STATES OF JERSEY

Heath, Social Security & Housing Panel
Long Term Care of the Elderly

TUESDAY, 2nd SEPTEMBER 2008

Panel:
Deputy A. Breckon of St. Saviour (Chairman)
Deputy S. Power of St. Brelade

Witness:
Dr. G. Ince (General Practitioner)

Deputy A. Breckon of St. Saviour (Chairman):

Thank you for coming. It is fairly informal.

Dr. G. Ince:

Okay, right.

Deputy A. Breckon:

We do record it. The reason we do that - and we will give you a copy of that - is not to try and catch anybody out, it is just so that we can make an accurate assessment of what people say. You know, if you say 30 and it turns out to be 50, you will get an opportunity to correct that. I am Alan Breckon. I am chairing today's proceedings because Deputy Roy Le Hérissier and Deputy Judy Martin are both absent; they are still out of the Island. That is Deputy Sean Power. I do not know if you know Sean. Then Malcolm Orbell, who you might have spoken to, and Charlie Ahier are our Scrutiny Officers, and Rebecca is recording the proceedings. What we are actually

looking at, we are looking at the long-term care of the elderly. We have all sorts of interesting information. We have spoken to different people; we have even been to Guernsey to see what Guernsey do there. What we did not have is things from the G.P. (general practitioner) perspective, really, so we wanted to speak to a representative from the G.P.s really just to find out how you are dealing with situations that you find where people do need support in their own homes or referrals somewhere else. So it was just a case really to find out from general practice if you could give us a typical example of what you might find in the community and how you deal with it, and then perhaps we could explore things from there. At the end, Dr. Ince, if there is anything you would like to add, you will get that opportunity as well. So, are you fairly comfortable with that?

Dr. G. Ince:

Yes, indeed. I was not quite sure whether I was here just to answer questions or whether you wanted me to let you know how things seem to work from the G.P.s' point of view.

Deputy A. Breckon:

Well, perhaps if you could give us that, that would save the questions if you could sort of give us the ...

Dr. G. Ince:

I will just keep it brief, but we meet 2 situations, one of the elderly who are not coping as well at home as they have done previously - in other words, they are no longer capable of a completely independent existence but can remain at home with

appropriate help - and those who need to go into residential care. The first group, those who need to stay at home with added help, I think these days are quite well served by the facilities and the organisations that we have available. Particularly important are Family Nursing and Home Care who run the whole thing from our point of view. We put the patient in touch with them and it is Family Nursing who put in place either qualified nursing care, auxiliaries, home help, that sort of thing. They are also well placed to advise on what benefits the elderly people are entitled to, financial benefits in particular, things like that. So that is one side of things. The other side where patients clearly cannot cope at home and need to go in somewhere, that can be a bit more of a problem. Really, the only immediate avenue to obtain in-patient care is through an admission to the General Hospital. In an emergency situation, it is unlikely that a nursing home bed would necessarily be found because it has been my experience recently that nursing homes, residential homes as well as nursing homes, tend to be full up. In a way they have not necessarily been, as the years have gone by ... the General Hospital is quite good about that, they understand if someone goes off their legs, as we call it, and literally cannot cope at home, then an initial admission is arranged. Then people like Dr. Richardson make an assessment of the patient and decide the appropriate care that they need, be that in the private sector or in the States sector.

Deputy S. Power of St. Brelade:

Can I ask a question, Dr. Ince? In relation to when you use the term “off their legs”, does that mean that they ... you are implying there that they have had a fall or that ...?

Dr. G. Ince:

No, what I mean by that is that they are no longer sufficiently mobile to be able to manage at home because in order to manage at home a patient will need a degree of mobility. That may be more for some than others. I mean, I have some patients who are confined to wheelchairs. They manage at home because their mobility around the house has been managed by themselves with wheelchair adaptations and so on. But the commonest situation is where an elderly person literally cannot get around their house any more and it is at that stage that they need to go in somewhere.

Deputy S. Power:

Into a residential ...?

Dr. G. Ince:

Into residential care or nursing care, depending on their nursing requirements.

Deputy S. Power:

There is obviously a degree of stress, tension and anxiety when that situation occurs and somebody can no longer ... an older woman or an older man ...?

Dr. G. Ince:

Well, usually not. The stress tends to come where a patient is not really coping and they have to take a decision on their long-term care, not an emergency decision, one when we can then put them in touch with the social workers at the hospital to plan their future. So if it is not an emergency situation but the patient themselves feel that they are reaching the stage where they no longer might be able to cope at home, then the social workers deal with that. They will come and see the patient, they will make

an assessment of their financial position, and they will take them round to the various residential homes so that the patient has an opportunity of looking at each of them and in a sense making a choice rather than the sort of emergency situation which would require admission to the General. It is then forced on the patient and they realise it is inevitable.

Deputy A. Breckon:

You would normally play a part in that care plan? You would contribute your knowledge to the individual, to the social worker in their assessment of the situation? Is that how it works in general terms?

Dr. G. Ince:

We really just start it off. We really start the ball rolling in the appropriate direction, whether it is to the social worker or whether it is by admission to the General Hospital. Then we pick up with the patient when either they go into the residential home or they go back home.

Deputy A. Breckon:

In general terms with referral to agencies, be it the General or the health services or Family Nursing, do you just do it on a sort of case by case basis or do you have a formal process that you follow?

Dr. G. Ince:

No, we do it on a case by case basis.

Deputy A. Breckon:

So you would assess the needs and, you know, if they need support at home you would say ... they would contact Family Nursing and not you?

Dr. G. Ince:

No, we contact Family Nursing.

Deputy A. Breckon:

You have a good working relationship with them?

Dr. G. Ince:

We do, yes.

Deputy A. Breckon:

What about the actual assessment for a person's needs, whether it is residential or nursing, would you have an influence over that or is that ...? The authority takeover?

Dr. G. Ince:

The district nurses usually make that assessment or the health visitors. They are protocol driven and they do it extremely well. It is all evidence-based and they go along with their clipboards and they do a very good job.

Deputy A. Breckon:

In your experience, is the funding of this stressful for the individuals and families?

Dr. G. Ince:

Yes. I mean, as doctors we obviously stand back from that, but I am well aware that funding is a major issue for families.

Deputy A. Breckon:

Are you aware of the Guernsey situation?

Dr. G. Ince:

No.

Deputy A. Breckon:

Just to say that Guernsey have a scheme where everybody pays, even the retired pay, and then you meet the first £154 of your care. For residential care you are entitled to £341 per week and for nursing care £630. Would you like to express an opinion on that?

Dr. G. Ince:

I think something like that - obviously it is a political decision - is entirely appropriate. I have patients in one nursing home where those who are on the H.M.A. (Household Medical Account) scheme, you know, the old H.I.E. (Health Insurance Exception) scheme, have their fees paid for them. I have wealthy patients in there who have sufficient funds to live off their interest, and yet the middle classes, they see their capital practically disappearing. That does not seem fair or equitable, really.

Deputy A. Breckon:

Yes. It is an issue; in your experience, people that you meet are conscious of the cost?

Dr. G. Ince:

Yes, indeed. It is one reason why, unless it is inevitable, a lot of people struggle to manage at home, whereas they might be better in somewhere.

Deputy A. Breckon:

Yes.

Deputy S. Power:

It is a classic scenario. I have a constituent out in St. Brelade who is in his 70s now and has severe arthritis and a hip problem. He is a widower. He lives in a reasonable house that is debt free now and he worries about what happens when he loses his ability to live independently because he knows that he is going to have to sell the house and then if he lives 10 or 15 years most of his accrued wealth, for want of a better phrase, will be eroded. He contrasts that with other people he knows in the parish who are, say, in a States social rented housing situation. They have never saved a penny, they have had bad diets or been unemployed for a long time and, you know, their whole care thing is picked up for them. He says that is very unfair.

Dr. G. Ince:

Yes. It is, indeed.

Deputy S. Power:

So I think Members will have to look at copying some form of the Guernsey scheme whereby everyone, it will be obligatory or mandatory to take out some sort of insurance policy for your care for when you are elderly.

Dr. G. Ince:

Yes.

Deputy A. Breckon:

I wonder if you could ...

Dr. G. Ince:

I mean, the doctors hope that a similar situation to Guernsey Foresters would eventually take off over here because while ... and I have been in discussions with the M.O.H. (Medical Officer of Health) on development of the Primary Health Care Law and funding of primary health care. The situation is it worked as far as doctors are concerned with the way we charge patients. It seems to work simply because it has evolved since 1967. It is a question of funding it in an appropriate way and patients affording it and an insurance scheme like the Foresters would have been ideal, I am sure, from everyone's point of view but it just did not take off over here because the tradition over here is different. There has always been a separation of general practitioners and consultants in Jersey, as in the U.K., whereas that was not the tradition in Guernsey where the 2 were combined, rather as they used to be when I first came over here at the maternity hospital when the G.P.s did all the maternity work and the G.P.s looked after the paediatric ward at the hospital.

Deputy A. Breckon:

Another area that we are looking at in some detail is dementia. I wonder if you could comment on what G.P.s are finding in the community and how you would deal with it.

Dr. G. Ince:

We have a very good care of the elderly mental health team run by Dr. Lesley Wilson with very able community psychiatric nurses. So if we come across someone we think is dementing, initially one would involve the ... make a referral to her and she would send one of her community psychiatric nurses to make an assessment. Again, it is protocol driven with questionnaires which the patients put through, and then she would see the patient and take a decision. I mean, those who cannot live in the community with the care of their families she accommodates up at St. Saviour. Well, not actually in St. Saviour, but is it still called Clinique Pinel across the road?

Deputy A. Breckon:

Yes.

Dr. G. Ince:

Where she has her unit. So I have never found any difficulty accessing those services, and I am sure my experience extends to all G.P.s.

Deputy A. Breckon:

In your experience, the sort of extended family support, is that on the decrease? Are people now too busy earning a living and doing their own things to have sort of 3-generation households and that sort of thing?

Dr. G. Ince:

I think they are going. That was only through tradition when I came back here in 1974 with the farming families, and there I think there were other reasons. There was money involved. Granddad was generally the one with the chequebook in spite of the fact that the son and the grandson were working in the business. So I think that that was the sort of driving force in it, but among the sort of working and ordinary classes, working classes and middle classes, I do not find very much has changed over the last 30 years.

Deputy A. Breckon:

In your experience, is dementia an increasing problem if we are all living longer?

Dr. G. Ince:

Yes, I suppose it is. I do not have figures. You tend to grow old with your patients, so I see more demented patients now than I did 35 years ago. But certainly it is a factor; if people live longer then more people do dement.

Deputy A. Breckon:

Would you say in your experience that perhaps people are vulnerable living in the community with dementia or are we as a government, do you think, doing enough?

Dr. G. Ince:

I think you are doing enough. I certainly have not found facilities with regards to dementia and day care and all that sort of thing wanting.

Deputy A. Breckon:

If there is a referral to Dr. Lesley Wilson's department, then you would still be involved with the patient?

Dr. G. Ince:

Yes, while the patient was in the community, yes.

Deputy A. Breckon:

That is generally the experience of G.P.s, you do remain involved?

Dr. G. Ince:

Yes, and we liaise with the community psychiatric nurses.

Deputy A. Breckon:

Yes. The quality of care there, is that at a high level or are they stretched or ...?

Dr. G. Ince:

What, with dementia care?

Deputy A. Breckon:

Yes, with some of the community things?

Dr. G. Ince:

I do not know. It has not been apparent to me that the care is stretched, largely on the basis that it has always been forthcoming. If a patient has needed a bed, a bed has been available. If I needed a community psychiatric nurse to see someone, the care of the elderly team are very fast, very responsive.

Deputy S. Power:

Can I just ask, with regard to long-term care of the elderly, just backing up one, would you be prepared to express an opinion on whether the States themselves should develop more residential beds or more nursing beds or whether they should continue the current trend of allowing the private sector to take up a lot of the work?

Dr. G. Ince:

I think that is purely a financial decision for the States because the standard of care in the private sector is very high largely because of the philosophy in the private sector these days, the English firms who have come over here, but more importantly as a result of the legislation which is policed by the Department of Health through their inspectors. Probably the biggest change I have seen in medical care in the last 35 years, since I have been here, apart from the advances in medicine and surgery, has been the improvement of the care of the elderly. It really was quite appalling in 1974 when I came back: 5 people in a room in beds.

Deputy S. Power:

In a dorm, yes.

Dr. G. Ince:

Yes, sometimes without curtains to pull around. But that was the way things were then and over the last 10 or 15 years it has changed tremendously. So, as I was saying a moment ago, people said at Silver Springs, for example, whether you are paying or whether you are being paid for, the quality of care you get is the same both in terms of the nursing care and the environment you find yourself in.

Deputy A. Breckon:

Do you find that below that level where people need some moderate support, in general terms does that come in enough substance, really, before they need to go into a sort of residence? Is it there, do you think, the quality care in the community? I know Family Nursing do a tremendous job but sometimes they are just top and tailing a day when perhaps people need staff during the day as well.

Dr. G. Ince:

I have not noticed that because I think if people need continuous care throughout the day then they need to be in residential care or nursing care. That is just the nature of things. The Island could decide to provide continuous care at home, but that would be very difficult and inequitably expensive. I know from wealthy patients I have had who have paid to have private care, whether it is for 12 hours or 24 hours, it is extremely expensive.

Deputy A. Breckon:

Because there is a move to obviously ... because of the comfort factor, if you like, for the patient's own benefit is to get people to stay at home as long as possible with support because ...

Dr. G. Ince:

Yes, and that is what people in the main want.

Deputy A. Breckon:

Yes. Of course, that is resource hungry and in your opinion ...

Dr. G. Ince:

I think it is pitched about right at the moment. I think people who need to go in do end up going in, and those who do not need to can be supported at home.

Deputy A. Breckon:

Do you find that if people are referred to residential or nursing care, then there is a long-term care package that sort of sees to their needs and caters to them adequately?

Dr. G. Ince:

I do not know about a package, but they go in and they are looked after depending on how their condition varies. I mean, one thing we have not touched on is with residential care sometimes a patient's condition deteriorates so they have then to be moved into nursing care. That sometimes means a move of residential home and sometimes just means a move of room within a nursing home.

Deputy S. Power:

Or a floor, yes.

Dr. G. Ince:

A floor, like at Silver Springs again.

Deputy S. Power:

You think dual registration, then, is a good idea or you have ...?

Dr. G. Ince:

I think it is but I think by the time a patient reaches that stage, they are not fussed whether they are put in an ambulance and taken somewhere else or whether they are just moved down a floor. We did not touch on the dementia unit, did we, at La Haule. I was just talking about St. Saviour, but there is, of course, a unit there.

Deputy A. Breckon:

Ronceray specialise as well, I think.

Dr. G. Ince:

And Ronceray as well, yes. A number of these nursing homes will.

Deputy A. Breckon:

We actually spoke to these people and they are very dedicated in what they are doing.

Dr. G. Ince:

They are, yes.

Deputy S. Power:

Very impressed.

Deputy A. Breckon:

That is your general impression, is it?

Dr. G. Ince:

It is good, excellent, yes. It seems to ... nursing homes these days seem to be staffed by people who genuinely want to look after patients like this rather than 30, 40 years ago, people who had sort of fallen into it as a means of making a living as an alternative to running a guest house or taking in lodgers.

Deputy A. Breckon:

Yes. With New Directions, we call it Old Directions actually because it is 2 years, you know, it has been in the consultation stage. Is there anything that you have contributed or you have seen in there you think that we should do perhaps quicker than waiting until the whole thing develops, especially in regard to care of the elderly?

Dr. G. Ince:

I do not think so. The idea is to enact it as a whole rather than piecemeal, is it not?

Deputy S. Power:

It is.

Dr. G. Ince:

I do not see any glaring deficiencies in the current system except the inequity in terms of payment that we have spoken about already.

Deputy A. Breckon:

Is there anything you think that, you know, G.P. practices in general terms could do to sort of contribute more - obviously if you are resourced - to the care of the elderly or are you there at the sharp end now?

Dr. G. Ince:

Well, we are there at the sharp end now. I have been talking to the M.O.H. about different funding streams for general practice because at the moment it is patient consultation driven. In other words, when a patient comes to see us, they have to pay us or they are paid by H.M.A. and that is that, but there is a perverse incentive on both sides. Obviously there is the incentive for the doctor to be busy because if you are not you do not make a living, but on the other hand that is balanced by the fact your patient has to pay to come and see you so they are not going to come and see you needlessly. That has always balanced quite well over the years. We are talking about another way of providing care, chronic care, really - and this could possibly include care of the elderly in the future - whereby an individual practice would be paid a certain fixed sum each year for looking after, say, the routine diabetic needs of a patient, which then the patient would not directly have to pay for but the funding

would still come from the Social Security fund or from the contributions. That could well apply to conditions in the elderly.

Deputy S. Power:

I think one of the trends that is going to come out on population ageing and people living longer, I think at the moment 17, 18 per cent of the population of the Island are in the elderly age group but that is going to increase to about 33, 35 per cent within the next 20 years. So every medical practice in the Island is going to have a much larger number of elderly as patients. That is going to have a major effect on private practice in the Island, is it not?

Dr. G. Ince:

Yes. I suppose it will. We have always responded to change, though, to whatever is required. We are not restricted in the way we were years ago. If an individual practice is getting busy, then we can take someone else on, whereas years ago, in the days of stronger regulation, it was quite difficult to obtain an extra partner.

Deputy A. Breckon:

I am just thinking there, regarding home visits, in your professional opinion people's ability to live there and their mobility, is it restricted by some of the homes that people are living in because they are inadequate, really, for them to live there with a degree of comfort?

Dr. G. Ince:

It is all about access. If there are steps up to the house or if there are stairs up to the bedroom and they cannot afford a chair lift, although charities, I believe, will help pay for chair lifts, so the problem is not really with the type of accommodation except in one or 2 circumstances. For example, I had a patient recently who lived in those flats in Don Road, you know, opposite where they knocked the church down, the block of flats there, what is it called? I cannot remember.

Deputy A. Breckon:

Yes, I know where you mean.

Dr. G. Ince:

You know where I mean?

Deputy S. Power:

I know the ones. They back on to Colomberie.

Dr. G. Ince:

Yes, they back on to Colomberie. They were built in the 1950s but there are no lifts, there are just concrete steps and she lived on the top floor. That was the sort of deciding matter because she got marooned up there.

Deputy A. Breckon:

Yes. What about the bathroom facilities people have got? Is it mostly baths as opposed to wet rooms and showers and things?

Dr. G. Ince:

Yes. The Occupational Therapy Department up at Overdale who work in conjunction with the district nurses have got all sorts of contraptions for levering people in and out of baths, rather like those things for putting knights in armour on horses. Literally, there are cleverly designed ones that people can have in their own home. In private housing, I have known baths converted to showers and the Housing Department is prepared to do that in housing property if an occupational therapist recommends it.

Deputy A. Breckon:

Just coming back to dementia again, how difficult is it in general terms to sort of diagnose that? Do you just say, like: "I am just getting old so I start forgetting things"? I do that anyway but ...

Dr. G. Ince:

Yes, it is actually quite easy with the tests we use. There are validated, evidence-based tests which ratchet up through different protocols. It starts with 4 objects on the desk, maybe a pear, an orange, a pen and something else, then you take those away and you ask the patient what was on the desk and they get a mark for that. Then it moves on to slightly harder things. There are 2 tests that are used so you can tell from that whether someone is starting a dementing process, in which case a psychologist would then repeat the test perhaps 3 months later to see whether there has been any movement. Sometimes these tests are limited by someone's intellectual capabilities, but there you do not see any deterioration, you see a sort of standard level, whereas with a dementing process you see a tailing off.

Deputy A. Breckon:

Do you have liaison with, say, the Alzheimer's Society and the Carers Association and do you know the sort of things that they are doing? Can you refer people that way?

Dr. G. Ince:

Yes. Oh, yes. But there again, the district nurses and the health visitors for the elderly are the pivotal person in activating these services so we rely on them to do that. In the U.K., if I was in practice there, I would have a health visitor in my practice and I would have a district nurse attached to my practice, and so one would feel slightly nearer it. But I do not think the system works badly over here because they work independently, because we have close liaison with them and they do exactly the same jobs as they would do if I saw them each day as opposed to speak to them on the telephone.

Deputy A. Breckon:

And they will sort of liaise with things like day centres and things like that as well?

Dr. G. Ince:

Yes, day centres, benefits, voluntary organisations, all that sort of thing.

Deputy A. Breckon:

So, in your experience, the agencies that you consult with and work with are reactive to and respond to that?

Dr. G. Ince:

Yes.

Deputy A. Breckon:

Again from the patients' point of view, are the patients comfortable, you think, with the level of service and the attention they get?

Dr. G. Ince:

I think they are within the financial constraints that exist.

Deputy A. Breckon:

Yes. That, you believe, really is an issue, the finances?

Dr. G. Ince:

Yes.

Deputy A. Breckon:

At various levels?

Dr. G. Ince:

Yes. Always is with everything, is it not?

Deputy A. Breckon:

Yes, it comes down to money. The other thing, we have just had some people in from Planning before, and I must declare an interest here that I am 55. There seems to be a

benchmark of over-55 in supporting, you know, people in the community from that age or designating housing at that age. In your experience, is there anything that you might be able to tell us that supports that 55? Do we need special living conditions at 55?

Dr. G. Ince:

Speaking as someone who is 60, no! I think it depends on what you have got wrong with you. I have had patients in their 90s living a completely normal, independent existence in their own home, going out shopping, doing everything. It is difficult to generalise, is it not?

Deputy S. Power:

The suggestion is and the proposition is that people once they get to their middle 50s tend to start thinking about downsizing nowadays.

Dr. G. Ince:

Yes.

Deputy S. Power:

Would you agree with that? Is there any evidence of that from your experience as a general practitioner over the years or is it a relatively recent phenomenon?

Dr. G. Ince:

I think it is a relatively recent phenomenon, but most people do not like leaving the house that they have lived in, and if they do they tend to leave it for financial reasons.

They might say they are downsizing because it is too big, but it is really because they feel they cannot afford it or manage it or afford to pay someone to do the garden and manage it for them. That seems to be the driving factor.

Deputy A. Breckon:

Yes. I mean, medically, I do not know, we have not seen anything that supports 55 being some sort of benchmark or watershed.

Dr. G. Ince:

No, not at all.

Deputy A. Breckon:

In fact, there was a fairly independent lady in her 70s who sat there last week and said: "Well, why 55? It should be 75." She was a volunteer for hospital car services.

Dr. G. Ince:

I agree. I had one patient of 92 who I sent to the pain clinic about her back pain, and Dr. Visel(?) Jones said to her: "Have you thought of having meals on wheels?" and she laughed at him and said: "Have them? I deliver them", which she did. **[Laughter]**

Deputy A. Breckon:

Very good. Now, Sean, have you anything to ask of Dr. Ince?

Deputy S. Power:

No. I am a bit like my colleague Alan here, I am 2 years away from 55 and I am certainly not thinking of long-term care of the elderly and accommodation for the over-55s because ...

Dr. G. Ince:

No, I am not thinking of the same for myself.

Deputy S. Power:

Yes. I again wrestle with this concept of planning for the over-55s because an awful lot of over-55s are very fit and healthy.

Dr. G. Ince:

The retirement age for us is 65, is it not? So I think you ... most men certainly go on thinking unless they are in some occupation where they can retire early, you know, your sights are focused on 65 and then giving up and then doing things that you have not done before, not staggering into residential care.

Deputy S. Power:

There is an interesting phenomenon in the U.S. (United States) whereby a lot of the big supermarkets and D.I.Y. (do it yourself) stores, they actually employ people who are in their late 60s, early 70s for 2 reasons: (a) because it is almost minimum wage, but they have actually started to find out that those active, elderly people who work, say, 15 or 20 hours a week, they actually enjoy it and it keeps them fitter.

Deputy A. Breckon:

And they have a knowledge of whatever they are selling rather than, you know ...

Deputy S. Power:

And they have time for customers, they have ...

Dr. G. Ince:

That is true. And there is no problem sacking them at that age!

Deputy A. Breckon:

Dr. Ince, thank you very much for sharing that with us. Is there anything that you would like to say to us that we might have forgotten about in general terms about care of elderly and your experience and that of G.P.s?

Dr. G. Ince:

I do not think so, other than just to summarise and say I think there is a good community service over here. Everything can be improved, but it is a good service and the biggest problem is the lack of immediately available beds if one wants them and the cost factor in it all, but there we are. Okay.

Deputy A. Breckon:

Okay, thank you very much for that.

Dr. G. Ince:

Thank you.

Deputy A. Breckon:

What we will do is we have recorded that. You will get a copy of that. We will arrange for that to happen. There should not be anything in there, but you ...

Dr. G. Ince:

Okay. That is fine.

Deputy A. Breckon:

Thanks very much.

Dr. G. Ince:

Thank you.