that their family can come and sit with them whilst if that person is having their end-of-life care in the hospital. If, for example, an individual is having their palliative care needs met at home, having their palliative care needs met at home, then the community nursing team will manage that. In the main in terms of pain relief, we'll have visiting doctors to support them. So, we will provide equipment as necessary and as is required, medication at home as is necessary and proportionate. So, in terms of the hospital setting, I think it's adequate to have the side rooms used for palliative care. And we do have a palliative care pathway, and I know this was mentioned by the EHRC in regards to or in other areas of the world, you've got Macmillan nurses who specialize in end-of-life care. I think that the service that we are. For is pretty good the community nurses are all qualified and all trained to deliver end of life care, and they do offer a really good level of care. It's the one area in particular that we get a lot of praise and thanks for is how the nurses are so compassionate in terms of how they support end of life care, as Ros has outlined previously, from a social care perspective, if there's practical areas that need, that family members need support, if that individual is having an end of life plan at home, then we'll go in and offer respite. We'll deliver personal, intimate care, and we provide support to that family in conjunction with the community team, so we sort of try to mirror what good practice looks like for end of life. Because everybody wants to make sure, I think specifically on St Helena, end of life and end of life care is really key. Everybody knows everybody. Everyone wants to support everybody in the best way possible during this really sensitive time.

The Hon Ronald Coleman
Thank you.

Tim McDermott - Head of Governance and Safeguarding Lead
So, if we, Sorry, just add in our response earlier, but I wanted to highlight it. We we're also moving towards a new model, of course, called the respect model, where we're moving to ensure that people have their wishes around the end of their life detailed in much clearer. So as it stands at the moment, people are engaged and family are engaged in end-of-life care and what the wishes of the patient are, the respect model kind of builds on that. It's a very established UK model. We've been in contact with them, with the resuscitation council. So, this all comes around, things like, DNACPRS Do Not Attempt Resuscitation, taking the person's wishes into account and the family wishes to make sure that the last stages of their life meet their expectation and that of the family.

The Hon Ronald Coleman
Thank you. I was just going to ask, how many patients could you accommodate at the hospital if need be, for palliative care.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
I think for palliative care, we should accommodate if we're talking about using the private rooms and the mental health room we've often used as well because, albeit we've had admissions more recently and more demand placed on that, but generally speaking, we also use that side room as another side room

for people that are heading towards end of life. And so, it depends on the demand. If you were to use three individual rooms, that'd be three people, but that wouldn't stop us from admitting somebody else that was end of life, and then we would make it as private as possible on a ward in a ward setting.

The Hon Ronald Coleman
Thank you very much. The other question I want to ask is who provides the cleaning service for the hospital, and is the arrangements working satisfactory?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Yes. So, we have a contract cleaner for the hospital, and I think absolutely the cleaning is done to a really high standard. I don't have any concerns or complaints in that regard. So, do you want to know the name of the cleaning?

The Hon Ronald Coleman
No, not necessarily, but do they do also cover deep cleaning and the external cleaning and car parks.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
No, they're not responsible for external cleaning. The external cleaning falls, unfortunately, to the handyman, who is a handyman that has to do absolutely everything in the hospital, including transportation, etc., etc. So, they have a very wide and varied role. We did use to employ somebody under the occupational therapy scheme who used to come in and clean outside and do the gardens. However, it was quite ad hoc that they would attempt to do that piece of work. So pretty much it's down to the hand, the handyman or we have to commission somebody to come in and do the gardens and clean out for it. For us, it doesn't fall into the cleaning contract.

Tim McDermott - Head of Governance and Safeguarding Lead
Thank you. Sorry, Councillor. Just to add on the cleaning contract, periodically, I'm not sure if it's annually or every couple of years, we get an updated schedule of cleaning activities, which is broken down into very specific tasks that are done every day, every other day, every week, or what have you. We review that every year as part of the every periodically, as part of the contract update, and we can tell the cleaning contractor what it is we need, what is working, what isn't working. But as the Director's alluded to, we've had no complaints around this, the standard offered at the hospital it seems, seems to be very good.

The Hon Ronald Coleman
Thank you. I just want to ask a few questions on doctors now, and some of the answers has been given. But how many doctors are required in post at any one time, and what positions do they hold?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
We have five GPs. We have one Ops and Gynae, one General Surgeon, Consultant, and Anaesthetist. We have a Chief Medical Officer and a Senior Medical Officer. Thank you. Externally, we commission a psychiatrist and a psychologist, so they both work remotely.

The Hon Ronald Coleman
Okay. Thank you. What arrangements are in place for doctors to take overseas leave, annual leave or emergency leave?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
The same as any other employee? So, you would want it where possible. So, in terms of annual leave, we plan it on a rated basis. So, the same you would with any other organization. You don't give five doctors the same holiday leave. You plan it so that you've got specific cover in place. We have for our doctors and our GP doctors and GPs and all doctors, we have locums in place to provide cover. So the anaesthetist, for example, or ops and Gynae, their leave has to be very much planned, and then we have a locum to cover their absence. If it's an emergency situation, again, we try to, we try to ensure that we've got cover. We've developed quite a good relationship with a couple of hospitals in the UK as well. So St George is being one, they cover all of our pharmacy cover in the absence of the post holder, and that, that arrangement is going to progress towards doctors as well as nurses, just to give them an opportunity to come and work in St Helena and experience something different. That's worked really well. For the three years, we've had a running rota when people are going on leave, for example, and then we have a pharmacist that will come over and cover from St George's. And that's worked really well, and we've developing, or in the process of nearly finishing, an MOU of St George's, so that we can look at different disciplines. Because London hospitals really struggle to employ and recruit and retain staff in the same way every other health and social care department does. But a really good carrot that they found in terms of retaining staff is that coming to St Helena and working in St Helena could be a really positive opportunity so that MOU works for us. It gives us good quality staff that have been vetted, trained and upskilled to a really, really good standard, but it also gives them the opportunity to come and work in St Helena.

The Hon Minister Martin Henry
Can I just mention, yeah, I mean, while all that is really good and it's very strategic from the portfolio, so there is two other elements which is really important, and one of them has already been mentioned in a roundabout way, which is that it is also really good to have returning locum doctors that people are used to, and then, because we are trying to target and focus on their community element without having constantly new faces, it's important that effort is achieved. But secondly, just to mention, like everything else, for all the good planning in the world, sometimes I notice, is done months and months in advance, things can fall to pieces at the last minute, but logistics, but people pulling out, etc. This happens across the board, and doctors are no different. So, while we strive to maintain our cohort, there you there are cases where there's elements of a couple of weeks where we are down to sometimes four, sometimes three, GPs. But this is purely logistics, not for the mind of the portfolio, trying to pre plan.

The Hon Ronald Coleman
Thank you. Can I just ask what other specialists are there provision for in each year?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
We have a specialist visiting budget, and that what we've done with the specialist visiting budget is we've based it on demand. So, for example, because we did bowel screening, we we've done we focused on scope so on endoscopes and etc., to make sure that we then follow through from the results of the bowel screening. So, we focused on those key areas, so we've had ENT, audiology, etc. Historically, what used to happen with the specialist visiting budget was that we inherited a cohort of specialists that had come, didn't actually meet the needs of the population, but utilized lots of the budget. So, with the Chief Medical Officer and the Senior Medical Officer, they've utilized that budget really well, and we've then managed, with the current provider overseas, to encourage to get the right people in to meet the demands on the Island. So annually, we'll do a different, we'll have it, we'll phase it so that we utilize that budget far more effectively. We're having much shorter visits, so isn't eating into that budget too drastically, whereas

historically, we'd have one individual that come for up to nine weeks at a time, and that was 60% of the budget gone. So, we've managed it much, much more effectively. You'll notice that we've had the orthopaedic surgeon on island, and it's the same orthopaedic surgeon that we refer people to in South Africa. So, it's continuity and approach. So, we're trying to develop and evolve the service much, much more efficiently than there's been in place historically. And that's not meant as a criticism, because it is a challenge to get the right people to come to the island and deliver care on the Island from a health perspective, but now we're starting to address the key areas. More recently, the Senior Medical Officer has negotiated an ophthalmology service in line with the needs of the island because we were responding to some of the complaints in respect of our previous offer, they didn't feel it was good enough, whereas this one is more interlinked to practice everywhere else in the world. So, we've tried to use that budget, even though that budget hasn't grown at all in years, more efficiently and effectively to get the right people on the island to deliver the care we need to meet the needs of the people.

The Hon Ronald Coleman
Thank you. I was going to ask a question about problems with recruiting of doctors and specialists, but we're going to change that now to ask if the hospital management is involved with recruiting and selection?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Yes, yes, we're all involved, because we've all got something different to offer. So, from a clinical perspective, obviously, I'm heavily reliant on my clinical staff and senior leadership to support me in that regard. But from a scrutiny perspective and an understanding perspective of how the dynamics of the service will be impacted, I'm ordinarily involved in recruitment as well. If it's not appropriate for me to do so, I'll step away, for example, if I'm conflicted in any way, shape or form. But yeah, we're all heavily involved in recruitment because we want to make sure we get the right people on island.

The Hon Ronald Coleman
Thank you very much.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
And that's not without, can I just add that's not without issue. The only reason I say that is because we can't always get people that we would really like to be there, there because of our geographical location, we don't offer the same weight that would be attracted to that rather elsewhere in the world, but we've been really fortunate in getting the right people, as we speak, to come and work on the island, probably because we've got the right value base.

The Hon Ronald Coleman
Thank you very much. I just want to ask one question on clinics. How many outpatient clinics do we have in operation, and we are they located?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Well, we've got Levelwood, Longwood, Half Tree Hollow and Jamestown,

The Hon Ronald Coleman
And what type of services you'll offer in those clinics?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care

The GP services are nurse led services, aren't they in those clinics so they're primary care settings. So, anything more complex would have to come into the hospital setting if need be. But generally speaking, it will be all primary care led services, so monitoring of diabetes, you know, just general GP appointments of new minor issues, etc., somebody wanting a referral for, I don't know more, specialist service, somebody that's presenting with something new, as you would with any GP service.

The Hon Minister Martin Henry
I think I just like Sorry, because it is the desire, I would say, at this point of the service to be able to develop, especially around the non-commutable diseases, which is, as I constantly mentioned, into the community, a totally different element to address from a medical perspective, rather than some of the previous acute methods used. The desire of the service is to be able to set up the service so the service reaches you as the end user. So, for instance, if you have diabetes at a particular and aren't dependent on particular drugs, that the service reaches you and get you in to be able to evaluate your circumstances at particular points, rather than people coming to us and booking up random sort of with different GPs. So, the whole idea of establishing, or trying to establish, a diabetic service going forward is to do the opposite. So, we can support the community, rather than the community coming as and when they think they require the need. We actually say, you come and we'll check and update?. So, there's a whole process that needs to happen over the next couple of years where we try to push back at some of the elements we're currently seeing, but people just taken up appointments because they want to check up. We come to you and say, here's your check-up. That way we can be more strategic with our current what we got in terms of resources, and also provide a better service across the board. So, there are aims and desires moving forward, and not just to leave it as it is, although it is at a very good standard at the moment, in my opinion.

The Hon Ronald Coleman
Thank you. My next question is going to be on appointments, but I think we've covered that well in session one. But I will ask if there is still a nurse led triage system for patients wanting to see a doctor?

Tim McDermott - Head of Governance and Safeguarding Lead
Yes, we still have on a Monday to Friday outpatient nurse, nurse led outpatient clinic, one in the morning, one in the afternoon, that sees, most days that nurse would see anything between 15 and 25 patients, and they get triaged to go into the Manchester triage system, occasionally treated by the nurse for minor things or escalated to a GP as required.

The Hon Ronald Coleman
Can I also ask, is it right that you have to make an appointment to get a triage.

Tim McDermott - Head of Governance and Safeguarding Lead
No, so the nurse out-patients clinic is done on a morning arrival. If you arrive at the out-patients clinic, you'll get booked in by the medical records team, if you will, then wait and wait for the nurse to work through that list. However, it doesn't come on a first come first serve basis. It is often also led by, you know, which patient may need to be seen more urgently than the other. But if you arrive there, you will get seen by a nurse.

The Hon Minister Martin Henry
Can I just say as well? Because there are also elements within it is, as it say, it is a triage, and there will be people or patients who will determine, as we often do, their health has been, you know, we need to

see them right here, right now, but it may be determined by the medical professional, in that case, that an appointment is needed within two weeks, because it isn't as that urgent at that particular point. And I think sometimes there is not only confusion, it creates quite a bit of animosity around that system. It is a triage system, and that's what it's supposed to do. It's supposed to triage the people most in need to the very top. And it's true, if there's people who are in need, but not in immediate need, they can then book an appointment. However, as I said at the very beginning, there are elements around the system which we still need to engage and still need to tidy up. A lot of it, actually, if you look in the background, is contributed to some of the IT systems we have in the background, and we really, really need to tidy them up so that once systems speak to each other a lot clearer, it will help our current admin staff to be able to work much more efficiently with it. There are elements which we do miss only because of those, those things needing to be addressed.

The Hon Ronald Coleman
Thank you very much. And I want to thank the panel for their very informative information this morning. Thank you.

Tim McDermott - Head of Governance and Safeguarding Lead
No, sorry, no, sorry, it's okay. I was interested expand ever so slightly on what the Minister said, predominantly around that triage session, one or two of the issues of the complaints that we've had, possibly over the last couple of months, has been around the decision by the nurse not to escalate the patient to the to the doctor. The triage system that we use is a very, very established triage system that will come out with a grading, depending on the band, the things you present with after doing your blood pressure, your pulse, your explaining your symptoms, that will very clearly come out on a on a grading. And if that grading is below a certain number, there is, there is a cap at which the most can escalate. They will say, no, you just need to routinely come in. I think when people present feeling unwell and they want to see a doctor, and they get told, I can understand the frustration within them, but this is about the prioritization of the people who really do need to see a doctor urgently, as opposed to those that can wait a few days.

The Hon Robert Midwinter
If I can just interject here because I actually experienced it myself last week. I think, I think there is also public concern sometimes around the capacity in relation of the triage nurse. And obviously the triage nurse can only see the number of people that they can see during the period of time that they're actually working, and if there are other people that require that attention, there has to be a case of priorities. But anyway, I am going to draw Session Two at this point to a break, because I'm mindful, we have been a whole hour. We are halfway through the questions, so we're not doing too badly, really, based on the order paper. But if we can break now, and I would suggest, rather than coming back at 13:45 if we can cut that down to 30 minutes. Is that okay with everybody? Is that okay with you, Tracy?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Yeah, that's great. Thank you.

The Hon Robert Midwinter
So, if we, if we come back for 13:30 and then hopefully we will close the rest of this out within the time frame that we had on the order paper. Okay. Thank you very much.

Session Breaks for Lunch

The Hon Robert Midwinter
Back. So, I hope everybody is suitably refreshed, and we will continue with session two, Health and Social Care, and I will immediately hand over to my colleague, the Honourable Gillian Brooks.

The Hon Gillian Brooks
Thank you, Mr. Chair. And again, my questions will focus CCC, sheltered accommodations. So, may I ask first, how many service users can be accommodated at the CCC and the sheltered accommodations, and are these complexes currently full to capacity?

Rosalie Brown - Head of Service, Social Care, Adults and Children
They're currently full. The CCC is 45 bedded, but we have additional now three places at the accommodation in Piccolo, which we opened last year. So that takes us now up to 48. Deason's Centre is nine, and Cape Villa is 15, and both the sheltered are presently full.

The Hon Gillian Brooks
Okay, thank you. So, I know we spoke earlier about social care patients remaining in hospital, but may I ask, in the event that after recovery in hospital and circumstances do not allow a patient to return home, can you explain to the committee the procedures that are followed after, as in, who decides if the patient remains in the hospital when they go into, who decides when they're ready to go into care and the discharge procedure?

Rosalie Brown - Head of Service, Social Care, Adults and Children
Yeah. So, as mentioned earlier, when a patient's ready for discharge, that is done by a doctor at the hospital, and then if that person is ready to be discharged home, there's a plan put together to see whether they can go home without any support, or whether or not they would need a package of care put in that sometimes is the old up because we because it'll due to lack of staffing. Sometimes in domiciliary care, we're unable to get that person open straight away, but there is a discharge planning meeting put in place. And as stated previously, we have MDT. We have doctors' meetings. And these, these are, these remain weekly on the agenda until we've got a package in place. If we have got a vacancy in one of our services, whether that's Cape Villa or Deasons or CCC, and including the learning disability services within what's called we have a placement panel. And the placement panel, then, is made up of myself and other professionals who come to that panel, and we go through the cases, and depending on it's not done, I know as the top of the list it is, depending on need for that bed or that provision at that time.

The Hon Gillian Brooks
And this would be taking into account family, family decisions?

Rosalie Brown - Head of Service, Social Care, Adults and Children
Everything's taken into account. We also look at the when we're doing, when we are planning a discharge. We look to see what other family is out there, or is there anybody else who can support, or that includes even neighbours, and whether, whether there is friends or anybody who can support it is, it is looked at holistically to see what support we can put in place to get that person, get that person home or even to one of our services.

The Hon Gillian Brooks

Thank you. What is the number of the staff that are required throughout the care complexes to meet the ratio of service uses within that complex?

Rosalie Brown - Head of Service, Social Care, Adults and Children
Ratios of staff are done on need. It's not done on how many beds you've got. It is done on need. And I'll refer to the CCC at present, the CCC has got five units, and them five units, they're all different needs on them units. So, I'll use the Sunnyvale unit, which some people refer to as the dementia unit. On that unit, there is predominantly people with dementia, but there's also people who's just got general health and well-being concerns and can no longer look after themselves. That unit requires its staff, all the units of staff, 24 hours and again at this moment in time, that unit requires three, three care staff per shift. That's a morning shift and an afternoon shift. And during the night, there's two staff on during the night on that unit. Each unit is different. We have another unit what's only got four individuals on during the day, that's got one member of staff on early shift and late shift and at the night, one member and staff on nights. But what does happen if somebody needs changed, then we have to pull from another unit to come and support during the day, from sheltered, again, that's done on that's done on need. You've got some residents, some tenants, sorry, who don't need as much care as the next one, but it's they have a social care assessment and a care all other care package put in place when that when they're admitted, and we work to that on the needs. So, some, some person may need two staff, some person may only need one staff. And again, it varies on a daily basis. So, some days you can have for sheltered at present at Cape Villa, it requires four staff some mornings, and then in an afternoon, it can also require three to four staff. And there's two there's two staff on an awakening night shift.

The Hon Gillian Brooks
Thank you. Yes, and also Piccolo Hill in the supported living. What is the number of staff in the supported living?

Rosalie Brown - Head of Service, Social Care, Adults and Children
The supported living? It's one staff. When you said supported living, do you mean the learning disability units, or do you mean the complex, what's attached to the CCC, sorry, the complex attached to the CCC, it's one staff, 24 hours on a shift basis, and that, again, is due to the needs of the residents or place there. They can all manage with one staff. If at any time that changes, then we would increase that two staff if need be. But again, everything, everything's done on assessed need and risk assessed at the time.

The Hon Gillian Brooks
So how many vacancies do you have now across social care? And can you break this down to how many vacancies you have throughout the different complexes?

Rosalie Brown - Head of Service, Social Care, Adults and Children
When you say vacancies, do you mean staff? This present moment in time, because we've had a big recruitment drive at the CCC. We still presently have got 10, 10 vacancies for care in the care team. Yeah, 10 vacancies in the, in the care team, we've got vacancies in the catering team, that's four, and at sheltered, sheltered accommodation, we've got about 15 vacancies across both services.

The Hon Gillian Brooks

So, this just leads me on to be talking about vacancies. Can I just ask, and you spoke about the recruitment, but what is the sort of plan for recruitment drives going forward, be it international or national?

Rosalie Brown - Head of Service, Social Care, Adults and Children
Recruitment drives? Recruitment's ongoing. Yeah, so we constantly have adverts out locally. It's always better if we can recruit, recruit locally. We don't have a lot of success with it because of people leaving, leaving the island, as you know, and taking up other opportunities. One of the biggest problems we've got is the pay, unfortunately, but with ongoing recruitment internationally, we're using, at present, an agency we're working with in South Africa, and that's worked really well, and that's where, the last six months, we've been able to fill some of the vacancies up at the CCC and also in sheltered accommodation. But it all takes time, because we've got visas, we've got references, we've got medicals, and it can take with the recruit, it can take three months for a person to get here, because of the limitations around visas, and particularly if a person comes from not South Africa, but that can come from say Zimbabwe, we have recruited as well through the agency. We have recruited people who do live and work in South Africa and lived, lived there for a time, but the nationality is Zimbabwe, and so they still have to go through the norm, the normal procedures with immigration, yeah. And just to give where we are at present, we interviewing nearly every week through agency in South Africa. There were interviews twice last week, and we have another one planned for this week. So, it's ongoing, because what happens is a lot of us local staff. It's quite an aging population, so we've got a lot of staff with their own health needs. We've also got some staff who no longer wish to remain on island because of careers and finance, so they take up other jobs in Ascension and Falklands. We get staff, we just recruit and then staff up and leave for a better life. Want to go to the UK. So, it's constantly, and I can only see going forward that we just, we just need to constantly have recruitment on the agenda. And look at it, there's not going to be a time when we won't need to recruit.

The Hon Gillian Brooks
So, in relation to that, then, in regards to low staff members, at what point, with this sort of bringing what we call, you know, a crisis alert?

Rosalie Brown - Head of Service, Social Care, Adults and Children
Well, it's done it's done that before, on many occasions with been at crisis point. And when that happens, naturally, our Director Tracy is involved, it's kicked up as well to Ministerial level, to Martin and to Julie, yeah. And we have to, currently put a risk assessment in place. And we have on a few occasions, and sure, Tracy and Martin can explain as well. We have, on a few occasions, needed to instigate, like, emergency plans and things like that. Because it's been critical?

The Hon Minister Martin Henry
If I just make a comment, I think members will recall the number of occasions. I think it was not last Christmas, but the Christmas before, when, when we actually went out to the public and asked for support to come in, because that was absolutely critical. I will just have to add that, after well, during our three years of us as a current team, pushing and pushing, there is that, but some light now with us being able to establish those roles. But as Ros has just said, as we are establishing and bringing in some new employees, we do have an aging demographic employee that now are coming to the end of their working careers. So, it is almost replacing those roles, and then going over and beyond which, which is why she's she believes that she still would be recruiting for some time yet. Just to add, thank you.

Rosalie Brown - Head of Service, Social Care, Adults and Children
And just further to add, we do work with H, human resources as well in workforce planning and looking, looking at the demographics and looking what we need in three and four- and four-years' time, because of the aging the ages of some staff who are near retirement.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
And also, to add to that, Councillor Brooks, we've worked very closely with the UK HSA and multi-agency partners to look at a Workforce Strategy for Health and Social Care, because we're so conscious of how we, the position we continuously find ourselves in, and what we need to do differently to address the deficit. So, we're just finalizing that strategy as we speak in order to roll it out. But it does take on board other agencies, other areas of the, of SHG, which includes Finance, HR, etc., but also working very closely with Education. So, we met with Education last week on the delivery of the Health and Social Care ETEC, so that we can develop a pathway into social care. So, it isn't just we're getting older people that come to work in social care. What we want to have a look at is how we can encourage younger people to choose that as a career opportunity, and to understand that it doesn't just sit in one area. You don't go to the CCC and work there for 40 years and retire. But what that can do, it can be a stepping stone onto a career pathway, maybe into social work or Public Guardian role or something along those lines. But you know, that's also another way in which we're trying to address it. So, I think by doing it holistically, with everybody on board, and we've also done hybrid recruitment so that we can use our budget more flexibly, but by using our vacancy rates, it's helped us to recruit from South Africa for as we've never been able to do that.

Rosalie Brown - Head of Service, Social Care, Adults and Children
You asked earlier Councillor Brooks about what we do when we have an, when we have an emergency and a recruitment and we're struggling for staff just to add as well, I said, like emergency plans will be put in place. But also, there's been necessary at times where we've had to stop some services, for example, day-care, because we're physically not had enough staff to deliver as main core services.

The Hon Minister Martin Henry
I just there one more thing, and that's just to sum up, I think the strategy behind this, and I've mentioned this in in public forum before, we were at a place and we start at a place where we need to stabilize the system fast, because there is no point in trying to do a lot of the fancy stuff on top of that, if you work and on a very, very disabled, disable, stable system. So first and foremost, we still need to get the numbers to the right place before we can start projecting a lot of the strategies that we would like to in social care forward. Because, you know, having shortage in numbers does mean that it's hard to then look through it, look up and come up with some more creative stuff. But hopefully we are moving in the right direction now, but it will take some time yet.

The Hon Gillian Brooks
Thank you. So how do you manage like rest days, days of the rota, leave, annual leave? How do you manage that with low staff numbers?

Rosalie Brown - Head of Service, Social Care, Adults and Children
It is difficult, but we do try to manage it, because it's important for staff, for their welfare and well-being, to get to get the rest days. So, there is a rota in place, and most staff, the contracted hours are five days a week. For some they do like to work the overtime and the extra shifts because, because it increases

the pay, and that increases the lifestyle and well-being at home, but we try to manage it the best we can. There have been times when, you know, somebody has worked a day shift unfortunately, and then because of shortage of staff and vacancies and the risk that it presents that person's had to come back and work and work a night shift.

The Hon Gillian Brooks
So obvious risk registers for the various care complexes. Risk registers, yes, there is, yeah, okay, so, so how often is this updated and who is responsible for ensuring that the concerns that are then highlighted are actually followed through?

Tim McDermott - Head of Governance and Safeguarding Lead
So, we hold a portfolio level risk register, which we bring to the senior management team meetings and then to the Advisory Board for the Minister. As part of that, we hold currently about 16 active risks across Health and Social Care, and from those then at the Advisory Board, we make a decision about escalation of those risks to the can't remember. They call that the strategic, yeah, the strategic risk group. They then should look at those, those risks that we escalate, and you'll look for thematic risks across all of that the civil service, and then escalate them up to Ministers as appropriate. We do hold as one of those risks, staffing levels across the portfolio. It is one of our risks alongside capacity levels of the services.

The Hon Minister Martin Henry
I'd just like to add in this totally outside of this conversation. But some of the risk escalation, etc., has only been put in place during the tenure of this Government, and so now risk can escalate all the way to ExCo, and if the risk is beyond that of the island, then it can sit there and then be projected along to the UK Government. I think that's an important point to make, because the staff, professional staff, shouldn't hold down risk which is way out of their scope to be able to manage and the need, nor should the Government of the island, if their case, it needs to be highlighted and formatted properly. So, I am now much happier with where we are going with risk factors, especially those which are national and those which could affect Governments going forward, not just the one currently.

The Hon Gillian Brooks
Thanks. And whilst we're talking about staff shortage. So how does the, how do you manage your mandatory staff training? How is that, then catered for? And was the training schedule that was transferred from 2023 to 2024 met?

Rosalie Brown - Head of Service, Social Care, Adults and Children
Sorry, training is difficult, particularly over the last couple of years, has been due to staffing levels, because there's always been a priority that we've got to ensure the residents and the and the clients need needs are met. But we do try, and we have had a number of trainings in house. Where we've done workshops, for example, per person, centred care, equality and diversity, different, different things we with ongoing now we have got, every month we've got Morgan and handling training with, we signed into something called call Safe last year, where that was going to be taken by the paramedics and pharmacy, and it would have been like looking at medication and looking at first aid that's been ongoing. Numbers, numbers have been, I've declined for uptake, but, but basically that has been at the time, down, down to staffing levels, but we continue with the plan and more. And everybody, as each of our services has got a training needs plan for the staff. We do comprehensive inductions as well as the SHG induction program as well, and where we can staff attend all training in line with the job role.

The Hon Minister Martin Henry
I'd just like to highlight, and probably bring the Director or Morgan on the care certificate as well. If you've not seen it, we can provide you a copy of what it looks like. Personally, I was very impressed with the broadness of the care certificate. It doesn't normally just cover it covers the whole holistic approach to care, and it's at a very good basic level. So, it gives you a much broader understanding of what is expected across the board. So, I don't know if any Tracy you want to comment on what Tim on that, because I think it's a very good introduction.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
I'm quite happy to talk about that. So, we work closely with UK HSA and again, as part of the Workforce Strategy Development, Suneeta and Laura came to the island last year, did lots of consultation and helped to launch the care certificate recently, which in some respects, has taken over what NVQ used to offer us, but it's at various levels. There's also assessors training, and it's a pathway onto higher and further education in regards to Health and Social Care. So, it's a really good offer, I have to say. It was completely funded by UK HSA, from the booklets all the way through to some of the support in regards to launch, etc., and making it bespoke to St Helena. This was already trialled on Montserrat, and it was really successful there. But the linkage that we have with UK HSA Professor Cummings will enable us to grow our own staff in in that, in that respect, really, and that's what we want, is we? What we really want is we've had a few successful apprenticeships. Some have worked really well. Some have decided it's not for them. But what we want to do is start to grow our own staff. So, whether that's people returning, saints, people changing of career, or people, young people leaving education. We want to develop that career pathway to make sure that we sort of capture those people. The care certificate sort of revisits all of that basic value base, basic skill set, because it's very vocational and based on operational activities, how you know to remind you of what you do and how you do it and why you do it. So, on top of the training that was spoken about, as well as the safeguarding board training that we offer, so there's a running program of training from that sits from the safeguarding board, and that's in conjunction with exploitation, effective safeguarding. So, there's a whole variety of training that we've delivered from there, and we will continue to do that. But again, as you say, if you've got 40 plus vacancies across your service, what comes first? It's a chicken and egg situation, really, in that you need to prioritize the needs of the people that you care for, and they're our main priority. But equally, you want the people that deliver on that care to be trained up, skilled to a good standard. But it is we need to have more numbers to enable us to deliver in all areas, if you will,

Rosalie Brown - Head of Service, Social Care, Adults and Children
Just to add the care certificate, a couple of staff is already started that this week, sorry, last week, with about five staff already started to undertake it, which is really good.

The Hon Gillian Brooks
What percentage of the 24/25 Health and Social Care budget was proportioned to the care complexes? And can you advise how this was broken down between the different complexes?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
No, so a majority of the budget for social care is allocated. The CCC, so that has the highest budget, and then the rest of the services have a very much a very much smaller budget in order to meet the needs of those services. I don't think this has changed much over the years. It's sort of stayed very static alongside the budget, despite the fact that the changing needs of the clients have not remained static.

So, I think, I think again, this is a policy priority area for possibly the next Ministerial Government about how we address the deficits between demand and delivery of services. So, in order to answer your question, I think a third of the overall budget for social care goes to the CCC.

The Hon Gillian Brooks
Okay? And if you're looking back as far as December 24, were you sort of within budget within the complexes, or

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Just a little bit over. I think 24/25 we're really quite compliant. We will have been a little bit over, because sometimes it depends on in terms of when our medical supplies order comes in and things like that. But in general, generally speaking, last year's budget, we were very compliant.

The Hon Minister Martin Henry
Can I just make an observation, especially from a budget perspective? And again, it is this, this whole idea of being a frontline service and responding to needs, some-times, people fail to understand those particular elements because they work in different environments and project social health and social care into their environments. That must be said, because that is the case. I found it up while being in Government. The reality is, though, when, when the, we have all of our bed spaces full, etc., when we have to provide needs in the community where we actually would want that person to be with us, because there is an option for a person to stay at home, but we want that person to be with us. The cost of that can be quite expensive as well. So, it is an added need, as per person that we have to provide care for, and that can go from one to 10 to 20. So, we just have to be very cognizant that while this year we may have been, you know, just on the borderline of our limitation that can be obscured at any given year. And that's something we have to take on board as we go forward, because these budgets aren’t stagnant . The population movement isn’t stagnant, and it makes it really difficult for us to my genuine statement of trying to, you know, that sort of round hole in the square box, which is what we try to do all the time in Health and Social Care.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
And again, like last year, for example, 24/25 and we think of that budget line for Social Care, we had to open and develop a secondary Residential Child Care setting overnight, and that's remained in situ, because that's what the need is. So those things have additional costs associated with them, and those are forecast costs. So, the only reason I say we're compliant is that, as the accounting officer, I have to attend PAC annually, and it is an annual event in as to why we spent our money in a certain way, and it's because, like many other service areas, the demand outweighs the budget. But with us, it's life and limb, it's life and it's from birth to death, and it's really complex, and you cannot predict what's going to happen so we could be so for the last two years, for example, I know we're talking about social care at the moment, but for the last two years, on the 31st of March, we've had a medivac. And you can't plan for that. You hope it doesn't happen on the 31st of March, because you've got through that financial year. You plan for the eventuality that there might be one, but you hope there's not going to be one. You hope that you're not going to have to create a secondary care setting for children or adults, etc., but we have to provide the response so there's always going to be, and I would imagine this year again, the eventuality that we will be somewhat overspent. Because despite the fact that we're really creative with our budget and try really hard to stay in line with our budget lines, as the accounting officer, I have to, we have to put need before money, and that's what we do every year.

The Hon Gillian Brooks
I understand its very demand led. I

Rosalie Brown - Head of Service, Social Care, Adults and Children
Yeah, and just to add Councillor Brooks as well, we only need a change in setting up refer to day-care. We get a change where we get some medical, Medical Referrals coming back. The needs have changed. The need eye level care. To remain, remain in the community. We can go from like having to put these, these packages in which then places additional cost on resources, but again, that's to ensure that that safety, safety is being met and that's been risk assessed.

The Hon Gillian Brooks
Thanks. Okay, so funding for home adaptions was removed from the Health and Social Care budget, but in light of limited capacity within the care complexes, is this funding being reapplied for under the upcoming budget?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
The home adaptations budget basically was absorbed by the reduction in budget, which is what we experience on an annual basis. So even though we might get an increase, we don't in reality, we don't see that in practice. So that basically was taken out of our budget because we couldn't afford to keep it in what we've done differently is we've worked with Health and Social Care being under one umbrella, we've worked very closely with occupational therapy and between adult services and occupational therapy, we then have approached on an individual basis the finance lead in regards to business cases specific to those individuals and that that worked quite well last year. It's not ideal, but it takes away, I suppose, the responsibility of having a set budget that you've to manage, if it's based on need, and there is an acceptance that we will be approaching finance for additional funds, then that is one way of how we achieve that, and we achieved that quite well last year, but it's about working together. So rather than having that just passing out budget, what does help is if we if we identify need, and if we don't have enough in it, within our budget lines, we go straight back to finance and finance support that, then that's absolutely fine, and that's what happened quite well last year. I don't think even the given the limitations in terms of the budget across the pace that we'll ever have, as much as we need for adaptations, equipment, etc., on our island to actually meet all of the needs, but it, you know, we are doing what we can with what we've got, and I think we're doing really well. It's having that good working relationship, working together to meet demand,

The Hon Minister Martin Henry
Just to come in, I think, from a political perspective as well, home adaptations is a complex matter. It is a complex matter, because besides the need, it is adding value to properties, etc. So, it goes beyond what we would project as support an individual. And when you're spending Government funds, there has to be set criteria around that. I think there's putting home adaptations all in one basket as one particular element may not be the best place. There may be potential to look at limitations. For instance, supporting someone with a handrail was totally different to potentially, you know, creating a road to get to their home because the road wasn't funded from that individuals private, private budget. So there's a it is a complex matter, and it is one that needs to be addressed and scaled out in the appropriate way, because it can stray itself into rather grey areas. There is also an underlying piece which we are facing now, is a community where houses were built in different areas. Accessibility is difficult, and all of these things should, as we move forward, be, in my opinion, at least addressed through the likes of building regulations, etc., to ensure that we future proof homes for accessibility as people age. This is,

unfortunately, something that wasn't considered many years ago, and for good reason, given you know the history of Saint Helena in terms of funding, etc. So just to add that outside element to this particular piece as well,

The Hon Gillian Brooks
Just something else about budgets, I'm thinking of domiciliary care. So would you know, from, say, April 24 to maybe March or even slightly earlier, the budget that's been allocated for domiciliary care so far? Do you have a specific budget for domiciliary care?

Rosalie Brown - Head of Service, Social Care, Adults and Children
Yeah, we do have a specific budget for domiciliary care.

The Hon Gillian Brooks
Do you know how much that sits, no? That's fine. Don't worry.

Rosalie Brown - Head of Service, Social Care, Adults and Children
No, I can get you that information.

The Hon Gillian Brooks
Thank you. One last question in, can you tell the committee?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Of course, sorry. Councillor Brooks, can I just come in? But I think domiciliary care is the one of the most important areas, and annually we have to ask, set other bits of our budget for that overspend, but that's because we are providing a need led service. So, Dom care in particular, is one of the areas that I think probably would really benefit from investment, and it's one of the areas that we maybe next year we should look at how, because it's subject to a review at the moment, because we want to review, are we using the money effectively and efficiently? Are we making the best use out of the service? So, it might be one of the areas we either ask for additional funding for, or look at what we do with it. So, a bit similar to health, I suppose, is that life living site became a priority. Again, it's taking it back to delivery of basic care, and not what people want, but what people need. So that's that, that's what we have to do with that service.

Rosalie Brown - Head of Service, Social Care, Adults and Children
That's under that service, I think I raised earlier that what we do we like doing, you know, we're doing cooking and we're doing cleaning, and that's what that that service is not about. What we should be delivering is personal care and safety and medication and welfare checks all to ensure that that that person can remain in their own safely and for the foreseeable future, if that's their choice.

The Hon Gillian Brooks
Okay, just one last question from me, simply around the fact that you know you have changing needs throughout the care complexes. So can you tell the committee how often fire management procedures are reviewed in the care homes to include professional inspections and the relevant necessary training for the staff?

Rosalie Brown - Head of Service, Social Care, Adults and Children

We've just recently, in line with evacuation procedures we've been working with, sorry, I've forgotten the name with environmental to look at all the evacuation plans and procedures for all our services. So that has just all recently emergency planning. Sorry, that's just been out, been reviewed. It's been ongoing since last year. We do have regular training, fire training in all in all our services, and we do red light staff attend fire training.

Tim McDermott - Head of Governance and Safeguarding Lead
We also recently ran a there was a training session to train fire marshals across the portfolio, so there was a good little uptake on number of people who then were designated fire marshals.

The Hon Gillian Brooks
Thank you very much for your responses. Thank you. Thank you, Mr. Chair.

The Hon Robert Midwinter
Thank you. Before I hand over further just going back, Tracy, you mentioned about the domiciliary care being an area that you saw as would benefiting from further investment going forward, just again, for the benefit of the listening public, in what areas would you see investment being undertaken for domiciliary care?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
I think it's more about resources again. So, before I ask for additional funding, what I like to do is review everything completely, and that's what we're in the process of doing again, at the moment. I introduced a process which was a resource allocation model for social care so that we could manage the service much better. I think the demands were outweighs that. So, Resource Allocation Model aligns need with service delivery, and that's what we did. So, we managed it quite stringently, and so I've asked Ros and a couple of other people to review the service, to look at what we could what we should be doing, and what we are doing and what we should be doing. I think the issue is that it's always going to warrant more capacity in terms of people to deliver support and care across the island, because as a population gets older, and we want to keep them at home much longer, then we're going to have to provide more care within the family homes or within their homes, in conjunction with family also supporting of course. So, in terms of investing in that area, it would just be around increasing the staff in numbers so that then we can provide more care and support to people in their own homes. We can enable safer discharges if we need to, as Martin's alluded to, we can provide complex care packages within the community, which we've done before and we do, and that will enable some discharges home as well from hospital. And equally, when we consider the people that are coming back from South Africa, following joint replacements, etc., some of them come back and they need support for a while. So it's also about rehabilitation and getting yourself back on your feet, and the same for anybody coming out of hospital. It might well not be that they're great in a social care bed, but they want rehabilitation, and at the moment, we do. We don't have a rehabilitation offer other than domiciliary care.

Rosalie Brown - Head of Service, Social Care, Adults and Children
And if we, if we did have that going forward, that that would really help and benefit patients and benefit people in the community. Just to add, we have these 10 staffs at present who work within domiciliary care, and they work predominantly between Mondays, Monday to Friday, a service what finishes about five o'clock on an evening. What we do need is to operate longer hours. We do work weekends, but again, the budget we've got at present only, we can only work up to about one o'clock on a weekend. If

we had other resources and money, we should be providing, like care well into evening to be able to support to put people into bed, to alleve families and alleve neighbours, and look at that as a whole.

The Hon Robert Midwinter
Thank you. And I think it was important to hear all of that, because again, when we were reflecting back on the session this morning, talking about the desire to keep people at home, in their home setting, as long as we can do, and certainly, both Councillor Brooks and myself have had approaches from the public about the number of staff that were in domiciliary care, and obviously the things that they do during the day, you know, the number of vehicles you see going around, staff attending the shops, for example, but they need to. They need to do that as part of their role in supporting somebody that is staying at home and is immobile. So, I think it's important to draw that out, that going forward, there is that need. Thank you very much.

Rosalie Brown - Head of Service, Social Care, Adults and Children
And just further, to add one of the challenges within and when we do review as well is, is transport and location and the like locations, like working out in Levelwood, working out in Sandy Bay, you cannot get vehicles down to some of the clients who we need to attend to. So, all that's got to be factored in into making the service more efficient to now and how we manage that. Okay. Thank you very much.

The Hon Robert Midwinter
So, I will now hand over to my colleague, the Honourable Elizabeth Knipe.

The Hon Elizabeth Knipe
Thank you, Mr. Chair. My first set of questions will focus on the Safe Haven and the Children's Residential Home. Thank you, Mr. Chair. My first set of questions will focus on the Safe Haven and the Children's Residential Home. According to the budget book for the current financial year, a total of 14,000 pounds was previously identified for the 23/24 for the operation of the safe haven. However, it would appear that there is no longer a bespoke budget line for this. So can you explain to the Committee why this change in the budget line has occurred, whether this is still being funded and how much the safe haven is costing each year. Thank you.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
So, the safe haven in itself doesn't come with a huge budget, as you know, but we aligned the two budget areas because they were set. We moved them out from underneath children's social care from a children's residential perspective, and put those two bespoke areas together so they were slightly more independent from statutory services, because we felt that they needed to be in the same way that the CCC is, or sheltered accommodation. So, in terms of this exact number, or exact costs within the budget aligned to refuge, I can't tell you off the top of my head, I'm afraid Councillor Knipe, because I've not got it in front of me, but the budget, the budget is allocated. The budget allocation is merely the IDVA. It's the economy. It's the funding for the IDVA, which is the independent domestic violence advocate. It's also the day to day running costs of the building and maintenance of the building. There isn't a huge budget associated with the safe haven, because it's managed. Mainly on a place of safety basis. So, and the remainder of that budget line, which sits on to children's residential is allocated for the running of those two service areas.

The Hon Elizabeth Knipe

Thank you very much. I understand that. Can you say whether or not there is a, is bespoke funding allocated to support the children's home. And if so, what is this?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Yeah, there is, there's an allocated budget for the children's home. Again, I can't tell you exact figure, because I don't have it in front of me. But again, this is in regards to staffing. It's in regards to the costs associated with running the building on a day-to-day basis, as many of the basic care needs that a child would need, such as food, clothing, etc. So, the allocation of the budget is in line with that it will be over this year because we have an additional residential setting. So, the costs associated with two, two residential units are obviously going to be higher than one. So, in relation to staffing, this also has a cost impact.

The Hon Elizabeth Knipe
Thank you very much. Within the document, safe haven admission figures that has been provided to the committee, it is noted that a total of 26 admissions were made to the safe haven between 2021 and 2024, would you say that this currently reflects the need for safe and secure shelter by women subjected to domestic violence or abuse? Or are these figures being inflated as a result of a shortage of suitable housing elsewhere?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
I think it's reflective of the need in terms of how many people have used the service. I think there are some occasions that we've had to use it as alternative accommodation, and that probably be less than a handful. I do think it's reflective of the need, and I think that's starting to grow in recent times, I will see more admissions to the safe haven in the last 18 months, two years, than we had previously. I think what is an issue is moving on from the safe haven, so the transition from being in a safe environment and moving on to accommodation elsewhere, and this is attributed to the lack of social housing on island or affordable housing on the Island. So more about the time spent in Safe Haven. So, you'd want somebody to be in the refuge until they were felt safe and ready to move on to the right accommodation. You wouldn't want them there for months and months and months just because of the lack of accommodation on island. But to answer your question, I think that probably is around right because I've had involvement in all of those years, but I would suggest more recently, it's become used more than historically, and I'm hoping that's associated with improvements around the MARAC process and having Deborah Knipe as an advocate, who's working directly with these people and sort of enabling them to make decisions to improve the safety that in their lives and that of the children.

The Hon Minister Martin Henry
Thank you. Just like to make a comment on the on the back of that, because I think it's, it's important that what the Director just established, because we could, we could interpret more results as an environment which is getting worse, or we could interpret more results, because the message is getting out, and we champion it. And as a whole council, we've championed this time as well. So, it's important to pinpoint or try work between what is the factors for a higher response, to enable us to be able to look at what we do in the future. But for me, the underlying score is it's important that the community is now aware of such services, and they are using them at the appropriate time.

The Hon Elizabeth Knipe

Thank you. Another question, can you tell this Committee how many support workers are employed at the safe haven and the children's home, respectively, and what training is provided to assist support workers, to assist the client's day and night with no support.

Rosalie Brown - Head of Service, Social Care, Adults and Children
As far as the Safe Haven with one worker, which is the IDVA, the Safe Haven, the support workers attached to the Children's Home. Within the current budget, we've got six workers, six full time workers attached to the Children's Unit again, as Tracy pointed out earlier, opening another facility has placed constraints on budget, because we now need one member of staff in one unit and another member of staff in the other unit so but there's six, six full time workers employed at the Children's Services.

The Hon Elizabeth Knipe
Thank you. When clients and children are admitted to the safe haven shelter, what costs are involved and who carries these?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
So, we utilize the budget from children's social care under a child in need basis, if it's a mum and their children, and if there are any additional demands placed on them from a financial perspective. So in regards to food, etc., etc., we would provide some child in need support, which is financial support, to make sure that all of their needs were met. If it was an adult, an adult without children, then that would go to Adult Social Care. And again, there's welfare assistance from that perspective. So, we always make sure that everybody's needs are met. We don't hold that sort of budget within the refuge because, again, like many services that are in huge demand. Although there's been 26 over the past four years, it's not always got somebody in there. It's better to have the budget allocated to those two services and when they can reallocate to those individuals.

The Hon Minister Martin Henry
Tracy, I think it's probably important, if you just mentioned the role of the Government as corporate parents as well, when we have to step in by law.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
So well for children, if we share parental responsibility, so those children that we looked, look after in the residential children's homes, we share parental responsibility with parents and as Government employees. We have a corporate parenting responsibility, which means we have to meet the needs of those children as we would our own children, and in some respects, they have to be prioritized above others. So, for example, in the UK, and I know you're not in the UK room saying to me, you know that in UK, they'd get a higher level of support within education. They'd get a higher level of support to seek employment, a higher level of support to seek accommodation when they move on to adulthood. And I have to say that's coming together on St Helena quite well. So, each child has an education plan in place. Here's a looked after child, and we have a number of children, not just two, that are in our care within residential settings. We also have we also share parental responsibility for other children on island, and we see this education plans in place for those children. Children that we've seen leave care have been very quickly accommodated and supported by housing, who've been excellent, and they also help to help us to support care leavers in maintaining those properties, supporting them with their life skills, etc. So having that corporate approach to parenting and leaving care has been is growing, and it's going in the right direction, if I'm entirely honest, everybody's working very well together to support those children and young people.

The Hon Elizabeth Knipe
Thank you. What assessment is made of clients before they are discharged from the safe haven?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Okay. So, if it's something with a child, we have a full assessment of the risks associated with the child in regards to emotional harm because of the abusive relationships or abusive adult relationships that they've witnessed and behaviours that they've witnessed. So, we'd have a multi-agency plan around that mum and their children to enable them to move on safely. So, we'd assess all of the risks. Deborah Knipe would continue to work with them as they moved on, as with children's social care, if it was absolutely necessary and proportionate to do so. But Deborah would also will have established a safety plan in place any and supporting in regards to any needs and issues that arise in regards to those children or the mum prior to discharge. So, what we make sure is that everybody has a safe plan in place. There have been instances where we've been. We've had we've accommodated people, and they've stayed beyond the necessarily necessary time, I would suggest, and we've moved them on ourselves, because we sometimes people get very comfortable in the refuge, Councillor Knipe, and they like to stay, so we do support them to move on.

The Hon Elizabeth Knipe
On so two ways really understand that, can you provide an overview of the admission criteria and procedures for children to be accommodated at the residential home, and say who makes the decision that a child needs to be accommodated there?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Yeah, we would not accommodate a child without the relevant order in place, or would only accommodate a child under a voluntary agreement with parents' consent. So, for example, if a parent had reached a stage in their life, or if they were too unwell to care for their child, they could consent voluntarily for us to look after their children for a period of time. And that has happened in a number of instances, and then we've gone to court to seek an order the only way we can remove a child from a parent's care or a carer's care who have an order in place, is for us to seek an order from the court. We can't just remove children. It doesn't work like that. So, for example, if we've attended court and the court made an interim care order with a removal, then we would remove that child from that original placement and place them at the children's home that would have been subject to all sorts of assessment prior to that point in time, because that is the last resort. Is to remove a child from their family. We want to keep them with their family for as long as possible and manage the risks appropriately there. So we'd have to have we'd have to have shared parental responsibility by means of a care order, or we'd have to have voluntary agreement that that child needs to come into our care, all of which would have been subject to assessment of need, assessment of risk, and full agreement about how that child can be can then become a looked after child, so the residential unit had all of their courses and procedures in place. Any admission into there would be subject to social work, assessment and a court order where necessary, and then we would review that placement by virtue of looked after reviews, although initially within the first six weeks of accommodation, and then every three months, and then every six months thereafter. That's ordinarily independently reviewed with an independent chair, and it's with the multi-agency team that work around that child to make sure that that placement is absolutely right. If the child is in our care and in the residential unit, ordinarily, they're going through public proceedings which care proceedings involving a child and that would have the scrutiny of the core and an appointed guardian as well to make sure that that was the right placement for that child.

The Hon Elizabeth Knipe
Thank you. Tracy, that was very explanatory. What training is supplied to the staff to enable them to adequately support the needs of children, such as trauma?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
So we had, previously, we had a manager that was she delivered trauma-based training to all of the staff that were employed at the Children's residential unit because she had experience and qualifications in that area. Unfortunately, we lost that manager. We've also, we do have some trauma informed practitioners on the island that help to support the staff to respond to trauma as a result of the harm that they've occurred in early life. And we're at the moment, we're going out again to advert to recruit a new residential manager, because we're really conscious of the fact that we've had to start up services very quickly in response to demand. And people have moved on, so they've taken their training with them. So, trauma informed practice is one of the key areas that we like to focus on, and it's one of the key areas of social work practice, really, especially with children and children looked after. So, we do have the same practice, that same residential manager that worked on the Island that's willing to update and upskill the staffing in regards to this area, because, again, it's a really important element of supporting children who are looked after. So, to answer your question, some have had training, and I'm conscious that they probably need to be updated again, and the newer staff need to also receive the training, but they are supported very heavily by the social workers who have trauma informal practice training as part of their overall social work qualification.

The Hon Elizabeth Knipe
Thank you. My next question, when a child is accommodated in a residential care facility, what measures are taken to ensure that they remain socially included within the community?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Yeah, this is a really difficult one, you know, because we've struggled on Saint Helena, and in not just Saint Helena in the UK as well. So, becoming a looked after child, some children feel slightly marginalized by the wider community and their peers, and it is about promoting them as an individual. So, for example, in school, the social workers advocate on behalf of the child in the absence of parents, trying to include parents where at all possible, and making sure that they feel part and parcel of their community and education without being labelled or marginalized by their peers. Children on St Helena, when I first arrived within the residential units were considered to be what they refer to, in brackets, naughty children, and I hope that we've moved on from that now too, and educated the community slightly through cases that have been openly heard within the court arena around the experiences that some of our children have had to endure as young people, and little is really in the care of their parents and carers. So, I feel that that's slightly lesser than it was historically. And children are children are starting to be seen as children and not naughty children, because it isn't their fault that they're in the care of the, of the Government, it's, it's the, it's because of the reasons around their care within their family unit, in terms of including them socially. We try to make sure that we that they access groups, etc., and support and we probably do support that wholeheartedly, and work hard struggles to do that, we put direct support involved from children's social care, so some of those SEOs go out and support them to access activities and just be generally part of the community. Also, we've supported our young people to get jobs in the same way other young people get jobs on island, so they could also play a sort of contributory role into the overall, you know, system of St Helena, really, and become part parcel of the community.

The Hon Elizabeth Knipe
Thank you. How many children, young Adults can be housed presently in the children's home?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Well, we could, in reality, given that we've now got two, two units, we could, we accommodated up to six previously, and I'd say we could do exactly the same again.

The Hon Elizabeth Knipe
I see, thank you. In the case that demand is more than currently capacity, what actions would be taken to increase capacity?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
We'd have to respond immediately, because it's the statutory requirement by law, we'd have to increase the number of looked after residential homes that we have. We've tried to recruit foster carers in the past, very, very unsuccessfully. We do, we have had an annual event where we've gone out and tried to recruit foster carers, but it's not something that sort of fits with St Helena as we speak. We've got lots and lots of carers that are not foster carers. They're kinship carers, so family members, grandparents, etc. But beyond that, we don't have a foster caring offer on island, which we would like to have, really, that would be an excellent approach to the delivery of care in a normal day to day home. But to answer your question, we would have to respond immediately, immediately, and increase our capacity by having yet another bungalow piccolo here, which we'd have to resource and manage.

The Hon Elizabeth Knipe
If I can ask a question here, coming in here, when you say that you've tried to introduce foster care, have you got a system in place where just for, let's say, eight hours or 24 hours, you need to remove a child because you want that child to be in. Nobody knows where it is, just until you can accommodate that child.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
I'm sorry I didn't quite catch the question, have you got a so, if you got 24 hours, I've got to accommodate a child, yeah,

The Hon Elizabeth Knipe
If in an emergency, if you don't have a place to accommodate the children, the child because you over capacitated, have you got names on a list where you are able to take that child, where the community don't know where the child is, just because of privacy to accommodate the child afterwards. Wouldn't that be an idea?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Yeah, that would be an excellent idea, and that'd be foster care. But no, we've gone out and we've advertised, we've recruited, we've offered training to people. We assessed a couple of couples about four years ago, but they were all expatriates, so we would like local people really, as foster carers. Those expats were only here on short term contracts, so that didn't meet the need so that we, I mean, it's something that we'll try annually. We try all the time, so we'll try again this year. But yeah, that would be an excellent way to look after children. So, it's much better to look in it look after child in a family home than it is in a residential unit. Don't get me wrong, residential units get and sometimes older children that

have been through multiple placements moves actually need residential care. Can't cope with that foster care environment. But we want, we would love a bit of both. We would love people to come forward and offer to care for children, even if it was a short-term period respite care. We would love to offer that opportunity, because there are children with additional needs and disabilities in the community, and the only respite offer they get is day care, so they go out with their social care officers, etc. But what we would really like is for them to have, you know, for carers, parents and carers, to have a complete break in the same I would say, would almost all older people who care for their sons and daughters, but we don't have that for the island.

The Hon Elizabeth Knipe
The reason why I've asked that question is because I have asked many times it's something that I wouldn't mind doing in the case of emergency, if a child needs to be taken away and because in Saint Helena, then, if you everybody knows who's there. But in a situation like this, where you've got to take a child away for the night or for the couple of hours, because a child like that, if you take them on for X amount of time, you've got to have carers so that, just specifically for more than 24 hours. That is why I'm asking because, I grew up in a situation like that where my parents took on three foster children. That's why I'm asking that question. Thank you.

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
Well, I'm going to bear that in mind Councillor Knipe and I will send a social worker around to start an assessment for you as a foster carer.

The Hon Elizabeth Knipe
Thank you very much. Where am I now up to? What age does the children's residential home continue to support young people and what transitional arrangements are in place to integrate them into adult society?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
So, we got to the age of 18, and we start the transitional process before that. So, it's called pathway planning. So from a sort of statutory social work perspective, so we start that pathway of moving on to independence. Start reducing the amount we do for them within the residential setting. Try and help them to increase their skills in regard, in regards to looking after yourself, cleaning, tidying, cooking. But have to say, St Helenian young people are much more advanced than children in the UK in that regard, but we have to promote that independence, help them to learn those independent skills as care leavers, we would ordinarily assign them an adult social worker as well, so that once they reach the age of adulthood, then they've got an allocated social worker or social care officer that can support that ongoing process. Because actually, just because you turn 18 overnight doesn't mean you are fully fledged adult, does it? So, and especially as the children that we've looked after, they've experienced significant trauma, so that's the process. We work really closely with housing they've been excellent and accommodate their children really well. They also provide support from a housing officer perspective, go and do regular visits with them and support them from a housing perspective. So, at the moment, the transition is okay. It could always improve and always get better. And I'm hoping that each child we move on to independence, but that does get better for each one, but that's the process currently.

The Hon Elizabeth Knipe

Thank you. Another question in respect of both the safe haven and the Children's residential home, what is the policy regarding curfews and what are the procedures either when these are not complied with, or if an adult or child appears to be missing?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
They're two separate entities. Each child has their own plan around them. Each child we look after has their own plan around them based on age. Development or anything the individual needs. They have their own plan around them, around what time they have to be home if a child doesn't return from her home, but we know where they are, the police would suggest they're not considered missing. They could just not come back on time. But if a child is missing or is missing from the residential unit, we immediately report them missing. There's a missing from home policy in place, and that covers both children and adults and the police, the police, the police, provide a response in regards to initial you know location, if they, if they can find them, or they can look for them. Say, for example, they're in the town centre, etc. They'll look out for those looked after children. Generally, they're only in a couple of places, if I'm entirely honest. But before we report child missing, will you do what you do with your own children in so much as you check your house, check the surrounding areas, try and make contact with them, maybe make contact with friends that you think that they would have been with, etc., so you do all of the normal common sense things in the first instance before you resort to reporting the child missing from home.

The Hon Elizabeth Knipe
Thank you. My last question, what ongoing support is provided to young mothers, in particular those who have integrated from care to adult society?

Tracy Poole-Nandy - Portfolio Director for Health & Social Care
We have a few young mums that have been looked after previously. So, where care leavers, and we provide support from an adult social care or a childcare social care perspective, dependent on needs. Some young mums are absolutely brilliant. Some young mums need a little bit more support, and some young mums we need to share parental responsibility with them and that child. So, it just varies from case to case, really. And we manage each case individually, dependent on need, risk of harm, etc., but we do support, do provide an awful lot of support for care leavers in terms of setting up home, etc. So, we do the same in readiness for a new baby, as we're really cognizant of the fact that we are parents. We're corporate parents. Even though they're 18, we still have a duty of care to those young people.

The Hon Elizabeth Knipe
Thank you. If I can just come in on the record, I want to clear it where I was saying that I was talking about the children being fostered for more than 24 hours, and I said that my parents fostered three children. So that's why I grew up in that I didn't want the public to think that I was in that position, but my parents fostered children, I want this for the public to know. Thank you. Thank you.

The Hon Robert Midwinter
Thank you. So that actually concludes the Select Committee's questions on our program of business for today, and I would like to thank members of the Health and Social Care Portfolio for attending and giving responses to the questions asked. The Committee will now evaluate today's proceedings along those, excuse me, the Committee will now evaluate today's proceedings alongside those of our previous hearing, and feed this into our inquiry as we deem appropriate. We will then ultimately submit a report to Legislative Council, together with any recommendations shortly thereafter. Before closing, I would again

just like to sort of reflect back on our last live session, and refer to the CEO of the EHRC, who actually said, I think we've seen significant improvements over the last year or so, and she also said she would like to thank everybody involved, because things have moved forward, and from my own experience, I would echo that she did also then say that one comment that she did have was about putting the information out into the public domain and making sure that people are aware of that. And I think today's session, I know it's been long and arduous, but I hope that it's been very informative to the public, and that they've gained a lot of information from that, and so again, I would like to thank you all for your attendance, particularly Tracy, dialling in from overseas, we wish you a speedy recovery and hope you return to the island soon. And so, in closing, we thank you the listening public for your interest in the work of the activities of this Select Committee, and may we express our gratitude to the South Atlantic Media Services for providing this live radio coverage, and take care and enjoy the rest of your day, what's left of it. Thank you very much.

Approved by Select Committee Chair:

Councillor Robert Midwinter

10th June 2025