STATES OF JERSEY

Health, Social Security and Housing Panel
Long Term Care

FRIDAY, 27th JUNE 2008

Panel:
Deputy A. Breckon of St. Saviour (Chairman)
Deputy R.G. Le Hérissier of St. Saviour (Lead Member on Health matters)
Deputy S. Power of St. Brelade
Professor J. Forder (Adviser)

Witnesses:
Mr. R. Jouault (Director, Corporate Planning, Acting Chief Officer Planning and Environment and Deputy Chief Officer for Health and Social Services)
Mr. J. Le Feuvre (Health and Social Services, New Directions Programme Director)
Ms. T. Fullerton (Assistant Director, Corporate Planning)
Mr. M. Littler (Director Manager of Medicine)
Senator B.E. Shenton (Minister for Health and Social Services)

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

We will go into transcript mode now. I would like to welcome you all on behalf of the panel. The panel will name themselves. There is Professor Forder who you may or may not know, but I think you will know the rest of us but for the tape we will introduce ourselves.

Deputy A. Breckon of St. Saviour:

Alan Breckon.

Deputy R.G. Le Hérissier:

Roy Le Hérissier.

Deputy S. Power of St. Brelade:

Sean Power.

Professor J. Forder:

Julien Forder.

Ms. T. Fullerton (Assistant Director, Corporate Planning):
Tracey Fullerton, Assistant Director of Corporate Planning.

Senator B.E. Shenton (Minister for Health and Social Services):
Senator Ben Shenton.

Mr. M. Littler (Director Manager of Medicine)
Mark Littler, Director Manager of Medicine.

Mr. R. Jouault (Director, Corporate Planning, Acting Chief Officer Planning and Environment and Deputy Chief Officer for Health and Social Services):
Richard Jouault, Director, Corporate Planning and Acting Chief Officer of Planning and Environment, and Deputy Chief Officer for Health and Social Services.

Mr. J. Le Feuvre (Health and Social Services, New Directions Programme Director)
James Le Feuvre, Health and Social Services, New Directions Programme Director.

Deputy R.G. Le Hérissier:
I would like to thank you all for coming. Obviously there was some consternation caused because this has preceded the New Directions study, but as we know, like you, we are all awaiting with great anticipation, and it was always the plan that once we had done the broad policy examination, we would start to drill down into one or 2 of the other policies and obviously the first chosen policy is care of the elderly. Our feeling was we have really got to steam ahead because a lot of ministries, yourselves primarily, have got policy initiatives either present or emerging and we feel we have got to help with the public discussion. So it is perhaps a little earlier than Scrutiny would intervene but it is an issue, we feel, of such importance, and there is so much discussion going on in different areas like 2035 and so forth, that we can contribute to this discussion and help to start to frame the discussion.

Senator B.E. Shenton:

No, we would agree with you, it is a very important area and we are pleased that you have decided to take this route.

Deputy R.G. Le Hérissier:

Good. Okay, so what we are going to do is we have got some general questions, they are fairly general, individual members of the panel will handle the areas. Julien has got his own little question but he will, in fact, come in and pick up various areas as well. Particularly areas like the continuum of care, for example. So what today is about is really trying to get a handle on the key issues and what your thinking is about on these key issues. So I will kick off with question one, which is, what do you see as the key issues facing government in the area of long term care?

Senator B.E. Shenton:

It depends whether you want me to give a political answer, so talking about stuff that we already know about, ageing demographics and the need to rethink healthcare going forward because of the increasing cost and the fact that people are living longer and so on and so forth, or whether you want to knuckle down into the more detailed aspect at this stage.

Deputy R.G. Le Hérissier:

It is up to the panel, but I would say probably unless you have got questions about the political side, you know, like you feel, I do not know, like for the sake of argument, Ben, that some of the assumptions of 2035, for example, might have been a little questionable. Unless you have got something like that, we will move to your internal ministry view.

Senator B.E. Shenton:

The only thing I would say about 2035 and so on and so forth, is obviously we are doing a number of different exercises as a States body with regard the Island Plan, with regard New Directions, and various other aspects, and yet we still have not had the debate on immigration and the actual -- the plus or minus numbers going forward coming on to the Island. Yes, from my point of view it would have been nicer to start with that out of the way because we are working -- we could be accused of saying: "You are working on a X number coming in every year, does that mean the States

have already decided ahead of the immigration debate that that is going to be figure?" So from that point of view it is a little disappointing that we have to take a more generalistic view with regard to trying to work out where we are going to be in 2035.

Deputy R.G. Le Hérissier:
That is a good point.

Senator B.E. Shenton:
That is the only political comment I would make.

Deputy R.G. Le Hérissier:
Okay, so we will move to what your department sees then as the key issues.

Senator B.E. Shenton:
Within the provision of long term care?

Deputy R.G. Le Hérissier:
Yes.

Senator B.E. Shenton:
We have come heavy-handed as normal. We have brought a whole posse with us. So it is probably a bit pointless me doing all the talking when we have got experts here. So I think we will use the people that we brought along today to answer a lot of the questions because that way you get a more -- I was going to say you get a more informed view **[Laughter]** but that does myself a bit of a disservice then, does it not? But you get a more professional ... from the people on the front lines.

Mr. M. Littler:
I think it was a useful document that Professor Forder forwarded to us. He gave some potential aims of the reform of the funding model. Just looking at that - and we are just talking about funding now, we can go on to the actual intricacies of the care packages - we are very aware of the need to reduce the financial risk that people face with regard to possible need for costly and long term care. We do believe that one of the aims is to introduce fairness, especially where we are coming from in terms of it is

manifestly unfair if you look at it. We do want the universality of the system, in other words, it is a full comprehensive package for all. We do believe within the limitations of small places like Jersey is promote choice wherever possible subject to appropriate standards. We are very much aware of the need to have efficiency in the use and deployment of resources, that is our obligation and that is why we have the scrutiny panels access. Above all, the sustainability. That is a big watch word for us. It is to provide the appropriate support for people in the Island but you have the means to sustain it. That is one of the biggest issues that we have got in our time now.

Deputy R.G. Le Hérissier:

We were going to look at finance separately but I can see it is very difficult to do that, but we will try and do that, shall we say, and Sean was going to pick it up later. But on the issue of sustainability can you elaborate on that. What do you see are the main issues in trying to be sustainable?

Mr. M. Littler:

As our Minister has said, we have got the ageing demographic and that brings with it certain potential dependencies. We have got issue such as, unlike several decades ago where there were tighter family groups or tighter social cohesion, they had people to look after them when they became more frail. We are becoming more aware that that social network or support is not necessarily there and that gap needs to be plugged. We are just aware there are many ways of plugging that gap, whether it is voluntary groups or whatever. Sometimes that low level help is a very big issue because if it is not there then it pushes the individuals to more formalised care packages. That is just one big issue that we are very much aware of. We are also are aware that we need a greater range and variety of support measures to ideally keep people in their own home, if they wish, as long as possible. We have not developed sufficiently the infrastructure yet, this will part of New Directions, to make that a reality. In order to do that there will be a large amount of co-ordination of all the various groups, whether it be voluntary, professional, such as physiotherapists, O.T. (occupational therapy), home care helps, as well as more traditional like G.P.s (general practitioners) and F.N.H.C. (Family Nursing and Home Care), and what have you. So it is the identification of the care bundles for the various cohorts of clients, and being able to

support that in a lightest touch as possible to promote independence and not drive them down the institutionalised route.

Deputy S. Power:

Can I come here, Mark. I think we all agree that what we referred to 50, 60, 70 years of the multi-generational family of our grandparents, the parents and the kids altogether, was efficient. One looked after the other, grandparents looked after the kids and when the grandparents were sick there was back up. That is not happening now. In Western society an awful lot of people are living on their own, either through bereavement, divorce, whatever, and we have to deal with that. That is one of the things we are dealing with in care of the elderly. You referenced twice the voluntary and the charitable organisations, would you think in Jersey, given where we are today in 2008, that the Health Department have a higher dependency on voluntary and charity than previously and would you care to comment on the balance?

Mr. M. Littler:

I think we very much value our partnerships with the voluntary organisations and, I daresay, the charities. They provide valuable information in terms of feedback from their constituents. They also assist in specific financial help for specific things, such as an extra item of equipment that ordinarily we would have had to think twice about buying. So, in other words, I look at them as not replacing what our obligations are but adding to it. They certainly feel that. Whenever I discuss potentially new ventures that they want to help on, there is a very clear dividing line between what Health and Social Services should provide, which is largely the revenue side in terms of staffing, and bits of equipment or such initiative like a research study that will just help take the service forward. So I think they provide valuable help. As to the current balance, I think in some ways, and I think with the New Directions, that we would need to make more use for volunteers that want to help in any way, especially when we are talking about low level care or popping in to look over and see that these individuals are being cared for. That is where personally I feel that we will need to ensure that we engage with the voluntary sectors in a far greater and more systematic way. There is lots of work being done in pockets, right across Health, not just care of the elderly. It is just that in order to meet this challenge we need to mobilise that in a

nice way and get it co-ordinated. So I see the balance potentially increasing, notwithstanding every effort that we will be making.

Deputy R.G. Le Hérissier:

In a way we are stumbling into finance. For example, Mark, we had Daphne Minihane yesterday with Bob Le Broq and she gave some very interesting little anecdotes which illustrated some of the points she was making. One of the points that has come to me also, which I have been in correspondence with Ben and Mike Pollard about, is, for example, patient transport service. Now, I understand this has been the victim of some cutbacks and the voluntary sector are struggling to find drivers for minibuses. I understand, for example, at some of the daycare centres you are cutting back on the use of minibuses to go, I do not know, to visit a restaurant for lunch and all this sort of stuff. When you do that, of course, the bigger issue is what it does is the very thing you mentioned, it takes away so called low level activity which is utterly disproportionately satisfying for the effort that is put in and could make for a very miserable day for people who miss the little outing, for example. So how do you allocate your budget to ensure that things that you get real value for money for keep going on and they do not get caught up in these general government cutbacks?

Mr. M. Littler:

First of all when there are, for instance, efficiency savings, or the need to maintain your budget, we are obligated on behalf of the States to deliver those objectives. Now, obviously in that it comes from the Minister to the Chief Executive and it goes into individual departments to look at how best they can deliver their service. Not only sometimes in the face of efficiency targets but more importantly in the face of growing demand. That requires new ways of working. So that is the challenge that we have got. In terms of patient transport, we have got a lot of challenges at the moment in that area. One of the things, for instance, we have got like an alarm system where vulnerable people have an alarm system that they can trigger and that will trigger a response, usually from the ambulance station. That has grown from something like a couple of hundred to well over 1,000. That alone is putting strain in terms of responding, which we are. But that is putting a big strain. One of the things that we are finding, and this is where this public Health and Social Services partnership and voluntary groups is going to have to up the ante. We are finding,

notwithstanding that we agree with the close relatives to say: “Look, if we get an alarm call, will one of you respond in the first instance or in the second instance.” What we are finding, this is back to social cohesion, it does not happen. So therefore, quite rightly, we are stepping into the breach in responding. I will got to the other -- in terms of daycare centres, we are finding because the demand is going up whereby that is putting extra pressure on the patient transport, and they have got something to juggle. Not only outpatients, daycare centres, but also when it comes for patient transport in terms of discharge and the times are creeping up. What we feel is going to be an issue that we have to tackle in order to sustain patient transport, and they do this in the U.K. (United Kingdom), wherever possible and wherever appropriate, that the patient should try and make arrangements to come into the hospital or go to the day centres. Quite rightly, we will provide a safety net but we have not got into that real debate yet about those that can, you know, reasonably - we are not talking about frail old people, but those that can - perhaps should be encouraged to do that and that will lessen the strain on the likes of patient transport for the more vulnerable people, or the people on their own or confused and so forth. So we are at the cusp now where -- you are right, Roy, there is a lot of pressure on the patient transport system but we will be getting into, for instance, this refurbishment project now, where we are trying to maintain our standards or improve our standards but also increase the efficiency. Now, that is going to put greater strain because of the throughput and this is where we will be getting into discussions with patients and their relatives about patient transport. So we are at the cusp now.

Deputy R.G. Le Hérissier:

I do not want to flog this too much but it is a nice little example, it was also the issue, as I said, Mark, that because you are so busy trying to get sort of the non taxi users focused on as opposed to some people might perceived as taxi users, people who enjoyed simple little outings are at the moment being sidelined because of the rush to reallocate places and cut costs.

Mr. M. Littler:

It is funny -- I am glad you picked up on this, because when you see about the big strategic initiatives that we are all involved in, when you drill down, at the coalface, this is where sometimes the action is at. It is the interfacing with the public and

helping them, individually sometimes, and that is where sometimes it can get overlooked but that is where a lot of our staff are focused on.

Deputy S. Power:

Can I ask a question on key issues? It is not really related to what we have been discussing but I would like to pick up on something we left off when we did the Overdale review. That is the balance between long term care beds in the public sector and long term care beds in the private sector. Where do you see the balance being struck because, given that we have a new Minister, and given obviously people have different opinions, would you care to make a comment on how you interpret that? How you would like to see it?

Mr. M. Littler:

I can tell you where we are now in terms of the balance, and I will give a personal view, subject to my Minister. In terms of where we are, at the moment we have got 147 nursing care beds. That is Health and Social Services. We provide that in house, i.e. in Limes, Sandybrook and McKinstry, 77 of those beds. So 77/70 split between in house provision and private partnership in terms of with either spot purchase or other contractual arrangements with service level agreements. That is where we are now.

Deputy S. Power:

Do you have your break down there on the public one, as to how many beds you have where, just at the moment?

Mr. M. Littler:

Yes, in terms of the Limes, which is big nursing care by Jersey standards, 36 beds; Sandybrook, 28 beds; and McKinstry ward, 13 beds. Now, in the very near future, we are talking about within a month and a half, we aim to close the 13 beds on McKinstry, which the scrutiny panel will know of our intentions. There is sufficient capacity in the private sector for us to safely do that with the requisite service level agreement and due diligence in terms of their operations.

Deputy S. Power:

So you will drop to 64?

Mr. M. Littler:

Yes, 64.

Deputy S. Power:

They are going to go up to 83?

Mr. M. Littler:

Yes.

Deputy S. Power:

Which means the private sector -- it is pitched that the majority are in the private sector?

Mr. M. Littler:

Yes, but - and there is a big but - that 64, and we will see -- unless we have got evidence to tell us otherwise, we see ourselves as providing the high dependency need of nursing care, because we have got the expertise with the most vulnerable and also the private providers either have not got the facilities or do not want to because of the effort, or it would be prohibitively expensive for us if we contracted them. So we definitely see that those 64 are at the higher end than the ones that we --

Deputy S. Power:

Is that where you see the departments staying, as higher dependency care rather than lower or medium care?

Mr. M. Littler:

I think we have to see in terms of the analysis of the long term and the varying packages and effects of the demographics but, yes, in terms of -- if you say: "Where have we got a niche?" It is the highest dependency patients because we are best placed to deliver that.

Deputy S. Power:

One last question. In terms of the 147 beds, then, that we have, what is the projection for long term care beds in 5 years' time?

Mr. M. Littler:

Obviously in forming the New Directions there is a much sort of higher level in terms of the proportion of monies that we will need to look after the care of the elderly, for instance. Within that --

Deputy S. Power:

Sorry, Mark, but irrespective of the money you are going to need more beds.

Mr. J. Le Feuvre:

No, we might need new beds - forgive me, Mark - but there is quite a large cohort up at Rosewood House up at St. Saviour and they are elderly patients, they just happen to have Alzheimer's or dementia, E.M.I. (Elderly Mentally Infirm) patients, so one option would be that we would reprovide those beds, possibly at Overdale, for instance, but also move to shift the stigma there is about whether people are cared for at St. Saviour or whether they are cared for at Overdale. So that would be an option because we know that Rosewood House has probably another 4 to 5 years in which we can usefully use it without having to do very significant refurbishment. So one option is to provide new beds at Overdale, perhaps shift the client group across and then decide what we will do at Rosewood House. There are a number of options around the 3 sites that we have.

Mr. R. Jouault:

But to come back to your question, Deputy, how many beds are required in 5 years' time is an impossible question to answer.

Deputy S. Power:

Do you have a projection?

Mr. R. Jouault:

I can give you a variety of different scenarios which will result in none to 1,000 or anywhere in between, depending on whether you are going to provide adequate

community care or whether you are going to continue to consign people to institutional care... You know, the reality is it is quite difficult to look at the long term care, although it is perfectly legitimate to do so today, in isolation. We have to consider, as Mark alluded to earlier, the state of primary care, we have to consider the management of chronic disease and all these other issues that are going on across the health domain. If we do not provide good quality community care with all the elements that are currently not present, good respite care, some of it is quite low level, as you alluded to Roy, things like carer support, transport. If these pieces are missing then the numbers of people going into institutions will increase, no doubt about it. The reality is that we expect, with the issues that are identified within New Directions, that with the population who are getting older now will grow old healthily, more healthily than they do currently. It is our intention that they do not go into institutions and they remain in place, age in place. That is our strategic direction.

Deputy S. Power:

You do not expect the number of patients in high dependency care to reduce?

Mr. R. Jouault:

We expect the *proportion* of older people to be institutionalised to reduce, because the *numbers* of older people are increasing we would probably look at the overall number to be static to mild to moderate increases in institutional care, but to be very clear-- we are developing capacity models but they are based significantly on what resources are available. Sorry if that is a bit vague.

Deputy S. Power:

Mark took the risk of making a personal comment, and I am not adverse to taking risk either, and one of the concerns I do have is capacity in this area. For instance, one spanner in the works -- well, not a spanner but one variable in the system would be that, as you say, if one of the private nursing homes closed. Typical example with property development, the one I am thinking about has a 20-21 bed capacity. It is an old building and it has been on the market for some time so how do you deal with that 21, because that is high dependency care.

Mr. M. Littler:

Yes, what we have done, Sean, is we are very much aware that where we enter into partnerships with the private sector about the issue about sustainability and what if scenarios, so we have tried to spread our custom widely. We have also structured our contracts -- we stagger them, you know, for 3, 4, 5 years so if there was a problem we would have forewarning a year in advance and there would be small groups of patients, no more than 10 at a time that we would have to deal with. So we will know whether they are trying to up the prices that we find would be unsustainable or -- that is our biggest concern. Therefore we have spread the risk on that. Also if we are finding we are having troubles in terms of relations, either on the financial side or we hear rumours in terms of what they might be doing, again, that just gives us -- because of the spread we have minimised the big blocks and we believe at the moment, with the new players like L'Hermitage coming in, we know that we can cover the contingencies that we have got in terms of potential liabilities. Of all the things that exercise our minds at the moment, over and above standards, is that very issue.

Deputy R.G. Le Hérissier:

We are stumbling into finance, and we did discuss this issue quite a bit, although it was not the prime focus of the Overdale study, Mark. Do you feel that we might possibly be sleepwalking into a duopoly situation or a monopoly situation because we know that in terms of property development - and Richard is losing his local shop, for example soon - the rewards are much greater obviously, the regulatory pressures from you guys which are done for the very finest of reasons, as we have discussed several times, this is all making it very difficult for the smaller operator in the older building. The irony is, when we talk about the quality of care -- again, I am obviously ready for it because somebody, whose name I cannot remember, was telling me the other day Silver Springs, for example, which we did visit with Julien is an excellent facility but a lot of people there, particularly the States financed people, they are from town and they want access, not necessarily them because they may not be able to exercise it, but they want their relations and their friends to be able to come easily to the place, maybe within walkable distance and with a few facilities around, and there is a feeling, despite the excellence of care, it is almost a gilded cage situation. So that is various issues I have wrapped up there. One, is this move it appears to duopolies and monopolies, and the other one is by putting our eggs in a sense in one basket are we sort of preventing the retention of other facilities in more urban areas?

Mr. M. Littler:

No. While I am aware with Silver Springs in terms of the numbers of beds that we have contracted, to some extent the imperative that we were faced with - McKinstry I will not go over that - the need to move our patients to more suitable care settings, and we were to some extent hampered by the available capacity in the Island at that time. What we have done, and this next round where we are closing down McKinstry is to spread that even further where we are putting 3 or 4 beds in small areas and small places. So, again, it aids diversity. It means to say we have got more care homes in different areas of the Island which will allow family and relatives easier access, especially when they are older, so that is improving, and we are recognising that notwithstanding we get good feedback on the big places like Silver Springs but we also get incredibly good feedback on the smaller homely homes. We recognise that and our spread of custom begins to reflect that. In fact, we are getting a bit more now sort of freeing up the market to enable us to do that. I could name a particular home that is quite idiosyncratic and the people love it, both the patients and the relatives, because of this completely different atmosphere to a more, should I say, formalised nursing type atmosphere in Silver Springs for instance, as excellent as that may be. There is a broad spectrum so long as the minimum standards, and these minimum standards are very good standards, are met. If we can provide a broad spectrum, different feel to the places, that is important. The other thing that we are majoring on now is not just the safety side, it is about the wider care in terms of access to outings and facilities and staff solely directed about entertainment and engagement with the residents. I say that like that but it is not just a case you sit in your room and that is it. There has got to be more to make it a better experience.

Mr. R. Jouault:

Can I put my planning hat on briefly? I think you have hit on something which is quite interesting that in the attempts to keep the market broad and have players in it, large players and small players, we have peculiarly ended up with some kind of west coast elderly homes run from the bottom of Beaumont Hill all the way to the airport which is peculiar despite being run by very good providers, top providers, Barchester and Four Seasons, and we should be very pleased that they are here. But we do have an issue about the east side of the Island and I think it is fair to bring that up and we

do need to address that. I think the States have the opportunity to on 15th July when we consider the lifetime homes proposition which within it contains a residential nursing care facility in our good parish of St. Saviour. That would also bring the third largest player, the Methodist Care Homes, as a provider which for an island of this size to have 3 large players I do not think we could ask for anything more than that. Was that a political pitch? I am sorry.

Deputy R.G. Le Hérissier:

In a way we are now trespassing to the finance area so I wonder, Sean, if you would like to lead off on the financial issues?

Deputy S. Power:

Not really but I will. We are all aware of Senator Le Sueur's utterings on financial pressures on Treasury and on the States coffers in general. How do you think increased services within the Health Department can be financed, particularly long term care of the elderly? How do we deal with what you referred to earlier, Mark, which was reducing the financial risk to the individual who is sitting in a 3-bedroom house with a garage and a garden and is petrified that it is all going to erode over the next 7 or 8 years when they go into care?

Mr. M. Littler:

I think we are putting a lot of store on New Directions as a means by which we are going to manage the inevitable rise in cost of care of the elderly and in doing so we will be engaging with the public for the public to have a big input in terms of scenarios that if they do not change their lifestyles, for instance with obesity and what have you, then there is a consequence for all of us, the Island. I just give one sort of crude example but it is a very pertinent example. So we are putting a lot of faith in engaging with the public on the New Directions. We are also putting a lot of faith in terms of having the additional monies that we will need to meet the extra cost. Then after that we get down into the detail that our efforts will be literally locked into the strategic directions and that we will try, as we are duty bound to do and it is sort of part and parcel, to deliver the services in flexible and efficient ways. That is when we come down to it. But we are putting a lot of store on this type of debate where the real costs, the real challenges for the future are addressed. If you say that we have got

a certain amount now then we are not going to be able to meet those challenges for the future, not on current models and current funding.

Mr. J. Le Feuvre:

To pick up on that, what we are doing, and we have had discussions with the board before and there is no secret around the notion that we have is that we put forward proposals for a social insurance model. The timing is going to be crucial because in the context where we are now with G.S.T. (goods and services tax) just bedding in or not, but it is there, it is quite a tall order to go back, in an election year particularly, too soon to say there will be a different form of raising money because we have to have a mature debate about that point.

Mr. R. Jouault:

It is simply a hypothecated tax, that is what it is, is it not?

Mr. J. Le Feuvre:

Well, it is if you call it that way but this is around addressing the very concern that you have that currently 55-year old children suddenly realise that they are going to be disinherited because the house will be sold to pay for the care. There is some very complex arguments about whether that is quite as inappropriate as people think it is because if you have a social insurance model it could be seen as regressive because everybody will be paying into it and there are some difficult questions which we are discussing at Social Security about who will be required to contribute. If it is just the 16 to 65s that are economically active that is quite punitive. There is the example from Guernsey where historically they never had the age cut-off at the end and we could conjecture there is no reason why a fairly prosperous 74-year old does not still pay into the social insurance model for the dividends she may get in her 90s in terms of drawing down from that fund. So Social Security has the lead on this and there is an acceptance from the Minister that this is going to be one of his prime tasks now that income support is bedding itself in but it is not an easy, quick solution. It is something that you project to the future. There are all sorts of complexities about transition arrangements. If you have been paying for 3 weeks do you suddenly go and access 4 weeks later or do you not? Very, very political questions but we think that is the only way, really, in which we can propose that there is an actuarially managed

fund that is kept away from the immediate fingertips, really, of any particular Minister so that people have an assurance that it is there building up for the longer term. The public have to understand that in a pooling arrangement perhaps only one in 6 is going to draw down from that but they might understand nevertheless that is a risk and an investment worth taking, particularly if you start contributing when you first go into the workplace. We do not have the precise figures but we do not think it is going to be a huge percentage increase. Richard has just said it, however you do it, whether you do it by Social Security, it is effectively another form of taxation.

Deputy A. Breckon:

Can I ask you, James, you said discussions but it is not apparent that Social Security are doing anything, to us anyway. Could you say how far advanced are those talks that have taken place and if there is any frameworks elsewhere that you have mentioned there?

Mr. J. Le Feuvre:

We are drilling down the things because these have to come into the long-awaited report that we take to the Council of Ministers about the probable investment that would be required and one of the big investments is undoubtedly around sustaining people into their old age and it depends on this relationship with Social Security. They are very receptive but they need to work through what the liability would be and what the quantum will be, the unintended consequences. We know now that there already are people who are making contributions for that care and one of the perverse things if you introduce a universal pooled arrangement is people who have hitherto made contributions will stop doing that and would expect the fund to pay for it. So you can model it and then suddenly realise you have got to have a whole lot of extra funds there because people who have currently been making other arrangements they will draw down on that fund as well.

Mr. R. Jouault:

I was just going to add, where we are, both S.S.D. (Social Security Department) and H.S.S.D. (Health and Social Services Department) have been working together for a number of years now on getting their house in order really, making sure that all the mechanisms are in place so that should the States endorse a move from the inequitable

lack in choice of systems (I use the word "systems" very loosely) that we currently have had for the last 50 years, if we are to move to a system whereby we have a social insurance fund that the mechanisms that enable the department to equitably place people, provide the care, are in place already. It is fundamental, one of the issues is that we do not introduce a system that institutionalises people, that pushes people towards institutions because they have paid into a fund. For that reason we must ensure, and I think we stress this in the strategy, that people can access community-based care from the social insurance fund.

Deputy A. Breckon:

Can I just ask from round the table what would be the timescale for that? Obviously a framework for a system will be required but then from an agreement generally politically and from the community to buy into this, then to paying £8 a week, how far away from that are you?

Mr. J. Le Feuvre:

The latest indications are that we would be making sure that New Directions is central to the strategy which the States will debate in the new year, the new House, the new Council of Ministers; fundamental within that is going to be New Directions. That is the first point. All the work that we are doing between now and then is preparing the ground and managing the stakeholders and doing some of the consultation that you are helping us to do in this particular instance. Probably then Social Security will have to introduce the regulations to enable it to happen. So that is 2009, there is a political debate about what we would wish to do. I would suspect the proposals would be fine tuned by 2010. I would be surprised if a system was up and running before 2012. That is the sort of timescale that we envisage. So you have the thrash about and the debate about should we do it, formal States approval for it in 2009, then Social Security come back with very specific proposals probably in 2010, and then you have to decide how you establish the transition arrangements - who is in, who is out and how do people get access to it - and you have to start building the fund, firstly from contributions but presumably there is going to have to be some initial upfront allocation of a significant fund to kick it off so it can start working. That was certainly the Guernsey experience and we have looked all the while to Guernsey. As Richard as said, the huge deficit in Guernsey was they did not make sufficient

investment in the community. They emptied the hospital quite readily but they just pushed people into institutional placements. That is where the care tools that we have developed around how we assess people's health and social care is going to be really crucial. One of the more contentious debates we have to have is whether people will still be able to walk into institutional care or whether we, as a community, can institute some gate keeping and that is going to be tricky politically because people have exercised choice, they have chosen to go into an establishment. They might drive there with their own car or they may certainly have their car parked outside and that has been their choice but the question we have to face further down the road is whether that is a choice that is reasonable or whether there has to be, when there is a scarce resource, gate-keeping about only people who need to go into that institution take up a place there. There is evidence that we have got an over-institutionalised model in Jersey and we wish to move away from that towards supporting it. So, for instance, the fund, if we have it, could be a real shot in the arm for Family Nursing and Home Care if they chose to work in partnership on this. There are lots of things that can be done and the person sitting at St. Ouens can use the fund to be supported in her home rather than being transported to St. Brelade and to Silver Springs which is where we have just been. That is a very, very important distinction between ourselves and Guernsey. We have learnt from their experience and we think that this funding stream could absolutely help support that. It would never ever really be used for the primary healthcare work. We have got quite clear ideas about what would be in and what would not be in. It would be absolutely for the longer term care needs of predominantly older people.

Deputy S. Power:

Can I just come back on that. If in an ideal world you were heading in the direction you wanted to head in, in tandem with Social Security, a financial health insurance scheme, a modified Guernsey scheme, would be your first preference?

Mr. J. Le Feuvre:

Yes. With all the caveats, you cannot stop at 65 because you cannot go on hitting the economically active who are in decline numerically vis-à-vis the other parts of the population. So there is another difficult political point that we have to get people to

accept that they will pay in their 70s, late 60s and 70s. Even though they might not be working they will still contribute but the home will be safe.

Professor J. Forder:

It struck me as you were talking, I really wanted to ask a question on whether you had clearly established a case that the current system is not one that you would see as fit for purpose in the future which is fairly evident from what you were saying but I wanted to be really clear about that. Secondly, just to comment that I fully recognise the problems that you have mentioned around the Guernsey system and that when you were talking it sounded more like the German system was one that you were aspiring to. That would seem to make a lot of sense to me as well because that does tick the boxes of first of all levying the contribution on all ages, including the retirement population, and it makes very strong provision for people in the community offering a cash alternative as well as a service benefit and it has a fairly rigorous assessment process that you have to pass in order to become eligible for support. So it seems to tick a lot of boxes in that respect.

Mr. R. Jouault:

We could all give you plenty of anecdotal examples of why the current system - again, I use that in the loosest possible term - is inequitable because of the multiple points of access, the multiple points of funding and the multiple decision-makers involved in that. It is not really a system. What has been happening over the last few years, recognising where the strategic endpoint is, has been about working together, developing relationships, developing assessment tools, developing pooled budgets, mechanisms to eke out as much equity as we can and efficiency as we can and minimise the transaction costs that occur in this.

Mr. M. Littler:

In answer to your question, we are not going to persist with the current model in terms of the future; that is clear. But we are also, and have been for the last few years, actively changing the current model anyway on the points that Richard said. For instance, I will give you an example, we are actively involved with the Social Security now and a number of the care homes to say: "Okay, we have got now a placement tool" which using all the various assessments will link into the placement tool which

we are using now to say: “These are the levels of dependency that we have”, 6 main bands, quite common in the U.K., but we are all engaged on that using the same language. The next step with Social Security and the homeowners will be to say: “This is the amount of funding that we will believe is appropriate for this level of dependency.” I know I am only talking about on the institutionalised but what I am saying is it is an example of where we are trying to make better, more explicit in terms of the rules of engagement and who is going to do what, the checks and the balances and also the payment. As we speak, this is what we are doing now. We hope to have something tangible or at least a proposal to send out to all the homeowners certainly this year on - because there is a wide disparity in terms of costs and what have you - this is what we believe the public should be funding. Then obviously there are lots of debates that will generate from that but we are doing this now, again, as a precursor to where we have to in the long-term funding have the appropriate systems in place to deal with this problem. If institutionalised care is required, and there is a big if, at the end how is that going to be funded and controlled and then obviously it comes in with the insurance type model. So there is a lot of detailed work of getting ready, systems in place, to make that a reality.

Deputy S. Power:

The more I listen to you guys the more I seem to keep coming round to the same thought process which is that Health almost needs its own social security model. Health insurance and social security, it is almost as if the Health Department needs its own social security model.

Mr. J. Le Feuvre:

No, I think it is important that Social Security have got the skill base, the technology, the experience to do the financial assessment side and the collection side. We absolutely do not want to get into that. In contrast, we think we have got the skill and capacity to do the health and social care needs assessment. So we are really saying quite openly we want to redefine the boundaries between what we do and what Social Security does. Their level of expertise is there and they are good at that and income support is teaching them more tricks about how they do that. We have got health and social care professionals who absolutely know working with families, they have relationships with them as well, about where it is best for them to be. The other thing

I wanted to add, and we really hope this is going to happen, by moving to the system we can put much more choice in the hands of the client or the patient or their families. We think money in the punter's hand is a very powerful motivator for change and that is where we will get to the choice about they do not just have to go to a place at St. Brelade. It might be a voucher but if they have that money potentially for them to use as a consumer that is going to transform our service as a provider and it really shifts other debates we have that are very sterile about whether we are give block grants to certain institutions or not. If the money sits with the punter they will inform real changes in how the services … they will become much more customer focused, to use the jargon, and they will respond to the needs that people have because people are going to have the money to choose and if they choose to purchase care to be delivered to them at St. John or St. Lawrence then they are going to be in quite a good position to help them develop those services out there in the community. So it all links in and it is quite a big change in putting the patient back in the driving seat.

Mr. R. Jouault:

I think there is a really interesting point here about the subtleties of what tips people from living in their home to living in institutional care and where the money goes. It is an old lady trying to change a light bulb in her hallway that trips and breaks her hip. Partners of people who are demented will put up with enormous amounts of incontinence, aggression even and physical disability, they will cope with all of that but there will be subtle things like loss of communication with their partner which will make them feel: "I no longer have a relationship and therefore it is now time for my partner to go into institutional care." It is how you support those people. Sometimes it is not necessarily professionals who have got all the knowledge there. The family know where they need their help to make them remain in place. So it is very important where the money goes and how it goes.

Deputy R.G. Le Hérissier:

You put that very well, Richard. You did mention earlier about the over-institutionalised model. That could be here for a variety of reasons. It could be because we have got a very high degree of private affluence and a lot of people are ending up in homes because they can afford what for some people are these outrageous sums of money. It could be because we have got in the public sector a

poverty of care provision in the community, despite the valiant efforts of people like Family Nursing. What are the reasons why we have ended up with this over-institutionalised model?

Mr. R. Jouault:

I think you have hit both nails on the head. My grandfather was like the major in Fawlty Towers. He resided at Le Couperon for his final years. That was not a residential care facility but he used it as one. So in Jersey people did go into residential care. As James said, they used to drive there and drive away at lunchtime to have lunch and go back again. So that is not an appropriate use of residential care resource. Why are they doing that? (1) Because they can afford it and (2) because there is not the provision and continues not to be the breadth of provision to enable them to age in place. F.N.H.C. provide a marvellous service, fantastically dedicated people who do it. I am slightly conflicted in saying that because my wife works there. Going back to the person who is changing the light bulb, this issue that we raise in the document around a handyman scheme is absolutely essential, a missing component, a fantastic thing that the parishes could run.

Mr. J. Le Feuvre:

Can I just pick up on something Richard said. It is unexplored territory but we think there is something that the parishes could be really invigorated to offer. Having dispensed with some of the functions around the shift there has been from parishes to the State provision, and it is a model we have not really teased at in any way, but it always strikes me that we have parish secretaries who attend to electoral rolls and rates and all of those things. Certainly in 9 of the more rural parishes there is something about having a social secretary there who is on the ground, understands how these people are faring in the community and properly connected into the system around links to G.P.s, to Family Nursing, to Social Security; they really could do something much more sophisticated than the community alarms do around knowing who is there. It is sort of neighbourhood watch, it is sort of snooping, making sure they are okay, but they would be a very good source of information about whether these people do need a handyman to come, to continue to support them, to be aware of where they are and how they are faring. If we can only get there that, I suggest, would reinvigorate that sense of community in parishes, that social responsibility that

perhaps is drifting, and it would give a real purpose again around a hub, possibly around the parish hall, around knowing how the elderly and vulnerable parishioners are getting on.

Mr. R. Jouault:

It ticks the box of we want our third-agers people who have just recently retired to be active and to be employed. Tradesmen who have just recently retired would be a fantastic resource, people in their 70s who are craftsmen, to be doing low level activities. People who age in place tend to be females who may need meals on wheels but what they actually need is someone to clear the gutters and to change a few plugs and to do some tasks in the home which will make their home safe.

Deputy S. Power:

My own experience in my own parish is that there is a vacuum left because the welfare system passed on to giving support and a number of observations have been made on the parish welfare system. It had one advantage over the new system - it was very flexible. So, for instance, the parish could buy an old gentleman a bicycle and he paid it back over 10 weeks. The bicycle might have been less £100 but what it meant was that the gentleman enjoyed the use of the bike. The other thing is that the parish secretary has a fund of knowledge of all the people in the parish that are borderline, slightly below the radar, slightly above the radar, and the ones that do need help and it cannot be done in the normal way. I think perhaps we will note that for part of our report that that is a fund of knowledge that perhaps could be capitalised but in the voluntary and in the charitable area and let the parishes take a more proactive and co-ordinating role. Can I pick up on one thing you said, James, about who cares for the carer. Where are we with respite beds at the moment?

Mr. M. Littler:

At the moment we have 6 and up to 7 respite beds; 4, maybe 5, we use for nursing care respite, higher level respite.

Deputy S. Power:

Higher dependency?

Mr. M. Littler:

Yes. We have got 2 other beds for residential type respite. So we have got up to 7 respite beds that we have got a high take-up, over 85 per cent, because of problems with availability of beds and the carers going off on annual leave and what have you. We are utilising those beds to their maximum.

Deputy S. Power:

Where are they physically?

Mr. M. Littler:

We have got some at Little Grove and some at Pinewood.

Mr. J. Le Feuvre:

Of interest, the Minister has invited his Assistant Minister to lead on a carer strategy and that is a piece of work we are doing this autumn with the carers' association firstly but with others as well and really teasing out what would be required. We absolutely know respite is central to that.

Deputy S. Power:

It was central to the *Overdale Report*, the respite situation was central.

Mr. J. Le Feuvre:

Very, very flexible. It might be a matter of just a couple of hours a week to enable people to do things, it might be to enable people to go on holiday, and we recognise that and we are going to be doing that in October. We have got an all day workshop around a rapid strategy development process that we have used in others. That really is highly participative and we are going to have 70 people coming with us from within the carers' domain in with the professional providers and we are really going to thrash out some of these issues.

Mr. R. Jouault:

Again, it is about flexibility there. Respite is a hugely important piece to keeping people in their own home and how it needs to be provided needs to be carefully

considered. It is not one size fits all. Why does the person have to leave their home so that their partner can get respite? Why does the respite not come to the home?

Deputy R.G. Le Hérissier:
Yes, very good point.

Mr. J. Le Feuvre:
We are also doing a piece of modelling, if I might try and describe this, that we recognise there is high cost in institutional care and one of our strategies is to defer the point at which people enter it. Mark talked about compressed morbidity. We want that period of institutional care to be very compressed because it is by keeping people out for 2, 4, 6, 8 months or longer living in the community will reduce the cost substantially. So that is the other push that we have. We understand there will be a need for some people to have this care at the end but we want to truncate the period in which they have to experience that.

Mr. M. Littler:
Specially in residential care, that is an area that we should see big changes.

Deputy A. Breckon:
Could somebody just take us through say the path of example rather than individual of somebody who might become a hospital admission, an elderly person who is an hospital admission with high dependency or dementia. Somebody comes to you on Saturday in that situation. How does that develop into their care plan? They might be known to you or they might not.

Mr. M. Littler:
As you can imagine, we get 2 routes of admission, either G.P.s or A. and E. (accident and emergency) and sometimes they are used intermingly to try and get access to our services, which is fine. If they have just come in and there is obviously something mentally or surgically wrong with them we will attend to that. Then, while they are going through their diagnosis and treatment, we will be looking at where and when we can discharge them from the acute setting into the appropriate setting. Most of that time it will be at home. Sometimes it will be home with appropriate level of

additional support, maybe from occupational therapy, a slight adaptation of their home, especially for the elderly, or they may need some physio support or they may need just to be kept an eye on in terms of F.N.H.C. Then you start going up the scale in terms of their needs and this is where the social workers come in, in terms of providing a package, whether it be permanent or front loaded and then tapered off, to enable that person to be at home with an appropriate setting and support, obviously talking with their loved ones and what have you. There are different complexities but this is where a lot of thought is going on at the moment about these complex care packages because at the moment, because of the lack of full infrastructure in terms of the community, there is only so much in terms of dependency that we can safely deal with. If there is a certain degree of dementia you can but there comes a tipping point where proper assessments are made, not only of the individual but also the care arrangements that can be provided, especially when they have become incontinent, their behaviour is bizarre and cannot be in keeping with their carers. That is when some more formal assessments are made with the discussion: "Where can we best support that individual?"

Deputy A. Breckon:

Whose responsibility is that?

Mr. M. Littler:

It is a multi-disciplinary team approach, always. We will have medical input, whether it be from our medics or G.P.s, we will have the therapists, usually occupational therapy come in, physios come in, and also the nursing services and social workers, most importantly. They come together, they are looking at the whole situation, the environment they are in at home, the amount of support, voluntary or otherwise, that they have got, the actual dependency of the patient. They say: "With a duty of care to promote independent living, how can we support that individual?" It all comes together using the placement tool with all the different professional assessments and voluntary assessments, and say: "Okay, how can we support this individual?" At the moment we have got a lot of people within the community who are in their own homes. It is for very good formal reasons why they have to be in, let us just say, institutionalised care.

Mr. R. Jouault:

The placement tool enables the family now to participate in that process and transparently see what it is that each of those professionals has said about their continence, about all their difficulties … and they can comment, whether they agree or disagree, about what they want to do with that patient. I would say one other thing, to pick up on Mark's point, is that it is kind of interesting that somebody who is 18 years of age, might be a tetraplegic, can remain in home but an elder person may end up being institutionalised. You could say that is discrimination against older people. The point is we perhaps do not invest sufficiently into maintaining older people in their own homes yet and there is no 2 ways about it, although institutions are expensive, good quality community care is also very expensive.

Deputy R.G. Le Hérissier:

Yes, good point.

Deputy A. Breckon:

Can I just add something there. Roy and I were -- Alzheimer's Society had an open morning on Saturday and we went and had a look. There was somebody there looked a bit like you, actually. It was James' brother. We went and had a chat and a look around but something I did not know is that many people are supported by services in the community already and the word we got was they are a bit stretched because they can have up to 90 people who are in the community who they are visiting and supporting, not just with dementia but dementia-related things at various stages. I was not aware of that, I do not know if Roy was, until then. Is this a sort of ticking time bomb? Where does that go in the assessment and how does that fit into your system? I wonder if anybody would like to comment on that.

Mr. M. Littler:

This is about whether or not the current model can be sustained and this is why we are going to the New Directions. We do not think it can be because with the extra demands that are facing us we have to do something different and more fundamental.

Mr. R. Jouault:

Dementia is an age-related disease. You do not have to be a genius to spot what the incidence of dementia is going to be over the next 20-30 years. It is going to rise and how we manage that is going to be a significant challenge. I do not know if they spoke to you about tagging, did they? It is quite controversial. There is a variety of different things that need to occur.

Deputy A. Breckon:

That was for Ministers, they said.

Mr. J. Le Feuvre:

You can bet it is going to double. If there are twice as many 85-year olds within 20 years then there is going to be twice as many and how do we care for them?

Mr. R. Jouault:

Technology can advance the way in which we manage that, though, from their home and in the … the fantastic thing about the Jontek system -- I hope it is by planning rather than accident, we landed upon a very good system for the community alarm system. The Jontek system that we use was future proofed for a lot of other additions to it so it can have alarms attached to it, not just so that you press the button: "I have fallen over" because half the time it is the cat walking on it. You have alarms which go off because you go out of bed in the night and have not returned. It has got a pressure point under the mattress. So if somebody goes to the toilet, falls in the middle of the night, the thing is ticking away, they are going: "They have not come back" and will alarm the ambulance. Similarly with the gas on the cooker, when you turn the gas on, if the gas does not go off it alarms. So we have a system already in Jersey which, when we fund it properly, can deliver that kind of security to enable people to remain in their own home. There is nothing worse than remaining in your own home with dementia if you are incontinent and you are sitting in your own urine and you are thinking: "Has the person just come to change me or are they going to be coming again in an hour?" and not knowing when people are coming. I keep on emphasising the same point, I know, but if you are going to make people age in place you have got to invest in it.

Mr. M. Littler:

The other thing which is slightly more controversial is about risk and the level of risk that professionals and society are willing to tolerate in the support and care of individuals. I think one of the debates is not only in terms of provision of services or support but it is also an understanding of the level of risk that we have. At the moment it seems that we are slightly risk averse and that has a lot of financial and service delivery consequences.

Deputy R.G. Le Hérissier:
Yes, good point.

Professor J. Forder:
Most services are. You ask service users, they are often far less risk averse than professionals, and indeed the families around them.

Deputy R.G. Le Hérissier:
Okay, that is excellent. We have strayed somewhat away from finance but I am sure we will come back to it. Alan, can we kick off on the role of voluntary bodies?

Deputy A. Breckon:
How do you see that as it is now, voluntary organisations. We cannot always measure that because sometimes it is the hidden carers. How would you see that now and how does it develop and how does it support where we are going?

Mr. M. Littler:
At the moment the voluntary organisations that we work with they do a sterling job but they themselves in many cases are getting older, like Meals on Wheels, for instance. Not the meals. So I see us strengthening that and working with more, Alan.

Deputy A. Breckon:
What about funding that? There are obviously service level agreements and things like that. Do you see that developing from where you are?

Mr. M. Littler:

Yes, I see there is a more businesslike approach coming in. Quite rightly you have to account for the money, that it is well spent and it is delivering proper outcomes. From the acute side we are getting into service level agreements and agreements in terms of: "We will provide you with this. Now what do you provide? What can you guarantee providing and the level of service?" It is not bureaucratic but it just aids the professionalism and to ensure that we are spending the money or supporting various groups appropriately but there is also governance issues to think about.

Deputy A. Breckon:

There was an issue of respite care from the Assistant Minister. Is that the sort of issues that people are coming back to you, you know, the voluntary organisations are feeling the pressure, carers' organisations?

Mr. M. Littler:

I think what James said that we are kicking off this initiative, I think that is going to come up. As we speak now, the amount of formal respite that we have got we believe there is far greater demand out there.

Mr. R. Jouault:

I think something on this charitable issue is that if community care is going to be so critical to the future of answering all the issues of an ageing demographic, is it right for the States to put all of its eggs in the charitable basket in responding to community care? Is it right for the States to be a minority provider in terms of institutional care? Is it right that primary care, which is so important going into the future, is a private business concern? Well, that is the reality of where we are and I think the future means that the S.L.A.s (service level agreements) between the State and the charities, the State and the institutions and the State and primary care have to be bullet-proof because otherwise we are not going to get strategic cohesion going forward.

Deputy A. Breckon:

Are you comfortable that within where you see New Directions going you can build in the money and resource that is needed to support people in the community with voluntary organisations as well as the official service?

Mr. J. Le Feuvre:

I think so but it is about what I said before, it is about empowering the client, the patient, because they hold the key to the funding stream and that is what is so different. We need to move away from the very crude block grants where we give out X many hundred thousand, whether it is to provide for 6 in this year or 12 next year, and maybe there is a formula where there is a base grant for the rudimentary infrastructure. We do not want places to close because they are short on clients this year but they will have twice as many next year. We have got to move away from this rather old-fashioned model where they get a lump sum, traditionally it is just annually uplifted by R.P.I. (retail prices index). We have got to get into a more sophisticated model where the money follows the client and that will inspire them to seek out those clients, to provide better services that are more attractive to those clients, because they will be in the driving seat as the purchasers. We will not go mad like they have done in the N.H.S. (National Health Service) but we want to really change the focus around it is not just us in a rather paternalistic way buying these block things. It is people choosing to stay at home or to go there or to buy respite for 2 or 3 weeks potentially. So it may be an option of the carers strategy is there is a voucher system and whether you use it to have 3 hours per week so you can go and watch football with your son and not look after your elderly dad or whether you use it for 2 weeks to go to Majorca with the family is potentially for the family to decide. So it is putting more and more emphasis on them. For some families it is more important to have quality time once a week, for others it is essential they get away for 2 weeks, and we think we can enable people to make those choices rather than us saying: "This is how it will be."

Mr. M. Littler:

Alan, I feel that with the process and the consultation process that we will be endeavouring with the New Directions the level of interest - because everyone is an expert on care of the elderly because we are all going that way - is going to be huge; the divergence of opinions is going to be huge. So when, let us just say, the States debate and there is a certain amount of money provided, it would be incumbent upon the professionals working with the wider community to deliver what people want and the level of scrutiny because of individuals, whether it be either complaints or views, in order to answer their queries sufficient for the political control, the level of

transparency that will bring to it, you will have to atone what are you delivering in this area or that area. There will have to be a clarity, not sort of vague generalisations, and you will be saying: "Where is your evidence that you are delivering this?" That level of debate will provide a degree of focus on what we do, how we deliver, why we are delivering it, the cost of it and the efficacy of it, that has never ever been, I would say, debated in Jersey before at that level.

Senator B.E. Shenton:

It is not to do with long-term care of the elderly but since I became Minister I am aware of at least 2 instances where we have been paying money to charities for services that we do not need and we have had to have quite strong negotiations with them to say that the money has to be directed where we want the money to go. I am pretty sure from one of them we will get some fallout later in the year at a political level but unfortunately it is a decision that has to be made and you have to make sure that the money goes where you need to spend it. A lot of charities are very well intentioned but if they are not delivering the sort of service that we require then they will have to do it on their own bat and they cannot look to grants from us.

Deputy S. Power:

Can I come back to the original point Alan made, and I think you alluded to it, Mark, that the role of the voluntary sector and the development and provision of services generally, much and all as you have a problem with recruiting we have a little evidence, and I am sure you have got some evidence, that the voluntary sector also have a problem recruiting. People are healthier as they get older, people live longer, people go on cruises, people play golf, people do bowls, there are a lot more things available to being elderly than there were 20 years ago. Do you have any evidence that activities in the voluntary sector are being curtailed by that area and have you addressed it?

Mr. J. Le Feuvre:

W.R.V.S. (Women's Royal Voluntary Service) folded earlier this year. That was a good example.

Mr. R. Jouault:

F.N.H.C. face the same challenges as we do in recruiting nurses.

Deputy S. Power:

The question I asked an hour ago about the balance, it may be it becomes less.

Mr. J. Le Feuvre:

It could go either way. If you think you are going to live longer people may be prepared to do rather more in an altruistic way in their 60s, and we spoke about extending part-time paid opportunities around the notion of looking after people in the community. It could be that people would be prepared to spend some time doing it. When we have done the profile around Meals on Wheels it is quite scary how elderly the service providers are.

Senator B.E. Shenton:

They are not all elderly. My wife …

Mr. J. Le Feuvre:

It may be a fantastic opportunity. If people are going to be fit in their old age, maybe there has got to be a debate about what you can do yourself in your 60s to help look after your neighbours and other people. I do not think I am that naïve about that; putting a value on that is not necessarily financial. It is about getting people to understand that that could be something they would get enjoyment from and they themselves, if they are active and they are involved, the evidence is that they are much more healthy themselves in terms of the intrinsic worth that they are doing something of importance.

Deputy S. Power:

I think there is a fund of goodwill out there for both the department and for the voluntary sector going forward together and saying: "We need you", very much related to the parish thing and bringing the parish back into it.

Deputy A. Breckon:

Related to that you will probably remember we did a scrutiny exercise with the schools. How far do you think we are down the road educating the young, if you like,

because you do not have the 3-generation households that some of us remember? So it is about tolerance and accepting people's conditions. Are we doing that, have we done that, or do we need to do a lot of work on it to get young people to accept us lot getting on? When we went they thought we were old. Is there anything where you are trying to involve young people through the schools?

Mr. J. Le Feuvre:

You can do that but when you talk to young people about the importance of having pension plans they are absolutely uninterested because people just do not think they are going to get old, I think is the honest answer.

Deputy A. Breckon:

Or they will worry about when they do.

Mr. J. Le Feuvre:

I think so. The work that you were involved in when we were in the schools they were very focused around health for life issues. They really, I do not think, can at that time attend to those things. There is so much else: where are they going to work, are they going to study, what are they going to do. I do not think they are thinking particularly about how it is going to be when they are 60, 65.

Mr. R. Jouault:

But attitudes change. It is a fascinating area to look at and we have done a bit of work in the ISAS barometer looking at attitudes changing. I think one of the biggest determiners of how young people perceive older people is what they see older people doing, and what they are seeing people over 65 doing now is wearing jeans and enjoying themselves. A 65 to 75-year old person does not look like a 65 to 75-year old person 50 years ago; they just do not even look like them. They certainly do not do the same things, as Sean was saying. So it is continuously changing but we do need to get around these softer issues about old people and young people have opportunities to interact and to pass on experiences. Jersey has some very peculiar aspects of good and bad. Little bits of the parish parochial system enables some opportunities in communities but also we have some idiosyncrasies which are different from the rest of the world. We have a lot of people who either they are

ageing in Jersey and their children are abroad or they are around but they have come over to Jersey and they have left their older people in the U.K. or in Europe. If you look to the ISAS barometer there are some very big differences about Jersey in relation to other communities about how often people see older people in their family.

Deputy R.G. Le Hérissier:
Yes, very good point, Richard. I think we will now move to the last area which in a way we have jumped in and out of but I am sure Julien will pull it together for us in his question.

Professor J. Forder:
I will try.

Deputy R.G. Le Hérissier:
We have the whole issue of a continuum of care.

Professor J. Forder:
We have certainly talked about it a lot and what you have been saying seems highly laudable in the sense that you want to see greater low level service, you talked about telecare, you talked about community-based options, you talked about keeping people out of care homes for longer, and indeed just a bit of anecdotal evidence of our trips around the Island is that length of stay in care homes does seem to be somewhat longer than we see in the U.K. So these things are highly positive moves, it seems to me, although there is part of me that says the evidence base on the full long-term preventive effect is still far from definitive as to whether this really does save you money in the long run. This is nonetheless an obvious direction and even if it does not have long term preventive effects it clearly has huge well being, improving effects for people experiencing these services. So having said that, the problem is, I think - and I would like your views on it but I think it is a fundamental problem that everybody is trying to grapple with - where you work with a limited resource or a limited budget and you see growing demand right across the spectrum of need, how can you take resource from very high dependency groups where that resource is already tight in order to fund these lower level services? To give an example, just talking to a director in England and he was saying that 92 per cent of his resources are

tied up with the very high dependency group and yet he is very keen to try and promote these lower level services, community based options, but he says: "How do I do this when I see ever increasing demand on this very high level of need, 92 per cent of my resources? How can I take resources away from that?"

Mr. R. Jouault:

You cannot really cut that cake. That is a classic 80:20 principle, is it not; 20 per cent of people absorb 80 per cent of the resources? You can re-cut that cake and not deliver New Directions or you can get yourself a new cake.

Professor J. Forder:

Yes, but it strikes me it is going to take some double running costs. I mean, there is going to be a period where you have to invest in your community options in order to see these dividends. But in the short run, that is the real dilemma, how do you square that? How do you find the extra resources to do that and still maintain a level of service? We talked a lot about the voluntary sector and maybe you can see a role for the voluntary sector to be the legitimate funders and providers of those lower level services but on the other hand, as you were saying, if you do want to move a service model down the need spectrum more then you do need maybe a more fundamental commitment which involves public money.

Mr. R. Jouault:

We can definitely produce a more equitable and more efficient system with better cost containment than we currently have but you are quite right we are saying that is not enough.

Mr. J. Le Feuvre:

I think what Mark has said is we are going to recognise we have to do the very high dependency stuff which crudely will come from within the existing resource base that we enjoy and we understand. That is why the gate-keeping assessment is so essential because it will be in our interests, to be crude, to make sure that people do not get into that sector until the last possible moment or that they are moved out of it, discharged if that is appropriate, into the other sector. It is this other area where we really are looking to this social insurance model to be an extra funding stream. Not to

complicate the debate; there is no suggestion that insurance model is going to provide for direct acute hospital services, neither for the long term high dependency beds for the patients at St. Saviours, if that is where they will be, or Sandybook. That is our responsibility but it is in this other greyer sort of sector where there are a range of options and choices where it could be community or it could be residential or nursing care of the lower order of provision in terms of the staffing that is required behind it, that is out with the hospital. That is the sort of boundaries that we think we are beginning to negotiate with Treasury and Social Security.

Mr. M. Littler:

Tactically, with the new extra money with New Directions, the sort of tension between institutionalised care and community care, the key area would be residential care. There is no doubt about it, it will start to run down in terms of the numbers there and that would be reinvested in appropriate packages of support. That is how I see the big shift. The high dependency will not change much.

Mr. J. Le Feuvre:

Some providers might see there is an opportunity to provide limited respite care, for instance. So those who are currently doing residential care may shift into a different level of provision which would meet the objectives of the carers' strategy. So, again, we are trying to stimulate growth in sectors that are not there at the moment.

Mr. M. Littler:

That middle ground is a huge amount of resource and money tied up there.

Professor J. Forder:

That is a good point. We have certainly seen that sector being squeezed and, as I said, now lengths of stay in what you call residential care are very low indeed. Some of the residential care provision now is almost at the level that your nursing care might be described as. People's lengths of stay are 18 months on average, so these are very frail people, and a lot of that resource, as you say, can be redirected into the community. So that is about targeting efficiency of resources. In fact, you are lucky in a sense to have that availability to make that resource change and to see improvements.

Mr. M. Littler:

Yes, because as we speak now I am very confident in terms of the beds that we either have or procure on nursing care, that they should be in nursing care. I am not at all on residential.

Professor J. Forder:

But I mean certainly recognised that intensive community packages can be as expensive, often more expensive, because you lose economies of scale on at least in terms of the care costs in residential care places, so the balance is difficult to achieve. You obviously recognise the problems and are moving in the right direction.

Mr. R. Jouault:

It is more than just the care, also I think it is ... you can be a prisoner in your own home if there are 20 steps to the front door, so our housing stock is not particularly well positioned to enable them to age in place, and there is a really big need to shift the housing stock so that they are up to lifetime home standards.

Professor J. Forder:

I think there is ... partly it is about grappling with this problem and we talked a bit about this yesterday, about certain levels of care and people's willingness to contribute politically, because you can certainly see that most people would support the idea of making a collective contribution to support people who are at critical levels of need. Who have real health risks and whose lives are in some jeopardy to give them support. It is a much less clear cut case where you are talking about improving the well being of people by providing them with social contact, things which are fundamentally important, as we have been saying to the people themselves, but making a political case for especially younger people, as we were just discussing, to pay out of their own pockets when they meet a lot of the other costs and have a lot of cost pressures in their own lives to support people to receive day care services or outings and so forth is a more difficult political sell.

Mr. R. Jouault:

First to get cut, are they not?

Professor J. Forder:

First to get cut and last to get funding, yes.

Mr. M. Littler:

I mean we are already having those debates whether it is criticisms that we get, patient transport, and we are grappling with high levels of dependencies here as opposed to that and trying to balance, but with the new direction and the delivery of that all that will come to the fore about what level are we really willing to support and pitch it at? That is going to be one of the key points.

Deputy R.G. Le Hérissier:

On that issue we have ... sorry, have I interrupted? I was going to try and bring Tracey in here. There is the issue of how we work out priorities and we do have maybe this naive feeling that services were ring fenced, and simply because you had to give more high level critical care you had to then cut back the patient transport service. I do not think it is as simple as that but that is the ... how effectively are you measuring within your Department the effectiveness of your services? How do you measure the effectiveness, Tracey?

Ms. T. Fullerton:

At this moment in time as you are aware we have the balance score card system. The items that we measure on the balance score card have come from what our objectives are in our business plan, so at this moment in time we would look at those on a monthly basis and obviously we would be presenting those at an S.M.T. (Senior Management Team) level and if anything is dropping out or we are not looking like it is on target then obviously we would put remedial actions in place and look to see how they could be rectified for the following quarter. So we are on the ball with those in the fact that we are looking at them on a quarterly basis. Now at the departmental level within social services, each department will have its own business plan, so we also look at what ... on a 6-monthly basis how they are doing as well and meeting their targets there. So we can marry all that together. So the idea really is I suppose to keep on the ball with it so we can have early warning systems to be able to do that.

Deputy R.G. Le Hérissier:

Do you go ... I mean, you often read about it with services like the Police where there are apparently these hundreds of Police officers sitting down doing their target reports every month and obviously they are not able to get out on the streets to meet anybody while they are writing these reports. I mean, okay, you can do the efficiency but what about if you come to a situation, Mark mentioned for example when people press the button the ambulance has got to be dispatched. When you come to the point, do you say: "Well, look, this is ridiculous, we are getting all these ambulances running up and down because Mrs. X stumbled while getting a jar of marmalade" or whatever, do you say: "We have got to reconfigure the service" and how do you move into that part of the discussion?

Ms. T. Fullerton:

I think that is for the operational manager to identify that there is possibly a deficiency or maybe a shift in what the current trends have been in the past and obviously they are monitoring those trends at the operational level. The operational manager would then bring that back to the Senior Management Team so that it could be discussed in forum there and obviously if possible there could be ideas that come from the Senior Management Team, but then even then it would probably go to the Minister if it was at that level.

Deputy R.G. Le Hérissier:

Is there ... one of the things with the target system, Tracey, is they often like these sort of central planning systems that you used to get in the Soviet Union, where there are people in these head offices sort of pulling these levers and saying: "You should not do this and you should do that", and you often hear ... some of it is anecdotal and some of it is very Jersey. You know: "I have had this sort of excellent meeting with the senior managers of Eltham. Are they not an enlightened bunch?" and then you start talking to the nurses or the ward sisters and they say: "Oh, if only we could get rid of these levels of management and they do not talk to each other and they certainly do not talk to us." How do you get staff involved in the process of improving services in the health service?

Ms. T. Fullerton:

I think it is really important that the objectives that are met which are made in each Department come from the staff who are involved at that level, so that they do understand and have contributed to what the objectives are for their Department, and then those objectives then obviously do feed into what the higher level objectives are and again straight forward into the strategic plan. But I think the other very important thing is that the objectives that we are setting and for instance with the score card is it is meaningful, so we are not just collecting data and ticking boxes, it is data that is meaningful to the Department and they can use it to improve their services and to see what they are doing really, really well and to see where the deficiencies are as well.

Deputy R.G. Le Hérissier:

Do you think the staff feel they are over-controlled?

Ms. T. Fullerton:

Do I think the staff feel they are over-controlled? **[Laughter]** I do not know the answer to that. I really could not say that. Coming from myself from an operational level I certainly did not feel that I was being over-controlled, I have to say, but I think it is about the degree of understanding that the staff have in what is going on, what they are doing and how it contributes to the overall objective at the end and I think we could probably ... we could all probably do that better but I think in some areas it is done very well.

Mr. J. Le Feuvre:

We are very pleased, we did the staff survey, all of the executive did the staff survey and I have to say that we have looked in detail at some of the things that came out of that. So for instance within the nursing profession, which is a hugely predominant workforce and there has been a lot of work around nursing midwife strategy and a lot of that is around communicating, getting them involved in developing strategy and genuinely making attempts to get down there to the shop floor to see what they are telling us, because they have got a very good understanding of what the key issues are. I think there is lots to do on that and it is hard in an organisation but we do recognise that.

Mr. M. Littler:

I think while we have the appropriate level of targets and objectives the nature of their work is so fundamental that you take your eye off the ball there at your peril. You know, individual patients, and we have certainly got a large number of different professional groups who are certainly committed on their professional lives and they would raise issues. Linking in with what Tracey says, and I have got a number of pressures at the moment, if there is a particular service pressure, for instance diabetes, say, then it would behove upon myself with a consultant and the nurses to come up with a business case which fundamentally looks at the problem and how best to deal with it and that would have all the matrix and the demographics and what have you, the costs and how we are going to deliver pluses or minuses and that would go to the S.M.T., the Senior Management Team, to discuss whether or not we fund that, if it cannot be funded within the resources of the directorate. So that is quite a process because by fighting for scarce extra resources you get a very good debate and sometimes in some of the areas it is a case of: "Should we be doing this anymore?" Not if it is done off Island, so this business about reconfiguration in gaining resources, that is the mechanism and that is quite a tough mechanism because a lot of people are involved in developing it and also there is a degree of internal scrutiny to ensure that only the most worthy cases go forward and it is linked in with our strategic direction.

Deputy R.G. Le Hérissier:

Okay. Are there any final questions from the panel?

Professor J. Forder:

I just want to check, what is your view on individual budgets and cash payments? Is this a direction you want to go in? You have hinted at it but ...?

Mr. R. Jouault:

I think it needs to be handled with an element of caution. James is absolutely right. The principle is that the consumer controls where the resources are allocated. That is essential. But let us not create a system whereby money goes from S.S.D. to the consumer to F.N.H.C. via upping the transaction costs. So the principle should be that the consumer determines how the resource is allocated. That may not necessarily mean cash payments to the consumer.

Mr. J. Le Feuvre:

Because the last thing we want is this huge infrastructure around transitioning. The wooden dollars going round is a nonsense and we have seen that elsewhere and we really want to try and avoid that if we possibly can.

Professor J. Forder:

Yes, I know. I agree. I mean I think there is a view nonetheless, and I agree with the transaction costs are going to be higher, but there is something fundamentally different about giving people money, because that really does make them empowered, as opposed to saying: "Notionally you have this budget. We will look after it and obviously we want your input" but that is qualitatively a different situation.

Mr. R. Jouault:

I suspect a bit of both will occur. We will see something like a component with income support being … I do not think they will have physical control over, but it will be bizarre for F.N.H.C. now to be thinking about having receipt of all this money from all these thousands of different positions where they get 5.5 million from HSSD that would be a huge increase in transaction costs.

Mr. M. Littler:

Julien, there is no doubt about the tension there, but the critical mass issues will come into this. You cannot have a million bespoke services, you are not going to ... there has to be a balance.

Professor J. Forder:

Yes, definitely.

Deputy R.G. Le Hérissier:

Okay. Any comments from our visitors?

Mr. B. Shenton:

Lovely to see you. **[Laughter]**

Deputy R.G. Le Hérissier:

That will not get you anywhere.

Mr. B. Shenton:

I was just going to mention, I got into home last night and my wife said: "Oh, Roy has been on the T.V. again saying New Directions has been delayed", and I did not see the news so I only got this second hand version but there is this general feeling that New Directions has been delayed but in reality New Directions has started and it has been going on for a while. We are doing a lot of work here in preparation for moving forward and whether someone turns around and turns a switch and says: "New Directions are starting now", it has already started to a large degree, so I think there is a little bit of a fallacy about all sitting here waiting for some start date and the other thing I would just say from a political aspect is ... and one thing I have picked up here today even more so is the community aspect of the Island is very important to the success of New Directions and I think when we build the next strategic plan as politicians we have to really take that into account and maybe make sure that we hold on to ... this is very much a political speech, but hang on to the community of Jersey going forward.

Deputy R.G. Le Hérissier:

Well, I think it came out in James' and Sean's comments about ... well, the States approved that welfare should move to get to an entitlement versus a somewhat dubious discretionary system as people saw it, but we have lost some community aspects in that transfer.

Deputy S. Power:

Well, I think if you galvanise our views that community point as a resource you have an incalculable asset there, and I think it has to be part of your structure and the other part I think that you made which is about tracking the monies to the individual as distinct from the categorisation approach is hugely important.

Mr. R. Jouault:

While we are reconfiguring the service for New Directions and there are elements that are just re-directing the service there are elements of it like the Social Insurance Fund

that we simply cannot implement until the States endorse it, so there are large components which have to be a States debate.

Deputy R.G. Le Hérissier:

Well, thank you very much indeed. I am sure we will be talking again but it has been a very interesting conversation.