SOCIAL AFFAIRS SCRUTINY PANEL
OVERDALE SUB-PANEL

OVERDALE REVIEW

WEDNESDAY, 4th OCTOBER 2006

Panel
Deputy A.E. Pryke of Trinity (Chairman)
Deputy R.G. Le Hérissier of St. Saviour
Deputy S.C. Ferguson of St. Brelade
Deputy D.W. Mezbourian of St. Lawrence
Deputy S. Power of St. Brelade

Witnesses
Dr. M. Richardson (Consultant Physician, Care of the Elderly)

Present
Mr. W. Millow (Scrutiny Officer)

*(**Please note**: All witnesses and Panel Members were given the opportunity to comment upon the accuracy of the transcript. Whilst the transcript remains a verbatim account of proceedings, suggested points of clarification may have been included as footnotes to the main text.)*

The Deputy of Trinity:
Good afternoon, Dr. Richardson. I would like to welcome you to our Scrutiny Panel hearing on the closure of Overdale. As I am sure you are aware, the panel is in the process of reviewing the ministerial decision to close 2 continuing care wards at Overdale and transfer those patients into the private sector. Part of our evidence gathering is to get information from other sectors and professionals. I would like to introduce myself. I am Anne Pryke, Deputy of Trinity.

Deputy R.G. Le Hérissier:
Roy Le Hérissier, St. Saviour.

Deputy S. Power:
Sean Power, St. Brelade.

Deputy S.C. Ferguson:
Sarah Ferguson of St. Brelade.

Deputy D.W. Mezbourian:
Deirdre Mezbourian, St. Lawrence.

The Deputy of Trinity:
On my left is William Millow, who is our Scrutiny Officer. There is a certain protocol and I understand that you have seen and read a copy of the statement?

Dr. M. Richardson (Consultant Physician, Care of the Elderly):
Yes.

The Deputy of Trinity:
This hearing is in public and it is being recorded and it will be transcribed and you will receive a copy before it is loaded up on to the website. Is that okay?

Dr. M. Richardson:
Thank you.

The Deputy of Trinity:
Just to set the scene, could you tell us what your role as Consultant Physician, Care of the Elderly, entails?

Dr. M. Richardson:
Yes, I have a wide-ranging role. Care of the Elderly is one small part of it. I do general medicine at the General Hospital. I cover rheumatology services and I cover Care of the Elderly. That is primarily rehabilitation of inpatients and outpatients. Continuing care services is a very tiny proportion of that service.

The Deputy of Trinity:
So what role do you play in the assessment of patients entering Health and Social Services wards?

Dr. M. Richardson:
Do you mean continuing care wards?

The Deputy of Trinity:
Continuing care wards.

Dr. M. Richardson:
They would usually be assessed to determine their need for continuing care. Now, that is often something that I would do but is also part of a multi-disciplinary assessment.

The Deputy of Trinity:

Who makes up this multi-disciplinary team?

Dr. M. Richardson:
It could be nurses, social workers, physiotherapists, occupational therapists, all sorts of people.

The Deputy of Trinity:
Do you see those patients at home or residential homes or wherever they are prior to them being admitted?

Dr. M. Richardson:
Most of them will be in hospital already.

The Deputy of Trinity:
What criteria do you use to make these assessments?

Dr. M. Richardson:
Well, it is fairly straightforward because residential care in Jersey takes people of relatively low dependency. If you cannot cope in a residential home, you will need a nursing home. So if you are going to be turned down by a residential home, your only option is nursing care.

The Deputy of Trinity:
So you just base your assessment on those needs?

Dr. M. Richardson:
Yes, because if you cannot place a patient in residential care, you are going to have to place them in a continuing care environment.

The Deputy of Trinity:
Do you have any budgetary responsibilities?

Dr. M. Richardson:
No.

The Deputy of Trinity:
No? None at all?

Dr. M. Richardson:
Not for these patients, no.

Deputy R.G. Le Hérissier:
Dr. Richardson, what --

Deputy S. Power:
Sorry, could I just come in on one supplementary? You mentioned your roles are broken down into a number of areas. If you were to say in percentage terms - this is probably an unfair question - what percentage of your time is given to Care of the Elderly in an average year or in an average month?

Dr. M. Richardson:
It depends what you mean by Care of the Elderly. If you are talking about continuing care, which is the remit, then significantly less than 5 per cent of my time.

Deputy S. Power:
Okay, that is fine.

Deputy R.G. Le Hérissier:
What involvement did you have in the decision to close Leoville and McKinstry wards?

Dr. M. Richardson:
Tricky that. It was a political decision. The politicians decided by cancelling the capital programme. We had arrangements in place. The arrangements were Belle Vue. That was cancelled by the politicians so we had no option but to place these patients in private care.

Deputy R.G. Le Hérissier:
Yes. When they --

Dr. M. Richardson:
It was not a health service decision.

Deputy R.G. Le Hérissier:
Assuming it was not a health service decision, when the decision was made did you feel that there were sort of implications to it which needed to be brought forward so that people were well aware of what underlay that decision, the implications that underlay that decision?

Dr. M. Richardson:
Could you just explain that a bit more?

Deputy R.G. Le Hérissier:
Well, the decision was made, and from what you are saying it was not made within the health service.

Dr. M. Richardson:
No.

Deputy R.G. Le Hérissier:
But when it was made, did you say: "Well, if you go ahead and do this, you ought to realise A, B and C could well happen"?

Dr. M. Richardson:
No, I did not have a problem with the decision because we already have patients in the private sector, the private sector being private nursing homes. Actually trying to retain patients within a hospital environment, it was something that was very outdated when I came here 13 years ago, so to try to continue that kind of service would really go against any sort of modern healthcare practices.

Deputy S.C. Ferguson:
So you would not be in favour of having another establishment like Sandybrook or The Limes built by the States?

Dr. M. Richardson:
I think it is easier to talk in general terms about that because what you have in Sandybrook and The Limes is exceedingly high quality accommodation and what you often have in the private sector, at least until recently, is not such high quality accommodation. So in actual terms of choice, you can choose to spend a lot of money on inferior accommodation or you can choose to spend a very small proportion of money on extremely good accommodation.

Deputy D.W. Mezbourian:
What has happened in the private sector recently for conditions to improve?

Dr. M. Richardson:
New homes have appeared and new ... historically, residential and nursing homes in Jersey have often been in non-purpose-built accommodation. Therefore, they are not appropriate, they are not fit for the use for which they are used. For example, you have had in the past residential homes with stairs and residents who are unable to use stairs.

Deputy D.W. Mezbourian:
So what have been purpose-built recently?

Dr. M. Richardson:
There is nothing purpose-built but there are things that have been really taken apart and put together

again, things like Lakeside, to a certain extent, and Silver Springs, where they are a much better size in terms of economy and they have much better design in terms of management. It is a better approach than, say, a townhouse or a converted house, which a lot of these places are.

Deputy D.W. Mezbourian:
You gave an example of not having presumably a lift for residents. Is that the only thing you can think of that ...?

Dr. M. Richardson:
Oh, no, there are lots of things. I mean, when I came here first there was a lot of people crammed in. The policy was cheap and cheerful. It was make sure there is somewhere cheap and make sure they are piled high, so you would find maybe 2 or 3 residents in a single room with a curtain if they were lucky and no privacy. Whereas these units now are tending towards single room accommodation.

Deputy D.W. Mezbourian:
Although the 2 or 3 residents in one room with a curtain and no privacy could probably be applied to Leoville and McKinstry at the moment?

Dr. M. Richardson:
Exactly.

Deputy S. Power:
Can I ask a question? You alluded to the decision-making process there a few minutes ago about the axe falling on what was the Belle Vue development. Judging by what you have said, you think that was an incorrect decision?

Dr. M. Richardson:
No, I am not saying it was incorrect. I am saying it was not a health decision; it was a political decision. The political context at the time was that the States could not afford the capital programme that was in place. Belle Vue was one of those projects which was dropped from the capital programme having already been slipped by about 5 years over the time it was that capital programme.

Deputy S. Power:
In your opinion, as a professional with grave responsibility in this area, do you think that was a mistake?

Dr. M. Richardson:
No. I think really what you have to look at is good accommodation for the elderly, appropriate amount of accommodation for the elderly and an appropriate funding and management system. Whether you are

doing that yourself or whether it is managed within the private sector is fairly immaterial provided you are managing a cost effective and dignified service.

Deputy R.G. Le Hérissier:
Thank you. I will just finish the question then we can move on to Sean's. Given what you said earlier about providing high cost care but for a comparatively small number of people, am I to infer from that that you felt that we perhaps, and given what you also said to Sean about the abandonment of Belle Vue, might have been going along the wrong lines in terms of our development and this was a good corrective, so to speak?

Dr. M. Richardson:
Personally, I feel that these decisions are political decisions rather than health decisions. I am not saying that is the wrong way to do it, I am just saying that is the politician's job, it is not my job. My personal opinion would not necessarily be that we need to manage all these patients ourselves. The patients that we have in Sandybrook and The Limes, for example, are managed by general practitioners on my behalf. There is no difference in their medical care as to whether they are in The Limes or Sandybrook or any private nursing home. There are inspection processes and legal arrangements to make sure that nursing homes fulfil certain requirements and they are inspected and they are managed in that way. That does not happen in the hospital, we do not have our own inspector coming around telling us to paint the walls or change the curtains or change the way in which we administer the drugs to the patients. So, in a sense, you do have a more independent policing system and therefore, possibly a better way to manage the patients. There are very few patients that would need a hospital environment. In fact, there are patients in The Limes on ventilators and things like that now that could be managed in private care provided they have the appropriate support, but if you have an economic model then clearly homes who are in a position will choose the easier patients rather than the harder patients. That purely depends on how you model the economics of the system and how many places and how many patients you have in that market.

Deputy S. Power:
Just one question related to that, Doctor, you mentioned that the 2 new entrants into the market, as it were, Lakeside and Silver Springs, would you encourage those new entrants in the market for long term care to get into areas such as using ventilators and stuff like that or do you think it is outside their remit? High dependency patients.

Dr. M. Richardson:
I think you would probably find it hard to get them to take those kind of patients at the kind of rates that have been negotiated. As I say, you have a market economy, if they can fill their beds with patients who are not on ventilators they are not going to choose to fill them with patients who are on ventilators.

Deputy S. Power:
Do you think, given the way political decisions have been made to close McKinstry and Leoville, you will see a day when private nursing homes, long term care homes, will enter that area at a higher rate for extra care?

Dr. M. Richardson:
No reason why not if that is what we choose to do.

The Deputy of Trinity:
Just taking up the point that Sean said, do you see any of the other nursing homes being able to take that high dependency?

Dr. M. Richardson:
What, you mean ventilated patients? Well, there are ventilated patients living in their own homes so there is no reason why anyone could not do it if they chose to do it and staffed themselves up appropriately and had appropriate training to do it. It is intensive because you obviously need to have trained staff on at all times. You need a higher ratio of staff for those patients.

Deputy D.W. Mezbourian:
So, how are those in their own homes being managed?

Dr. M. Richardson:
Very expensively. At States' expense.

Deputy D.W. Mezbourian:
Are Family Nursing and Home Care involved with that?

Dr. M. Richardson:
Not to any great degree, these people will need 24 hour nursing care in their own environment so that is one person looking after them, nobody else. So, there are inequalities of scale there.

Deputy S. Power:
Do you have many patients like that, Doctor?

Dr. M. Richardson:
No, that is really just an extreme example, there are not many. Predominantly people assume that a nursing home patient requires nursing care but it is probably more appropriate to think of them as patients who need a higher level of care. So, in other words, patients who are likely to either be immobile or need the assistance of one or 2 people to try to help them walk. They may need assistance

with feeding, certainly need assistance with dressing, toileting, et cetera. Most of these tasks do not require a nurse they just require people who are trained to do it correctly.

The Deputy of Trinity:
Regarding another point, you talked about the regulatory body that visits all the nursing homes and the residential homes but does not visit the hospitals. Do you think that it should?

Dr. M. Richardson:
Difficult because we employ them. They are not that independent. In actual fact, although they visit the parish homes I think the parish homes believe, to a certain extent, they are above the law as well. They choose whether to follow the guidelines or not.

The Deputy of Trinity:
We were just bringing that point up with Caroline Vibert from the District Nurses, and it says in the law that they are exempt. Well, our understanding of it is they are exempt, as the hospital is.

Deputy S. Power:
Doctor, now that we see the first of the patients transferred from Leoville McKinstry out into the private sector, how do you think your role will change in that you will now have to embrace an increased private sector role in long term care?

Dr. M. Richardson:
Well, I will not because these patients are managed by GPs.

Deputy S. Power:
But you said earlier that the GPs report to you.

Dr. M. Richardson:
Well, the current system is that the patients are within the hospital service. They are therefore officially under my care. They are managed by GPs who are contracted to the hospital. So, these are hospital patients. These patients are being transferred to the private sector, they will therefore have GPs of their own and they will be lost to me as patients. So, I will not have an increased role, I will, if anything, have a very slightly diminished role. But I will obviously still be available if I am required to make any decisions or assessments on these patients. So, I do not see it making a real difference to my workload.

Deputy S. Power:
So, would it be fair to say that the time that you spend would probably diminish slightly?

Dr. M. Richardson:

Yes.

Deputy D.W. Mezbourian:
So, your 5 per cent would reduce down.

Dr. M. Richardson:
Yes, 5 per cent was very generous.

Deputy D.W. Mezbourian:
When Deputy Pryke asked you to explain what your role as consultant physician care for the elderly entails, you mentioned a number of areas. What is your priority among those?

Dr. M. Richardson:
Well, about half my time is spent looking after -- because we are all general physicians, there are 7 physicians in the hospital. Those 7 physicians all have responsibility between them for all the medical emergencies that come into the hospital. So, any acute adult medical emergency who comes in on my take will be my responsibility. So, that means about half my workload will be acute medicine, which is sick adults of any age. The remainder of that time will be spent between out patients, elderly care and rheumatology, so looking after joints, bones, et cetera. So, maybe 15, 20 per cent of my time, tops, is spent on elderly care in total and that is everything. So, the proportion I spend on the patients you are thinking about is miniscule in relation to that because these are continuing care patients. Patients who are essentially stable, essentially requiring a lot of looking after, nursing wise, but who do not have high medical needs because they are coming towards the end of their life. Most of the kind of care or decisions I will make about them will probably be ethical decisions about what not to do rather than what to do, because it is not fair on the patient to subject them to a lot of things that may not improve their life or lengthen their life.

The Deputy of Trinity:
You talked about the medical responsibility, now they have left Leoville McKinstry, referring to the GPs, so even though the contract at Silver Springs is with Health and Social Services, the medical responsibility is purely with their GPs?

Dr. M. Richardson:
Correct. That already happens though, that is not different from the system we have in place, which is why we put that system in place because it is what already happens.

The Deputy of Trinity:
So, Health and Social Services have no medical responsibility at all for the patients who are transferred?

Dr. M. Richardson:
We already have approximately 30 patients in private nursing beds that are contracted. In other words, Health and Social Services are paying for patients to be in nursing homes already. Those patients are being paid for by Health and Social Services but their medical care is down to their general practitioner. These patients in Leoville are going to be in exactly the same position because it would be inequitable to do anything else with them. So, these patients will move to private care and within that time will have a 3 month window of contracted GP care, and within that period can choose, at any time, to move to a GP of their choice. So, they could revert within a week to their original GP if that was their choice. Most of these patients, when they go to continuing care, they are quite distressed to find that they cannot have their own GP. They cannot have their GP any more, they have to have the one that we pay for. Most of them would prefer to have their own GP. So, a lot of them may well go back to having the GP they had originally, or alternatively, they may continue with the contracted practice but on a private basis, if that is what they choose to do. We are doing that because it is what we are already doing and it would be inequitable to have 2 different streams of patients, ones in private care that pay for themselves but we pay for the bed, and ones in private care that we pay for the bed and we pay for all their health care as well and all their drugs. So, we need one system.

The Deputy of Trinity:
Which is going to be put in place now.

Dr. M. Richardson:
Which is already in place for the patients. It has been in place for 2 or 3 years.

Deputy D.W. Mezbourian:
What would an example of an ethical decision be?

Dr. M. Richardson:
Well, the example just now, for example, is there is a man in hospital who has come from one of these continuing care wards that we are closing down. He came down to the hospital because he was sick and he needed to be sorted out, he was vomiting. When we investigated him we found there was a massive tumour within his abdomen. He has previously had a stroke, he is very disabled, he is quite elderly. So, there are numerous choices in what you can do with him, you can operate to try to remove the tumour. You could biopsy the tumour, which is still quite an invasive procedure and could be dangerous, to see if the tumour is going to be responsive to things like chemotherapy or radiotherapy, or you could just try to make his symptoms as minimal as possible with treatment without invading him, so to speak. So, that is an example of the kind of decision you might have to make. So, when I saw him, I said: "Okay, we do not do anything, we look after him and we stop him being sick." So, with the right drugs we have stopped him being sick, he can now eat and drink. He still has his big tumour but we have not poked him with needles and knives and basically, probably finished him off earlier if we had done anything

like that. So, it is a complicated process but it is trying to do the right thing for the patient and it is not always an easy thing to do.

Deputy D.W. Mezbourian:
So, what decision has been made about whether to move him or not?

Dr. M. Richardson:
Well, it is interesting, because we now have him in a position where we feel it is reasonable to send him back to where he came from but he is on the list to be moved to Silver Springs. Now, he has stated categorically that he wants to go to Silver Springs even if it is only for a couple of days because he would rather die there than anywhere else. So, he has made his choice in that, although he has serious issues, he desperately wants to go there before these other issues overwhelm him.

Deputy D.W. Mezbourian:
So, that, presumably, is the course of action that will be taken?

Dr. M. Richardson:
Yes, that is right.

Deputy S.C. Ferguson:
Which really takes me on to the next thing. When you are dealing with patients receiving continuing care, what sort of emotional and psychological needs do you usually find they require?

Dr. M. Richardson:
A lot of them are confused or demented. So, for a significant number, there are really different areas that you are trying to deal with. For most of the rest I would not say there are any particular issues we come up with. I suppose, in general terms, these patients would rather be somewhere more homely than the provision that we can provide for them. So, in terms of emotional or psychological need, what you really ought to be doing is providing them with as homely an environment as you can. So, that is really providing them with privacy, dignity, trying to appropriately manage their social needs, trying to keep them occupied or entertained so that they are not bored stiff. What you do not really want to do is have them sitting in a circle in a room with Radio 1 blaring or a television blaring cartoons that is of no relevance to them. That is often what we do. I think we will find that a lot of the homes now have people who are specifically there to engage these people socially and give them a better quality of life. Because we are a hospital type environment, then these things can get missed in a way because our whole focus is on health and that is often physical health, which is making sure you are on the right pills, making sure you get the pills at the right time, making sure your disease is under control. But for patients, in their general life, that is a pretty small bit and often a bit that they would rather not bother about. There is other things that they would rather spend their time doing. So, I think for a lot of those

patients we probably currently do them a disservice and hopefully we can provide them with a better service elsewhere.

Deputy D.W. Mezbourian:
If you say that that is what is happening, certainly in Leoville and McKinstry, that you are allowing elderly patients to sit in a semi-circle in front of a television - that is happening at the moment?

Dr. M. Richardson:
Yes.

Deputy D.W. Mezbourian:
Why is it not being addressed now?

Dr. M. Richardson:
Well, partly because there is a certain degree of choice in where they go and for patients with more mental health problems and physical problems they probably migrate to those kinds of areas. So, the patients you see in that ward will often have a greater degree of dementia or confusion than perhaps patients in the Sandybrook and The Limes, where they may be better able to appreciate the different quality of the surroundings.

Deputy D.W. Mezbourian:
So, does that mean it is appropriate to allow them to do that?

Dr. M. Richardson:
Not necessarily appropriate but in any health service you have a limited amount of money and if we put down a bid for a social organiser, for example - I mean, the staff do what they can but if you wanted somebody to come in and do things with them - there is no way that would hit above the line in terms of getting money or priority compared with drugs or machinery or anything else that we need to keep patients alive. So, a health service will always prioritise life above quality.

Deputy D.W. Mezbourian:
It seems incongruous, you have life but you have no quality of life.

Dr. M. Richardson:
Yes. If you wanted to put it in black and white, if you employed someone to manage their social engagement, what would you not do because you were now employing that person. There is something else you are not going to be able to do. That might be not buying drugs for rheumatoid patients. It might be not buying a dialysis machine for the renal unit.

Deputy D.W. Mezbourian:
So, who makes the decision?

Dr. M. Richardson:
Those decisions are health decisions, we make them all the time.

Deputy D.W. Mezbourian:
What is your opinion of the standard of medical care in Leoville and McKinstry at the moment?

Dr. M. Richardson:
The standard of medical care is high. It is maybe the quality of social care, because they are in a hospital, is maybe difficult. In terms of the money, I think for 2007 we have 6 - what is the money just now, Andy, that we have had in health - we have £300,000 or £600,000 to spend and £3 million bids?

Mr. A. Bannister:
The investment bids? I really do not know but it is something like £3 million with £12 million bids.

Dr. M. Richardson:
Yes, that is about right. So, we have £12 million worth of bids, £3 million worth of money and £1 million worth of savings to make. It is something like that. So, for any amount of money you want to spend in the health service, we are lucky if we get 20 per cent of it.

Deputy D.W. Mezbourian:
Do you foresee an improvement for those patients who will be moving to perhaps Silver Springs with regard to their socialisation?

Dr. M. Richardson:
I would hope so, yes.

Deputy D.W. Mezbourian:
Are there people who would be aware of the improvement?

Dr. M. Richardson:
Yes, because part of the process involves utilising some of the staff from these areas to continue to monitor these patients. What we do not have is a system of monitoring within that private environment, we will rely on the GP or the home to flag up any issues.

Deputy D.W. Mezbourian:
Although, I believe, a care sister will be attending them on a weekly basis.

Dr. M. Richardson:
That is right, that is a new thing and that is what will hopefully pick up any improvements.

Deputy S. Power:
Will that care person report to you?

Dr. M. Richardson:
No. They will probably report to -- I lose track of all our changes. I do not think we are allowed to call them modern matrons any more but these are nurses so they will report through the nursing management rather than to myself.

Deputy S. Power:
But if they throw up an issue in one of the private nursing homes, it will eventually get to your desk?

Dr. M. Richardson:
It should reach my desk, yes. But the thing about a big organisation is there is a lot of people involved and there may be other people who feel it is more their job than my job. If it was an issue with a particular patient, I can see it would certainly come to me. If it is a general issue about, say, socialisation in a particular home, then I can see it may not come to me; it may come to somebody else. But if any issues are raised with me then I will deal with them or arrange to have them dealt with.

The Deputy of Trinity:
Do you see with the patients being transferred to the private sector this ending up a saving to Health and Social Services?

Dr. M. Richardson:
I think that is difficult to work out. We have had I do not know how many people, working groups, committees and everything, looking at this for a long time, and basically, as far as I can understand it, the way the private sector manages itself and the way a public sector manages itself are different. So, you cannot equate like with like, pound for pound. We think we are getting a good deal as near as it goes but when we are costing a continuing care unit, we are basically costing the staff. We have not included the cost of rebuilding the buildings, which is really what you would want to include if you wanted to look at the appropriate costs because these buildings need to be rebuilt. They have been refurbished to the nth degree over the years. The other buildings on Overdale that have already been shut down are shut down because all their utility services are flooded and full of asbestos. So, to demolish, lift and remove all that lot I am sure is going to cost a fair amount of money and a fair amount of specialist help.

The Deputy of Trinity:
That is another issue. Were you part of the negotiating team?

Dr. M. Richardson:
No.

The Deputy of Trinity:
Did you have a look at the contract and the service level agreement?

Dr. M. Richardson:
I have been involved with the group that has been overseeing this. So, anything like financial negotiations, risk management, discussion with relative staff and everything else, has come to that group on a regular basis since we started. It has been micro managed to an incredible level, as far as I can see. I think they have not just left no stone unturned, they have looked under every pebble they could possibly find to try and make sure they managed the process as well as they could. They put an immense amount of effort into that. So, I think the process of transfer is going as well as it can and certainly I have been privy to all the arrangements and agreements and contracts that have been going on. I suppose the kind of problems we have experienced though is that we are stuck. We are in a small island, everyone knows what is going on. You read the *Evening Post*, you can see that the quality of buildings in Overdale is poor and Frank Walker, I think a year ago, said: "This is dreadful we are going to close these." Obviously that puts the private sector in quite a strong position. We have nowhere else to go but the private sector, we have no choice, so they can hold out for a good amount of money because they know we have to buckle at some point because we cannot continue because Frank Walker has told us we cannot continue.

The Deputy of Trinity:
Do you think that has happened with negotiations with Sandown and Silver Springs?

Dr. M. Richardson:
Certainly our officers feel they have been negotiating with one hand tied behind their backs for predominantly those reasons. We do not have options, we only have one or 2 providers who can provide. If we need a provider, we need a provider; therefore, they can ask us for what they want.

Deputy S.C. Ferguson:
However, given the fact that a number of these homes really will not want to take on high dependency patients, then really we have no option but to build another continuing care set-up whether at Belle Vue, which is a bit small to be economic, or perhaps on the site of Overdale. Is that a fair comment?

Dr. M. Richardson:

I think you either need a system that encourages the private sector with appropriate measures, in other words, to make sure you are getting value for money, or you do it yourself. You have to work out the numbers. The private sector usually has a little bit more flexibility in terms of staff costs and they are a hell of a lot more efficient at putting up buildings than the public sector. They can throw up a building in months and have it open and working. It takes Health about 10 years to think about what they are going to put in a building once they have decided to build it.

Deputy S.C. Ferguson:
Then the lifts will not take stretchers.

Dr. M. Richardson:
Do you mean like the new building at Overdale where they have patients upstairs but we needed to build a ramp to take them in and out because the lifts were for people that could stand up? Yes.

Deputy D.W. Mezbourian:
What are your comments on the facilities at Silver Springs?

Dr. M. Richardson:
They are very high quality. I have not been there myself because they had a visit and I was away when they were doing that visit so I have not been myself, but from everyone that has been, and that is lots of different staff from lots of different areas, I have not heard anyone who has had an issue or a problem with it.

Deputy D.W. Mezbourian:
Is it your intention to visit?

Dr. M. Richardson:
Yes, I will go there when I can and see what it looks like. But it is one thing to say the building is very nice and it looks as if it will function well, but it has to work like that in practice and you need the staffing and the commitment and the leadership and all those other things to make it work. It is all very well saying the building looks nice but there is more to it than carpets and curtains. That is what I always say if I am discussing things with relatives or patients, I will say: "By all means, go around but there is more to life than carpets and curtains." There is smell and there is staff and there is how quickly they respond to things and there is dignity and privacy and all those things, which is pretty difficult to measure.

Deputy D.W. Mezbourian:
So, who has judged that those things that are difficult to measure have been provided?

Dr. M. Richardson:

They will have to be judged on an ongoing basis. You cannot prejudge it, you are just going to have to rely on the experience of the people that go in and out, the relatives, the friends, as well as the professionals like family nursing, doctors, inspectors, et cetera. That kind of informal network would quite quickly pick up any problems. If someone was naming names to me I could say: "Yes, that is a good one to visit" or I could go: "Are you sure you want to go there?" But my judgment is not necessarily the one to go on, you would need to sample a few people's judgments to see if that was the right thing to do. Going to one place does not preclude you going to other places. We have placed patients, in the past, numerous times in homes. Numerous times because as soon as they get there they phone a taxi and they go home again. You cannot keep them there if they do not want to go there.

Deputy R.G. Le Hérissier:

Moving to a more micro issue, so to speak, Dr. Richardson. If you were asked for advice, and you may well have been in this instance, what consideration needs to be given to balancing the need for patient privacy and the opportunity for social interaction?

Dr. M. Richardson:

Well, they are often 2 sides of a coin really, are they not? For a lot of people, I think it boils down to the kind of person you are. Certainly when I talk to older people it is not difficult to put them in the: "I like my own company" category, or: "I am really lonely and I like company." You could get someone who is living at home on their own and could be adequately supported in their own home but they are just lonely and sad and they would prefer company. For that person being in a residential home might be the best option for them but there may be somebody else who prefers their own company and these people would not enjoy being in a home. So, if you are in a home you need to be able to have your privacy, your dignity, your solitude if you want, which nowadays is usually managed within a single room environment, so you have your own personal space but you have communal space that you can use if you choose to. That has to be managed on an individual basis really. You really have to be able to give people these opportunities. They can choose to stay in their own room or they can choose to socialise.

Deputy R.G. Le Hérissier:

Would you extend that, for example, to the eating of meals?

Dr. M. Richardson:

I think for most people that is the way it works as well, they can choose to eat in their own room or they can choose to eat in the dining room. Obviously there are other factors that may depend on rather than simply choice, but I think, as far as possible, you have to allow patient choice. In fact, nowadays, patient choice seems to be number one, it is not always the right way to do it but that is currently the way it sits.

Deputy S. Power:
In a review of continuing care and respite care provision, it was noted that the result of relocation is a cause of great stress and anxiety to both patients and their families and is linked to increased mortality rates. There is a reference to that in the 1967 report by Holmes and Rahe, Social Readjustment Journal of Psychosomatic Research. To what extent and what measures have you put in place to try and minimise mortality rates as a result of the closure of Leoville and McKinstry?

Dr. M. Richardson:
It has been something that we have thought an awful lot about. It is a big issue. As far as I understand it, the research is often conflicting on this, partly because the kind of patients that we are dealing with die on a fairly regular basis anyway. There was a time in the past, in fact I think it was not long after Shipman, when we had something like 13 deaths on Leoville within a few weeks and we investigated that because it seemed an enormous number of deaths. We were not concerned, we just wanted to be able to move through the logic of investigation and ensure that there was nothing we were missing. That turned out to be fine but you do get spikes and troughs, you can go through somewhere like, for Leoville for example, no deaths for 3 or 4 months and then you can go through a spate of frequent deaths. There does appear to be a link with death and movement but no one can really be quite sure why. The arrangements we have had have been full and frank discussion with relatives and patients, over a very prolonged period of time, trying to make sure any anxieties or problems were resolved before there was any consideration of moving. Making sure that there was consensus with everything and every group so that everyone was basically going where they wanted to go and there were no issues really. Trying to follow through the move with some continuity of staff so that the patients would have familiar faces in a sort of transitory phase when they had moved. So, things like that to try to minimise any problems.

Deputy S. Power:
When you discussed the moves with, obviously, patients, but specifically with their closest relatives, have you had the need to discuss the fact that there may be increased mortality rates because of the move? Did you make the families aware of that?

Dr. M. Richardson:
I did not do it personally but I know that the families were made aware of that and are aware of it. I think everyone is just accepting of the fact that it is a difficult scenario, it may happen but it may happen anyway. It would statistically certainly be very difficult to prove a connection. You would really need quite a significant number of deaths before you could say that you had determined there was a link, as I say, because the death rate is so frequent anyway.

Deputy S.C. Ferguson:
One question related to that, there have been a number of references in the UK media, and that is a heavily qualified statement, relating to cases of patients starving to death and are dying from

malnutrition because they were not eating properly or they were not eating enough in some of these places in the UK. In your 13 years in Jersey, have you ever come across anything like that here where it might have been a patient was not eating and was not noticed?

Dr. M. Richardson:
I cannot recall coming across that at all. There is a fairly robust assessment system available for anyone to access with things like speech and language therapists. The biggest issue in this group is probably not being able to swallow properly, often due to strokes or other problems. If they are not able to swallow properly, a common complication is aspirating food or liquid into their lungs, which leads to pneumonia which leads to death. So, chest infection and death because that has been missed used to be quite a common problem. Certainly in Jersey, that has really been minimised because of the aggressive approach that the speech therapists have to dealing with that. The other side of the coin, with people not getting enough to eat or drink, I have not come across that. It is a very difficult area to deal with and we often have people in hospital who do not eat or drink and if we feel that is their conscious decision then we have to respect that. If it is for another reason like they cannot reach their food because it is at the end of the bed, then obviously there is an issue there. But that is not something I have come across.

Deputy S.C. Ferguson:
Yes. I think, to be fair, it is something possibly that is more in hospital but there are patients, particularly if they are dementia patients, who just do not bother to eat unless they are assisted.

Dr. M. Richardson:
Yes.

Deputy S.C. Ferguson:
Obviously the question is are all the residential homes keeping an eye on that and, I suppose as a corollary, is the hospital keeping an eye on it and does this come under your remit?

Dr. M. Richardson:
If you are talking about these homes in general then these issues would not come under my remit or the hospital's. These are community patients so they have nothing to do with us. The patients in residential or nursing homes are going to be under the care of their GPs and it would be the GP's job to notice there was a problem, or the staff within the home to notice there was a problem, and to address that and then refer to the hospital if they felt we needed to be involved to deal with it.

Deputy S.C. Ferguson:
Is it something that should be put in the guidelines for the homes?

Dr. M. Richardson:

I am sure it is already.

Deputy S.C. Ferguson:
What about the hospital? I know this is slightly off point but it is a situation that does exist and is quite crucial.

Dr. M. Richardson:
Are you talking about simply trying to assist people to eat?

Deputy S.C. Ferguson:
There are patients in hospital who, because of something like dementia, are a bit sort of hit and miss about feeding themselves and do need assistance and there does not seem to be any --

Dr. M. Richardson:
That should be addressed because there are usually systems in place to determine the type of food a patient requires, either through diet or consistency if they have swallowing problems. There should also be a system in place with tray covers so that patients that may have trouble getting through their food have a specific colour of tray which identifies to the staff that they need to keep an eye on them or give them some assistance with their eating. So, it should be under control.

Deputy S.C. Ferguson:
Well, it is not. It is a bit outside the remit at this point so I will have a word with you after.

Dr. M. Richardson:
All right.

Deputy S. Power:
One final question, Doctor, if I may, on mortality rates. Has the department made a provision for a spike in the next 6 to 9 months on the movement of 30 plus people out of the ...

Dr. M. Richardson:
What kind of provision do you think we might need?

Deputy S. Power:
For more than the normal statistical acceptable rate of mortality at Leoville and McKinstry.

Dr. M. Richardson:
There is a sort of risk management profile and the assessment that at least one or 2 patients would die shortly after transfer was felt to be inevitable and it has already happened. So, that point was proven.

The possibility of a larger number of patients dying we feel is less of a risk but we have a process in place to try to address that and deal with it.

Deputy S. Power:
The party that died, that was transferred from Leoville McKinstry - I am not quite sure which one - to Silver Springs, will you now correlate the assessment before the movement?

Dr. M. Richardson:
That has already been done. Yes. It was felt they were fit when they were transferred and they developed a chest infection after transfer and the decision with the relatives was not to move that individual to hospital. They stayed at Silver Springs and they died after about a week. So, that sounds, from the description, to me like a fairly natural death in the circumstances and that is the kind of thing we would have expected to happen anyway and we would continue to expect to happen. Obviously, with those kind of patients, the assessment and the decision to treat is often quite difficult because once you get to the hospital it is not always easy not to get treated. You are often into a roller coaster and it can be difficult to stop it.

Deputy S. Power:
So you would put that death down to the chest infection, *per se*, and not reduced resistance due to tension or anxiety.

Dr. M. Richardson:
We have no evidence of that.

Deputy S. Power:
That is fine.

Deputy D. W. Mezbourian:
How often do you think reviews of patients' needs should be carried out, when they are moved from Leoville and McKinstry to the private nursing home? I believe there is a suggested process of looking at that.

Dr. M. Richardson:
The process is that we have some very qualified nurses who are going to visit these patients on a frequent basis. I cannot remember off the top of my head how frequently that is.

Deputy D.W. Mezbourian:
What is best practice?

Dr. M. Richardson:
There are probably a few things you have to assess. You have to assess the suitability of that individual within an environment. Now, you could argue you should be doing that with all the patients, not just the ones that we have moved there but to get the best fit with your limited resources, you need to be constantly assessing patients. For example, sometimes patients within our continuing care environments improve to the degree that they could be managed in a residential home. We are then often left with the difficulty of trying to persuade them to move to a residential home because we do not feel they should be there and they do not see why they should be moved. So, people can improve as well as deteriorate. So, maybe if you were being absolutely scrupulous about it you might want to assess an individual's needs in terms of their placement, maybe 2 or 3 times a year.

Deputy D.W. Mezbourian:
I believe that the one of the outlying requirements, when the tenders were sent out for the provision of nursing beds, stated that initially it would be 6 weeks after placement.

Dr. M. Richardson:
Yes. But that is probably simply to assess other things, you know, their health, their happiness with their position and other things. So, yes, they will be assessed quite closely from that point of view because that is part of the transitory arrangements. So, there is a transitory arrangement to ensure that this new system is working and then there should be a more general assessment that maybe happens less frequently that assesses firstly that your patients are in the right environment and that they are being managed appropriately in the environment they are in.

Deputy D.W. Mezbourian:
I believe the wording is: "We will review the care of each patient."

Dr. M. Richardson:
Yes.

Deputy D.W. Mezbourian:
It is not specific. It is the generic term "care".

Dr. M. Richardson:
Yes.

Deputy D.W. Mezbourian:
After the 3 and 6 monthly review following placement, the recommendation is that they will be conducted annually.

Dr. M. Richardson:
Yes. That sounds fair. I would not disagree with it.

Deputy D.W. Mezbourian:
Thank you.

Deputy S.C. Ferguson:
What do you see as the most important issues for care of the elderly, facing health and social services in the future?

Dr. M. Richardson:
Personally, I would say your biggest challenge is preventive.

Deputy S.C. Ferguson:
More primary care and not so much concentration on the hospital, secondary care.

Dr. M. Richardson:
The biggest issue is trying to persuade people to lead a healthy life, which will give them a healthy old age. So, it is really public health issues. There are all sorts of research and grafts and all sorts of things. I could talk for hours on it but, basically, a bad old age is usually self-inflicted. It is not something that just happens. It is a consequence, perhaps, of over eating, over drinking, too much smoking, not enough exercise, too much manual labour, too much sport; general bodily abuse will give you a bad old age, whereas a healthy lifestyle will give you a healthy old age. So, if you made everybody have a healthy life, you would not have a problem with old people because they would be healthy. So, the issue is not what are we going to do with all these old people. It is what are we going to do with all these people your age to make sure that they do not turn into old crocks. How are we going to make them stay healthy? **[Laughter]** Then you get accused of nanny state and all that stuff. You have to give people the liberty to damage themselves but also the liberty to demand the treatment for that from the State. That is politics for you though.

Deputy S.C. Ferguson:
When are you joining us? **[Laughter]**

Dr. M. Richardson:
Fat chance.

Deputy A. Pryke:
On page 10 of the review, continuing care and respite care provision, the long term strategy for continuing care is described as follows: "That the development of alternative community continuing

care and respite care model should be in partnership with other stakeholders, such as Family Nursing and Home Care and independent and voluntary organisations." So, a question on from that, what consultation has occurred with you with regard to the long term care strategy and also have you been in any consultation with district nurses and other voluntary sectors looking at that?

Dr. M. Richardson:

There is always a lot of talking goes on about care for the elderly for the future. Part of the reason you are in existence is because we are often talking about what is happening in the future, whereas we are kind of forgetting about what is round the corner. The things I have been seeing for many years is that one of the critical factors that needs to be managed is a comprehensive financial restructuring of the funding of this group of patients, which is happening at the moment. There is a group dealing with this but the current arrangements are chaotic, absolutely chaotic. In fact, the current provision means you have no law in place that permits you to ask anyone to pay for their care, or at least pay an appropriate amount towards their care. So, you are now in the iniquitous position of having people in residential homes paying a fair amount of money who, because they cannot now afford the official nursing home rate, are going to be paying half what they are paying in residential care for you to provide them with nursing care. So, in other words, instead of paying 100 per cent of their costs, they are now going to pay 25 per cent of the costs and save, in the bargain, several hundred pounds a month. That happens now and it will only get worse because if that spreads around, clearly there is no reason for anyone to pay. If their neighbour is not paying, why should they pay? So, you know, the whole system would potentially melt down within a month if there was an appropriate article in the *Evening Post* telling people how to manage the system. I am not planning on doing that but if there was, you would be bankrupted within a year because nobody has addressed the issue. From a political point of view, again, that is probably the biggest priority; sort out the finances and have it dealt with appropriately.

Deputy D.W. Mezbourian:

If we were able to sort out finances and were in a position to build a new nursing home for health and social services, you mentioned earlier about the provision of lifts as being one of the physical requirements. What would be the medical requirements for a new home?

Dr. M. Richardson:

You would not need any over and above what you have already because most of these patients could be managed by general practitioners. You have 100 on the Island. I think Guernsey has 30. So, you are certainly well provided with doctors in the private sector to manage patients; one doctor per 800 patients. In the UK, it is one doctor per, maybe, 2,500 plus.

Deputy D.W. Mezbourian:

So, the importance, really, would be based on the building itself and the facilities --

Dr. M. Richardson:
I think the issues in terms of future buildings, it is not so much what you are going to build, because everyone has an idea of what you ought to build, it is who builds it; should the States build it, or should the private sector build it, or should there be a partnership of some description? In terms of staffing it, should the States staff it or should the private sector staff it? We struggle to staff our hospital, never mind anything else. We have a hospital full of agency nurses and nurses from all over the world because we cannot recruit enough staff and that is the same throughout the UK.

Deputy D.W. Mezbourian:
What is the reason for that?

Dr. M. Richardson:
Well, I suppose it is always the same reason. You do not pay them more than somebody else pays them.

Deputy D.W. Mezbourian:
Is there a lack of qualified nursing staff to recruit from?

Dr. M. Richardson:
Yes.

Deputy S.C. Ferguson:
We are not exactly exceptional in this, surely?

Dr. M. Richardson:
No, you are not. No. You are typical.

Deputy S.C. Ferguson:
Because it is the same in the UK and it is the same in the US.

Dr. M. Richardson:
Yes, but your private sector in Jersey has managed to suck some very senior nurses out of your hospital system. Now, they have not done that by paying them less than the hospital has. So, your State sector is obviously able to look after these patients at what the hospital seems to feel is a fairly economical rate and they seem to be paying their managers more money than we were.

The Deputy of Trinity:
So, has the closure of Leoville and McKinstry, with the redeployment of staff, helped with staffing levels within the general hospital?

Dr. M. Richardson:
Yes, because the staff that were on those wards will now be redeployed to fill vacancies elsewhere, and there was a small amount of medical input from some of my junior doctors and that can be redeployed because of changes in working patterns and shift working. In general, it means that they can fill in some of the gaps there as well. So, it has helped all round in terms of staffing.

The Deputy of Trinity:
Will they need extra training to be brought up to date in whichever area they been redeployed to?

Dr. M. Richardson:
They may do. It depends where they are being deployed, but I think you may also find that those staff are taking different skills and there may be education that other staff will able to receive from them, like making sure the food tray is close enough to the patients. There might be other things that are not obviously apparent. So, I would hope that there is going to be learning on both sides.

Deputy R.G. Le Hérissier:
This is near the end you will be glad to hear.

Dr. M. Richardson:
I am getting to quite enjoy it now. **[Laughter]**

Deputy R.G. Le Hérissier:
Obviously it is an absolute canon(?) of looking after the elderly, or not looking after them, that, until the absolute moment of the decision, they should be able to stay at home; (a) do you agree with that and (b) what are the care implications of trying to implement that particular approach?

Dr. M. Richardson:
I think superficially you would agree with it but I suppose what takes priority these days is the autonomy of the patient; the patient's choice. If the patient chooses to be at home then we do our utmost to manage them at home. The hardest thing is wanting to stay at home and having no relatives and no money because then you are relying on a very scanty family nursing service to support you. If you have 6 daughters who do not work, who are prepared to do a rota and all live in the same parish and you have enough money to fill in with a bit of private care here and there, you have no problem whatsoever and you can stay at home until you die, even if you are severely disabled. So, you can stay at home with severe problems if you either have appropriate informal family support or you can afford professional support or a mixture of the 2. If you need hospice care then you have the additional help of a bit of hospice which, thrown in, can make all the difference. As I said before, for patients who are at home, some of them desperately want to be at home, some of them really could not care less. I think for a fair number of those, moving them to a long stay environment might see them moving to a better

environment than they have ever experienced before in their lives. If you are living in an undeveloped cottage with an outside toilet, which some people do, and you are moving them into a beautiful new air-conditioned, heated room with en suite and all the necessaries, they may feel this is better than something they have ever had before. As I said, some people would rather not be at home for various reasons. It might be social. It might be pressure from family or friends that they cannot cope at home any more. There may be other reasons. So, in terms of determining who should stay at home and who should not, it is often down to the individual with as much consultation as possible in terms of what they want to do. But I would agree that ideally we should be trying to keep people in their own home for as long as possible. If you are keeping people in their home for as long as possible then that virtually removes the need for residential homes and there is I think at least 1,000 beds out there charging up to £800 a week.

Deputy R.G. Le Hérissier:
Do you think if family nursing could provide more help, or if indeed they were financed to provide more help, do you think it would have a serious impact on the residential sector?

Dr. M. Richardson:
I am not sure if it would make a difference on the residential sector. It might make a difference to a proportion of people who are able to stay at home longer. Because family nursing is independent, they kind of do their own thing and it can be difficult to know exactly how they work or operate, family nursing at tops might give you 3 visits a day, average maybe 2 visits a day, but you are still left alone for substantial amounts of time during the day. The way I always look at it as the critical factor is getting to a toilet or a commode. If you can do that on your own, you can be left alone in the house. If you cannot do it on your own then you cannot be left alone in the house, and if you cannot be left alone, you need 24-hour care. Twenty-four hour care is paying at least 4 salaries a week to cover the hours and that becomes prohibitive. So, even if it is managing to get from a chair to a commode, if someone can do that safely and confidently, you can afford to leave them alone and therefore the amount of care they need diminishes markedly.

Deputy D.W. Mezbourian:
What consultation do you have with Housing with regards to keeping elderly people in their own homes?

Dr. M. Richardson:
None. That is the easy answer. Even when we have these joint areas like The Limes where Housing and me and the social workers were going to decide who went there, that was fine until they opened and then Housing took them over. So, we have no input at all.

Deputy D.W. Mezbourian:

You do not have any input with regards to aids that may --

Dr. M. Richardson:
If somebody requires aids and things in their home then, yes, the occupational therapy department will manage that. But the only input I could possibly provide is writing to Housing and saying this person has particular problems, they need to move. But then they go on the list with all the other people with medical problems who need to move. I suppose the point is you need the right balance of housing in the first place and if you do not have the right balance of housing you are going to have a waiting list. Everyone wants a ground floor flat. Nobody wants a second floor flat.

The Deputy of Trinity:
Thank you.

Deputy D.W. Mezbourian:
Sorry, I just have one more. What is the long-term strategy for care of the elderly then within Health and Social Services?

Dr. M. Richardson:
In terms of accommodation?

Deputy D.W. Mezbourian:
Overall.

Dr. M. Richardson:
Overall? There are an awful lot of strategies in place and an awful lot of strategies to put in place. I have always felt if you want a strategy for elderly people, health is a little bit of it. A big bit is going to be social and housing and all sorts of other things. For it really to work and save money, you need to be engaged in social engineering before they get -- because once they get to 70, you are not going to change their habits very easily. You have to pre-empt that. I do not know how you could do it. It is an enormous burden to try and manage it and you cannot make people be healthy. People choose to be unhealthy and therefore we have to deal with the consequences. All we can do is show them that you can -- I think it is a misperception. People feel that getting old is a bad thing because they perceive that being old is unpleasant and therefore, if I do all the wrong things, I will be able to die before I get old. But they have it wrong. If you do all the wrong things you do not drop dead. You become one of those old people that you were trying not to be and the ones who did try are quite healthy people and we never see them because they are out there having a good time and enjoying themselves. I have not implemented this but I did think about starting a 100 club. Anybody who wants to live to be 100 can join my club and I will help you live to be 100. The numbers of people who were prepared to join that club were miniscule. Most people said: “No thanks, do not want to join. Another 2 or 3 years is fine for

me." So, there is a lot of work to do on that. It is interesting.

Deputy S. Power:
I would image that, to get people to join the 100 club you would need to start targeting people our age group.

Dr. M. Richardson:
Yes, or even the 10-year olds. **[Laughter]**

Deputy S.C. Ferguson:
The games (...several inaudible words).

Dr. M. Richardson:
Yes. Burn all the Xboxes. Buy them all footballs.

Deputy S.C. Ferguson:
It starts at an early age.

Dr. M. Richardson:
Yes.

The Deputy of Trinity:
Thank you very much indeed, Dr. Richardson, for coming here and we will get a copy of the transcript downloaded.

Dr. M. Richardson:
Thank you.