SOCIAL AFFAIRS SCRUTINY PANEL
OVERDALE SUB-PANEL

OVERDALE REVIEW

THURSDAY, 5th 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. Bayes (Jersey Association of Carers)

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.)*

Deputy A.E. Pryke of Trinity:
Good morning, Dr. Bayes. I would like to welcome you to this Scrutiny Public Hearing on the closure of Overdale. As you know, the panel is in the process of reviewing the reviewer decision to close the 2 continuing wards at Overdale and to transfer those patients into the private sector. Part of our evidence gathering is to get information from other sectors and professionals like yourself.

Dr. M. Bayes (Jersey Association of Carers):
Thank you.

The Deputy of Trinity:
I would like to introduce myself. I am Anne Pryke, Deputy of Trinity and Chairman of the Sub Panel.

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

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

Deputy D.W. Mezbourian of St. Lawrence:
I am Deidre Mezbourian of St. Lawrence.

The Deputy of Trinity:
Deputy Sean Power will be joining in about 10 minutes or a quarter of an hour or so. On my left is William Millow, our Scrutiny Officer.

Dr. M. Bayes:
Thank you.

The Deputy of Trinity:
There is a certain protocol, and I understand that you have seen it and read a copy of the statement?

Dr. M. Bayes:
I think so. This one?

The Deputy of Trinity:
Yes.

Dr. M. Bayes:
Yes, it is the protocols.

The Deputy of Trinity:
This hearing will be held in public and it will be recorded and transcribed. You will get a copy of it before it is loaded on to the website.

Dr. M. Bayes:
That is fine, thank you.

The Deputy of Trinity:
Very good. What role does the Jersey Association of Carers play?

Dr. M. Bayes:
We are interested in the welfare of carers altogether. Can I just go through a bit of the history of the working party which has been set up? At the end of last year, December 2005, we were concerned about the current arrangements for respite after the closure of Edith Secker Ward and patients transferred to McKinstry Ward. I did visit McKinstry Ward as a potential carer bringing my mother in and was not really very happy with the situation there. It did not compare with Edith Secker Ward, in

my opinion. We decided that we would adopt a positive attitude to this change and try and move things forwards. So, Fiona Hagg, who was our Carer Centre Manager, and I had a meeting with Marnie Baudains and Mike Pollard. We asked at the end of that meeting if we could have a working party to examine the situation with regard to respite in Jersey, which he agreed to. The working party was set up: Fiona, myself, John Cox and Marnie Baudains. We have had about 10 meetings, when I looked back through my diary last night, and we have held 2 workshops. We had a half-day on 15th March this year, and a whole day just recently on 25th September. We invited all the relevant statutory bodies, people from Social Services, Mike Pollard, and Health. Our guest list included -- I went down the Jersey Association of Charities members and invited all the health and social care agencies that we felt would be involved. It was a very good attendance on 15th March. They wanted to move things forwards and have the review one in September, which we did have. As a result of the first workshop we have produced a draft report, which I think you have a copy of from John Cox, and that is still in the process of being completed. We sent it out to all the people that were invited in September and have taken on board -- we had 2 workshops, morning and afternoon, to look at things we had left out, things they did not agree with, and the way forward in the afternoon. In our report we looked at all aspects of respite, not just beds at Overdale, because it does consist of quite a lot of elements, including the domiciliary respite which is care in the home, and not necessarily just the sitting service but maybe also a care break for the carer where a more expert person can come in and take over their duties but the cared-for person does not have to be moved out of their own home. We have been seeking to set that up for quite a long time, similar to a system in England called Crossroads, which everybody finds quite useful over there. Day respite consists of things like day centres, schools, workplaces, all kinds of things like that, where people go for the day and the States of Jersey do have quite a provision of day centres for people. Residential beds with nursing care were provided at Edith Secker and then McKinstry Ward. Emergency respite we have seen as a problem. When I first started work here as a GP if we sent somebody in who was caring for somebody we had to send into hospital the person who was being cared for as well to take up another hospital bed, because there was nowhere to put them if family or friends could not cope. So we need a provision for emergency beds for respite. The key issues that came out really were that carer and service users' views must be taken into consideration. We looked at the current provisions; access and co-ordination is a very important part of that, availability and provision of carers' assessments. The recommendations that came out, especially after the last session that we had on 25th September, were to evolve a carer strategy, and it has been suggested that this has a one-year length, and report back and have another day session so they all come and see the results. It has been suggested that we try and have an external facilitator for that strategy. They would like us to provide a directory of services for carers and respite services that are currently in the Island, because we have found there are pockets of respite organised by lots of the voluntary agencies, as well as the States of Jersey, and the Jersey Association of Carers is in the process of co-ordinating this information and to produce a directory that carers can have and find out where they can get access to these. It has been suggested that we get more facts or statistics from the Jersey Annual Social Survey on the current provision for carers and the amount of carers in the Island that are receiving

help at the moment. We have not had our meeting following this workshop yet and I am not sure whether time will allow us to do that at the moment. We will have to look at the time restraints of that. Regarding the closures at Overdale, Edith Secker was very popular with carers and the people that were going in there. I think they felt safe, that it was a short-stay facility, and the staff were very welcoming and got to know them and everybody was happy with that but, obviously, with the buildings at Overdale being in a poor state, it could not continue. McKinstry, we have had very nice staff, the same ones I think as at Edith Secker, but it is a hospital ward. My vision of a respite bed perhaps for my mother would be somewhere where she could go on holiday while I went on holiday, and not be put into hospital and also not be put into a residential bed in a long-stay residential home. Marnie and John are quite content that people now understand that respite beds are not the same as residential beds. Residential beds are where people live and that becomes their home. Respite is just a short stay, a holiday break, and is not the same at all and should not really be mixed up because you get a conflict with people who are staying in the wards seeing other people coming and going and it is not suitable for the long-stay patients either to be mixed up with the respite patients. As far as I can see, the main problem at the moment is lack of information on current arrangements, and I understand that they have not yet been finalised and therefore cannot be announced. What I have asked for is for this to be addressed as soon as possible. I understand you cannot go off making announcements until you have completed your arrangements but hopefully we will have some respite beds in a unit in the private sector, not just odd beds in long-stay residential homes provided by the States of Jersey, but I am waiting to hear the details of that. The carers are waiting to hear, and they are getting very confused, I think, at the moment about who is paying, where would it be, how would it work, and we cannot tell them. So that is, as I see it, where we are. Thank you.

The Deputy of Trinity:
Thank you for that. It was very broad and obviously you have done an awful lot of work over this last year.

Dr. M. Bayes:
We are continuing it forwards. The good thing about it is it has not stopped. We are now going to try and evolve a carer strategy for all aspects of looking after carers.

The Deputy of Trinity:
Has that been well received within Health and Social Services?

Dr. M. Bayes:
Yes. Mike Pollard has attended both of the workshops. He gave an address at the beginning and the end of the last one and he was there most of the day. He did have to go off and manage the hospital a little bit of the time, but he was there a lot of the time and attended the workshops. He is very positive that the investment in carers is important because this care in the community is very good care for the

people receiving it, and it is the cheapest option really for the States of Jersey. In order to support the carers there must be adequate respite facilities available for all these different parts of the respite, not just the beds. He sees that as an investment in the future which will save a lot of money to the taxpayer.

The Deputy of Trinity:
How many members do you have within your association?

Dr. M. Bayes:
At the moment we have only about 20 paid-up members, and we have about 10,000 carers in Jersey. We do not make them all join, the people that come along to the centre. We offer them membership and we still put them on the mailing list, because I think it is difficult to -- we do not want to exclude people. We run the Carers' Centre at the hospital which is open 4 days a week, and we also have a newsletter now every 2 months which we mail out to everybody that we can think of as another way of communication. We find the trouble mainly is that carers do not recognise themselves as carers in the main. They are busy at home doing what they are doing. They do not come to meetings and they do not join associations. They think if they join the Association of Carers they might have to do something, and they are already doing so much that they cannot do anything else. So, it does not have a large membership but it does have a large potential client group there who we are all working for.

Deputy S.C. Ferguson:
You reckon there are about 10,000 unofficial -- or could be designated as carers in the Island?

Dr. M. Bayes:
Yes. Not all providing large amounts of care. Some people are just popping in doing shopping and keeping an eye; other people are doing it all day and night every day of the week. There are quite a large proportion of them. They are very long-suffering and they do not complain in the main. They do appreciate respite and it does help to keep them healthy in themselves and to keep them going really and make it a viable proposition, because sometimes you take on a caring role and you do not realise it is going to last 5 or 10 years, whatever. You think you can do this and then after about 5 years, when you have not had a break, you crack. I have been guilty of not recognising myself as a carer, and it is a difficult thing to come to terms with really. It seemed to be part of family life that you just look after your relations. I think that is one of the problems with getting people to recognise that they are carers, but at the moment I feel they are not using the respite facilities really because they are not confident in the arrangements. They are confused as to how it is being produced.

Deputy R.G. Le Hérissier:
Okay, thank you. I wonder if we could switch to the other issue that is preoccupying us; when did you as an association become aware of the proposals to close the McKinstry and to purchase beds in the private sector?

Dr. M. Bayes:
I think it must have been when we saw it in the newspaper. We had not had any official letters to us about that. It was just what we heard in the media.

Deputy R.G. Le Hérissier:
Well, in a way that answers my next question then. What consultation did occur?

Dr. M. Bayes:
There had not been any consultation as such, except with this working party all during the year. We have been looking at the issue but not the direct, sort of hands-on things, such as the closure of the ward.

Deputy R.G. Le Hérissier:
When you saw it in the paper, did you make a submission thereafter?

Dr. M. Bayes:
No, no, we did not because we are looking at long-term arrangements really and we were very pleased with the reception that we have had. We feel that it is a positive move and we realise it is going to take quite a long time to evolve into the service that we feel that we need. I think I personally see this move of patients into the private sector as a short-term measure. I do not know how long it will go on for but it is hopefully an improvement on what is available at the moment. With this strategy and this sort of feeling and recognition that carers must be supported with adequate respite I feel hopeful for the future.

Deputy R.G. Le Hérissier:
Good, but at the moment you are not contributing to the discussion around that particular policy move?

Dr. M. Bayes:
Only that I have said to Marnie and John that I feel we need an answer as soon as we can have it, basically. Also Mike we have asked.

Deputy R.G. Le Hérissier:
Is it your intention to set up proper consultation procedures for the future?

Dr. M. Bayes:
I think we are waiting to see if we can get this carers' strategy going.

Deputy R.G. Le Hérissier:
Okay, first, yes.

Dr. M. Bayes:
Part of that will also hopefully have a reference point. It may be a carers' co-ordinator within the States who people can go to who need help. It is not only from Health and Social Services. It is also from Social Security, and it involves Housing and all sorts of other people as well within the States. So, I think I am trying to look at the long-term view. I do believe that it is trying to be resolved in a suitable way but I have not yet seen what exactly is going to be offered.

The Deputy of Trinity:
So, that is why you see purchasing beds in the private sector as a short-term measure?

Dr. M. Bayes:
Yes. It may turn into what we need. At the moment I think it is the only way that they can be produced because it would take too long to build another unit somewhere. I cannot see any other building that we could move into, that I know of, and so there are beds there available. There is staff and everything, so it would make sense as long as it is seen to be respite, not just odd beds that are available in a residential care home.

Deputy D.W. Mezbourian:
Dr. Bayes, you mentioned earlier about facilities you have in the hospital at the moment for carers. Did you say you have an area that is open 4 times a week?

Dr. M. Bayes:
Yes. We have a Carers' Centre, which is just in the foyer of the General Hospital.

Deputy D.W. Mezbourian:
Which implies to me that as an association you are being taken seriously by Health and Social Services?

Dr. M. Bayes:
Yes.

Deputy D.W. Mezbourian:
What liaison then do you have with them at the moment, prior to the fact that they have chosen to close the 2 wards at Overdale? Are you normally involved in discussions with them?

Dr. M. Bayes:
No. We have been granted a facility of the office in the hospital free of charge but we do not receive any grant, any financial support. We are very grateful for that office because that is worth a great deal of money to us. That has been the limit of the contact really. We have not been invited to discussions on anything else.

Deputy D.W. Mezbourian:
Do you have a member of staff there that you would go to had you any concerns? Is there someone that you liaise with directly at all, or you are merely just there in the office in the hospital?

Dr. M. Bayes:
Yes. The people that we liaise with most I would think would be the social workers who have an office next door.

Deputy D.W. Mezbourian:
Okay.

Deputy R.G. Le Hérissier:
Well, that is good.

Dr. M. Bayes:
There is quite a good liaison now between us and the social workers. They come into the Carers' Centre, talk to the staff, and the staff can make referrals to the social workers.

Deputy D.W. Mezbourian:
How would you like to see the situation improved, if it can be?

Dr. M. Bayes:
I do not know really in that way. I mean, the one thing is when we asked for a meeting with Mike Pollard and Marnie we were given one straight away. I think we feel able to go and ask to have meetings with people on that level. I do not know what else we would need to do at the moment.

Deputy D.W. Mezbourian:
Do you think that you as an association have been overlooked by Health and Social Services with regards to the closure of the 2 wards, because it impacts upon you?

Dr. M. Bayes:
Yes. I think maybe some information would have been helpful to us but I understand that these closures have to happen. Maybe it was just felt that they needed to go ahead and that was that. Maybe some more information to us would have been nice at the time.

Deputy S. Power of St. Brelade:
Good morning, Doctor, I apologise for running late. I am Sean Power from St. Brelade. Getting back to Overdale again, what was the view of your association in terms of the respite facilities that were and are

available at McKinstry Ward?

Dr. M. Bayes:
The view of our members really was that Edith Secker was popular and well used and McKinstry Ward was used by some carers, but there were quite a lot of people who felt that a hospital ward was not a suitable place to put their cared-for person for a holiday break while they went on holiday or had a break; that it was too much of a hospital ward, and it was mixed with long-stay patients who were living there, and the mixture does not work. You have much better facilities if you just have your respite beds in a separate unit.

Deputy S. Power:
So, we are dealing with areas of decency, privacy, and respect for the individual?

Dr. M. Bayes:
Yes. When I went to the ward I asked if some people could have a single room, and they said, yes, if it was available but then if somebody else needed it they may have to move out. So, they could be moved around because of the mix of male and female patients, and patients with things like MRSA (Methicillin-Resistant Staphylococcus Aureus) who needed to be in a single room. I just felt that if I was taken there and then put in one bed and -- if you are in hospital, you accept that as a need: you go in a single room if it is available; you are moved into another ward if that is what you have to do -- I do not think I would have been very happy about that myself if I had been the recipient of that. I felt it was established as the best that could be available at the time, but I am very glad that it has been accepted really that this must not continue as a long-term measure.

Deputy S. Power:
It is your view, and that would reflect the view of the association, that the time has come for these open wards that do not have levels of privacy in them and the modern standards that we need today?

Dr. M. Bayes:
Not for respite patients to be in a hospital ward at all.

Deputy S. Power:
Right. Those are the comments you have made on the physical aspects, the building aspects of respite up there. What is your view on the professional levels of help up there?

Dr. M. Bayes:
The staff I believe were very good. They were very nice when I went up there, and the patients have all said that they were pleased with the staff and the staff attitudes to them and the help they received. They were just not pleased with the surroundings and the situation of being mixed with long-stay patients and

being in hospital, basically.

Deputy S. Power:
So the main reservation was mixing long-stay with respite, although temporarily, just --

Dr. M. Bayes:
Yes, and a hospital setting.

Deputy S. Power:
Right. One final comment: have you had any feedback from your own members as to the closure?

Dr. M. Bayes:
At the moment they are confused. They know that McKinstry is closing and they do not know what is opening. So, some people feel that they are going to have to pay £1,000 a week to be in a private care home, et cetera. Because there is no information coming out, they are making up their own information, which I feel is confusing for them and probably not true. I understand, as I said earlier, that we cannot know yet what the finite proposal is because it has not yet been finalised. I have requested that this is treated as a matter of urgency to stop people being worried, really.

Deputy S. Power:
Yes. It has come to us in the panel hearings that the nursing homes are fairly well equipped and some of the residential homes are fairly well equipped to deal with different levels of dependency. Now, when you get to high levels of dependence such as you see at McKinstry and Overdale, how do you think the Health Department is going to deal with high levels of dependency when Overdale is closed?

Dr. M. Bayes:
How do I think they are going to deal with it?

Deputy S. Power:
Yes.

Dr. M. Bayes:
Well, I understand they are going to deal with it by purchasing beds in the private sector in a unit of beds all designated as respite beds together, but that is only what I have heard, and, you know, it still is not finalised as far as I understand.

Deputy S. Power:
Would you have a view on whether the new entrants into the nursing home market, for want of a better phrase, in Jersey, would be able to bring the same level of skill and care to high dependency units that

has always been available at Overdale?

Dr. M. Bayes:
I think so, yes. My mother at the moment is in a residential bed in a home that is dual registered, as far as I understand, and they have a nursing floor, where I have been just for a walk around, and they appear to have very high dependency cases being cared for in the nursing area. I am sure they will be able to look after the patients but I do not think the patients should be mixed up with the long-stay patients; that is the main problem. As well it is partly a feeling that this is the thin edge of the wedge, "Am I coming here for a fortnight and tomorrow when I am going home never comes?" People were very confident to go into Edith Secker because they knew you could not stay there longer than 2 weeks. Therefore, you could not be deposited in there for ever and so it was a really happy situation where everybody was happy with that. If you go into one of the other care homes where you do have long stay, I think the respite unit must be very clearly separated if possible.

Deputy S. Power:
So your argument would be that out there in the private sector there perhaps should be a section of a unit, which is clearly identified as a respite care, in bite-sized chunks of 2 weeks?

Dr. M. Bayes:
Ideally a whole building that could be a respite unit, but I do not know how the discussions have gone about it and then who would be involved in doing that.

The Deputy of Trinity:
I understand there are 7 respite beds up at Overdale, so you would like to see those 7 beds in one area in one residential home, rather than one bed at one residential home and another couple of beds in another?

Dr. M. Bayes:
Oh, yes. All together with staff that are dealing with respite patients that come backwards and forwards and they meet the same members of staff when they come back the next time, and they feel much more relaxed and happy in that situation.

The Deputy of Trinity:
Yes. Are Health and Social Services aware of what you would prefer?

Dr. M. Bayes:
Yes. That is part of taking a note of the carers' and service users' opinions.

Deputy D.W. Mezbourian:
Doctor, you mentioned earlier that your members are concerned that they may be charged £1,000 a

week. Are there any charges levied at the moment for respite care?

Dr. M. Bayes:
No. When it was Edith Secker and McKinstry I understand not.

Deputy D.W. Mezbourian:
So the concern would arise from the fact that perhaps respite care may in the future be moved to private homes. Would that be correct?

Dr. M. Bayes:
I think because it has been rumoured that the beds were going to be in a private care home, nobody really knows who is going to pay the bill for that. Obviously somebody must.

Deputy D.W. Mezbourian:
Is this something that was raised at your workshops that you held recently when you said Mike Pollard attended?

Dr. M. Bayes:
Yes. He felt that he could not give a public announcement at the moment because the arrangements are not finalised.

Deputy D.W. Mezbourian:
You know that there are 7 beds at the moment that are available in the wards and there are about 10,000 carers. Does that mean that there are 10,000 people being cared for?

Dr. M. Bayes:
Yes, but not that need high dependency residential beds, I do not think so. We found at Edith Secker that there was enough provision really at the time. I think in a way if a suitable unit is established you may find it is becoming very popular and then that there is not enough provision if people like the service and use it. Then you may find it needs to be extended.

Deputy D.W. Mezbourian:
Is there a difference in the level of staffing that is provided to respite patients which would be needed by them?

Dr. M. Bayes:
I do not know.

Deputy D.W. Mezbourian:

Generally, would it be perhaps medical issues that would need to be addressed by the staff? You were talking earlier about that holiday break, so perhaps they would need to have a break away from their daily routine but may not need in-depth medical care?

Dr. M. Bayes:
Yes. I think the residential beds really do cover more medical care but I still think it should be made an enjoyable experience for the person that is going there. They should not just be kept warm and given their medications, let us say. I still do not see why there cannot be some input of entertainment or trips out even, if they are able, arranged for them but it is something which is not being provided at the moment. That is my vision of the future.

Deputy S. Power:
Can I ask one more question, please? This a question relating to distress and anxiety specifically in respite care. When somebody ends up in respite care for 2 weeks in the existing wards, would you say, Doctor, with your amount of experience, that there was less distress and anxiety and a better environment in the old Edith Secker Ward than there is in the 2 existing wards that are just about to be closed?

Dr. M. Bayes:
So I have been told, yes. People really wanted Edith Secker to reopen, but that was not to be.

Deputy S. Power:
So, because the respite unit was a unit, people who used it repetitively 2 or 3 times a year, or maybe 4 times a year, in your opinion, there was less distress and anxiety caused with them going in than in the situation now?

Dr. M. Bayes:
Yes.

Deputy S. Power:
So, continuity and consistency and familiarity with staff is an important element in reducing distress and anxiety?

Dr. M. Bayes:
Yes. The familiarity with the staff continued, I understand, at McKinstry but the surroundings were not at all the same.

Deputy S. Power:
Okay, that is fine.

Deputy S.C. Ferguson:
You have mentioned the sort of mental stimulation input. I was going to ask what do residential respite facilities need to provide, but I think we have covered a fair bit of it. There is mental stimulation on top of the keeping warm and looking after. I think the other thing, going on from that, as I understand it there was always a waiting list to get into Edith Secker. You had to book well in advance, I think.

Dr. M. Bayes:
Yes, I think so.

Deputy S.C. Ferguson:
It was generally on a GP's say-so, or on …

Dr. M. Bayes:
There was an assessment carried out by the nursing sister, I understand, and I think she still does assessments for McKinstry for patients to see whether they need the level of care and whether they are suitable to be cared for in that unit. I think once the new facility is opened, if it does develop a great long waiting list then it may have to be considered that it will have to be enlarged. I think that is the way it will have to go.

Deputy S.C. Ferguson:
Is it still more cost effective to care for people in the community?

Dr. M. Bayes:
Yes, but if a carer has a break, when they collect their relation from the respite they would like to feel that this person has had an enjoyable experience, not had to put up with it. So, they are more likely to seek the respite and get the benefit of it if they are confident that their loved one is happy where they are being placed.

Deputy S.C. Ferguson:
Yes, and if the "caree", if I can use the term, knows that they are not just getting dumped off and left behind?

Dr. M. Bayes:
Yes.

Deputy S.C. Ferguson:
Respite beds are important but if you had to rank the services to carers, what would you put at the top of the list?

Dr. M. Bayes:
I think respite in general is the one thing that carers have asked for but a lot of the respite that they seek is really someone to come round at home and look after the person for them. This is only available to family -- nursing and home care as a sitting service, which is quite limited at the moment. I think there is quite a lot of work to be done to look at that part of respite. So that the person does not have to move out of their own home, somebody else will come in and look after them while the carer has a break, even for a week, or something like that. I know that that has happened for some patients, high dependency patients, it has been arranged for them to be cared for at home, and that is a cheaper option than establishing beds. One of the carers did say when they are asleep at night they do not need too much looking after. It is during the day that a lot of the people need looking after, young adults, and people like that, and they do not need to be in a bed but they do need to be looked after all day.

Deputy R.G. Le Hérissier:
Margaret, this issue was raised with us that the test in a sense of whether full-time care is required, either in the home or in a specialist facility, is whether the person can make their own way to the toilet or a the commode. That was the test we were told, in that sort of simple sense. If a person, shall we say, fails to meet that test, are you looking at a 3-shift support in the home for the period of respite?

Dr. M. Bayes:
Maybe, yes. We are really hoping to build a future on this and not look at it in a negative way, but try and look at it in a positive way and move everything forwards and upwards. We started with a meeting, and we have had a working party, then a workshop, then another workshop, and now we are looking at a carer strategy, with a report back in a year, and the whole thing is keeping the momentum going. It is going to take time. It may evolve that a separate unit is built. It may evolve that a building is utilised. It may evolve that the private sector comes into it. The States may purchase it out or provide it, I do not know, but I think I am quite hopeful that in the future we will have what we need. I think this is just a stepping stone at the moment.

Deputy S.C. Ferguson:
Yes, because I think for an aged parent, as you have said, the day is the important part because once they are tucked up in bed there is very little to do until the following morning. So, would you not think that although Health and Safety may say you have to have X people on duty, or whatever, it is not strictly necessary?

Dr. M. Bayes:
Well, it may be the level of expertise of the people on duty need not be the same as during the day.

Deputy S.C. Ferguson:

Yes, but Roy was talking about 3 shifts in their own home. In actual fact you would not really need that?

Dr. M. Bayes:
The night shift may not be a fully-trained nurse, for instance, but it could be a carer who can make sure that everything is all right. It would depend on the person's level of dependency how that would be arranged, but I think that it is an aspect. The other aspect that is very important to think about is the emergency respite, because it is a worry to carers, "What will happen if I fall over and break my leg, or something? What is going to happen to my husband?" or whatever.

Deputy S.C. Ferguson:
I do not know that they generally want to go to hospital with their caree in the next bed, do they?

Dr. M. Bayes:
Well, it is not where the person that is being cared for should be, and it is a very expensive bed, as well.

Deputy R.G. Le Hérissier:
How is that dealt with at the moment, Margaret, emergency respite?

Dr. M. Bayes:
At the moment, the social workers do come into it and do try and find a placement in a suitable care home but there again, it is probably going to be in a long-stay bed somewhere.

The Deputy of Trinity:
If they did find a place somewhere in a care home, who would pay for that bed?

Dr. M. Bayes:
That depends on the financial circumstances of the people involved, as far as I understand, and the social workers do look into that. There is a provision, I think, for it to be provided, if the people have not any money or are on low income.

Deputy D.W. Mezbourian:
I was not really being very clear in my question earlier, which I apologise for. In the draft document that you produced earlier it states that 40 per cent of people receiving care are receiving it for age-related problems. What sort of problems would they be?

Dr. M. Bayes:
Very varied, really. Mobility problems are a large part of it, and also mental problems such as dementia, and all the spectrum in between, really. There are quite a few very mentally able patients who really

have very difficult mobility problems or medical problems, and the other end of the spectrum, very active people who have dementia.

Deputy D.W. Mezbourian:
I was trying to establish earlier the levels of care that would be necessary to cover the whole spectrum of those who need care, because age-related problems, I was trying to say, are not always medical, per se. If your mobility is slightly impaired, you would not need a registered nurse, perhaps, to be responsible for you if you were in care.

Dr. M. Bayes:
No. Then there are also things such as visual impairments and things. A lot of elderly people do need someone to be on hand to help them.

Deputy D.W. Mezbourian:
Not always necessarily a medically-qualified person?

Dr. M. Bayes:
Not always, no.

Deputy D.W. Mezbourian:
You spoke earlier about social activities for people who are having respite care but you also said that you thought respite-care patients should be separate from residential patients. Do you think they should be separate, even as far as social activities are concerned?

Dr. M. Bayes:
I would think so, really. I think they have a different sort of need because they are all going to be going home and the long-stay patients are not going to be going home. I think if they do mix it is a conflict, really. I think it would be nicer if it was a separate arrangement.

Deputy D.W. Mezbourian:
You may well have covered this question earlier, but how many respite beds do you think should be available in the Island, compared to how many are available?

Dr. M. Bayes:
Well, I do not know. I do not know how many were proposed, but if it is proposed that there should be a similar number to the ones available in Edith Secker, I would think that would be a good start, and we should see the availability.

Deputy D.W. Mezbourian:

What would that similar number be?

Dr. M. Bayes:
I understand it is going to be 7.

Deputy R.G. Le Hérissier:
Yes, 7. Just carrying on Deidre's question, Margaret, and maybe we should not ask you, but do you know how many times of 2-week entitlements you get over a year?

Dr. M. Bayes:
No.

Deputy R.G. Le Hérissier:
You do not know how many times? It was intimated that perhaps somebody might wish to go 2 or 3 times for 2-week blocks.

Dr. M. Bayes:
No, I do not know of any arrangements, sorry.

The Deputy of Trinity:
Just tying in with that, do you have any further comments on the Isle of Wight's or your long-term strategy for this matter?

Dr. M. Bayes:
No. I am looking forward to our next meeting with Health and Social Services to discuss finalising our report, which then will come forward to the Minister, I understand, and looking to see how we can produce this carer strategy. The only thing I would like to say is that I feel if these arrangements can be finalised and announced it would be a great help to everybody, as soon as possible, really, and clear up the worries.

Deputy R.G. Le Hérissier:
Have Health given you any timetable for making their announcement?

Dr. M. Bayes:
No.

Deputy D.W. Mezbourian:
Not at all?

Dr. M. Bayes:
They said they would do it as soon as possible.

Deputy S. Power:
I do not know if this was covered before I came to the meeting, but how often do you meet officials of the Health Department?

Dr. M. Bayes:
At the beginning, Sir, I gave a resume of how we produced our report. We have had 10 meetings since December 2005 and 2 workshops, one half day and one full day.

Deputy S. Power:
That is fine

Dr. M. Bayes:
So, it has been a lot of time they have given us.

Deputy D.W. Mezbourian:
They were at your instigation?

Dr. M. Bayes:
Yes, but when we asked for it we were given it and I felt that we have always been able to go and ask.

The Deputy of Trinity:
Just one final question. You are aware that there is going to be a new income support scheme next year, and Social Security are in the process of doing a consultation programme?

Dr. M. Bayes:
Yes.

The Deputy of Trinity:
Have you been asked for your views?

Dr. M. Bayes:
No. I have been sent a document which says I can download the draft from the website. I am going to do that.

Deputy R.G. Le Hérissier:
Issues like the attendance allowance are obviously absolutely key, and the mobility allowance, as you

well know, is going to be a contentious issue, so it is well worth looking at.

Dr. M. Bayes:
Yes, that is another story altogether, yes.

The Deputy of Trinity:
That will be very important, perhaps. Thank you very much. Are there any other comments that you wish to make?

Dr. M. Bayes:
No, except to say thank you very much for taking an interest in this topic and trying to help us find a way through.

The Deputy of Trinity:
Thank you.