STATES OF JERSEY

Health Social Security and Housing
Long Term Care Hearings

TUESDAY, 29th JULY 2008

Panel:
Deputy R.G. Le Hérissier of St. Saviour (Chairman)
Deputy A. Breckon of St. Saviour
Deputy J.A. Martin of St. Helier
Professor J. Forder (Adviser)
Mr. C. Ahier
Mr. M. Orbell

Witnesses:
Ms. K. Huchet (Chief Executive Officer, Family Nursing and Home Care)
Ms. P. Massey (Divisional Manager for Clinical Services, Family Nursing and Home Care)
Ms. J. Hinks (Team Leader, Home Care Support Team, Family Nursing and Home Care)

Deputy R.G. Le Hérissier of St. Saviour (Chairman):

I would like to welcome you to this panel. It is a sub-panel of the Health and Social Services, Housing, Social Security Panel under Alan Breckon, but this one is obviously the Health sub-panel and we are looking at directions in long-term care. First of all, we will introduce ourselves. I am Roy Le Hérissier.

Deputy A. Breckon of St. Saviour:

Alan Breckon.

Deputy J.A. Martin of St. Helier:

Judy Martin.

Professor J. Forder:

I am Julien Forder.

Mr. C. Ahier:

Charlie Ahier.

Mr. M. Orbell:
Malcolm Orbell.

Deputy R.G. Le Hérissier:
If you would like to briefly introduce yourselves and tell us your positions, please.

Ms. K. Huchet (Chief Executive Officer, Family Nursing and Home Care):
I am Karen Huchet, Chief Executive Officer, Family Nursing and Home Care.

Ms. P. Massey (Divisional Manager for Clinical Services, Family Nursing and Home Care):
Pam Massey, Divisional Manager for Clinical Services, Family Nursing and Home Care.

Ms. J. Hinks (Team Leader, Home Care Support Team, Family Nursing and Home Care):
I am Jean Hinks and I am the Team Leader for Home Care Support Team at Family Nursing.

Deputy R.G. Le Hérissier:
As you may remember, Karen, from your last time, there was a formal witness statement. We will not read it out now but basically you are protected for anything you say as long as it is not of a malicious or unsubstantiated nature. I mean, it is a fairly standard thing.

Ms. K. Huchet:
Okay, thank you.

Deputy R.G. Le Hérissier:
What our intention is, we will go through a series of questions but we will not religiously stay with them and, if necessary, on our behalf, our adviser, Professor

Forder, he will jump in maybe from time to time and ask a question, if there is elaboration needed or something of that kind.

Ms. K. Huchet:
I expect about an hour, is it? I do not know.

Deputy R.G. Le Hérissier:
Yes, about an hour.

Ms. K. Huchet:
There are copies there. That is our response to the questions which is probably easy and there are some packs there of the organisational information. So, as we go through the questions, at least you have something to refer to. We have tried to keep it short and readable, so it is not a long drawn out mission.

Deputy R.G. Le Hérissier:
We can only read so much, Karen, as you know.

Ms. K. Huchet:
It is quite short, I think, so yes, okay.

Deputy R.G. Le Hérissier:
Thank you very much for doing that. That will be very good assistance for us. Just to set the scene, can you tell us what the range of services are that you provide? Can you tell us what the balance is between nursing and home care and although we are obviously going to get into it in more detail as the session proceeds, can you just give us an indication of what you see as your medium and long-term challenges?

Ms. K. Huchet:
If I could start on the strategic, sort of obviously the bigger picture and then hand over to Pam or to Jean. Obviously as you are aware, but perhaps the rest is not, we are the largest charity on the Island, the largest health sector organisation. Current budget is £7.8 million of which £5.8 million is provided from the States of Jersey for outsource services. We currently employ 260 staff, well around 260 staff, some do obviously

more than one job, but we provide services from birth to end of life so starting obviously with new births, going through obviously to end of life issues with our oldest patients. The charitable side of the organisation has to raise £2 million obviously to match the States of Jersey funding so, from our point of view, there are services that we believe are provided by the funding from the States and there are additional enhanced services that we provide from the charitable money obviously to assist. I think probably the best thing is on question 1, I think Pam was going to take this one and this was really about the range of services because we tried to explain that in long-term care, when much of it is around the ageing population, we have long-term care issues coming through from chronically sick children, head injuries, mid life issues, young disabled, so we have put everything in from the very start until the end. If Pam can just take the range that we have down there as the answer, that would be good.

Ms. P. Massey:

Okay, the clinical services care delivery is really split into 3 sub-services, the first being district nursing service and certainly their core services are for people with identified nursing needs and the majority of those are for the elderly population, but they also look after and do a lot of preventative work on the long-term care of chronic disease management. We have also spent quite a lot of time working collaboratively with our colleagues in the acute care setting looking at the long-term placement tool and that, at the moment, is only looking at the elderly placement, but we are looking to develop that further in looking at the more chronic sick and using the principles of that to promote care and decision making around their care. Also we have clients with disabilities that have long-term nursing needs within the district nursing service and we also, at the present, have social care. So a district nurse would go and assess those patients that are requiring social care and the actual care is delivered by our home care service, but they remain on the district nursing caseloads and Jean will talk you through the service development that we are looking to change that process in the future. Our other core services centre around the home care service and we have 2 levels of care that are offered within the home care service and that is level 1 which is domestic support service, and these are really about embracing people and trying to ensure that they can stay at home, so capturing them before it gets -- and it offers a cleaning and shopping sort of service. The level 2 provision looks at the personal care

service which includes the bathing, the showering, the toileting and those sorts of things. No complex nursing needs required, but certainly some help about enabling people to stay in their own homes. Also which comes under the home care service at present is the twilight service, and that service is a service that is offered from 6.00 p.m. in the evening until about 9.30 p.m. with home care services, popping people to bed, ensuring that they have those sort of services, but within that twilight service we do have district nurses on call responding to any nursing needs that may need a joint visit of social care and nursing or just the acute nursing needs that need to be addressed in an evening time.

Deputy R.G. Le Hérissier:
Sorry, can I jump in on that? One of the comments we have heard going around is because of the pressure you are facing, some people are being put to bed a lot earlier than they would wish to be. Is that the case? Are you finding you are under that pressure?

Ms. P. Massey:
We do not have the flexibility of offering appointment times for clients at this moment in time and it is true that very often people are offered a service at a time that does not really suit their lifestyle. I have to say that we are looking around the flexibility of our service and within service development we are looking to increase capacity so that we can offer a longer sort of time bench but we will not ever, I think, be able to do appointment times. It is too restricting and it is too difficult to get an appointment time as such. Most of the people would want that 10.00 p.m. slot and it is about trying to be equitable and deliver a service that we can deliver for everybody really.

Deputy R.G. Le Hérissier:
I do not want to flog it too much, but does that mean, for example, like people would have to miss their favourite T.V. (television) programme like some people would --

Ms. P. Massey:
I think what we would like to do is to get some flexibility in the service so if it was a T.V. programme that they wanted to desperately watch then it is about listening to

them and trying to provide service around their needs. But you are quite right, at the moment, what we do is say: "These are the slots we have available, can you fit into them" rather than saying: "What do you want? Can we fit into your slot?"

Deputy A. Breckon:
Can I just ask the question of what you find in people's homes? Are there facilities like a wet room or are people struggling with old bathrooms and mobility issues around small flats?

Ms. P. Massey:
As part of the home care service we do have a physiotherapist and occupational therapist working alongside that team and certainly the majority of their work is around interventions to maintain function and maximise independent living so there will be an assessment by that team who will then assess for adaptations to their home to make it a safer environment. We are usually working in a lot of homes below the optimum, but it is about making their environment, which suits them, fit the purpose of our nursing and care staff going in and enabling a safe delivery of care.

Deputy A. Breckon:
I know Social Security do have a fund to grant any of that. In your experience of that, does it work? Do they give the money?

Ms. K. Huchet:
The O.T.s (occupational therapists) and physiotherapists are involved in meetings with Housing and Social Security in relation to looking at clients who have exceptional needs and they try to do the best they can to address it.

Deputy J.A. Martin:
Talking about the contact with Housing and Social Security and your first point about the implementation of the long-term care placement tool, is this as well as Social Security and Health or do you have your own one or is it all working -- they have now a vigorous placement tool for people who need to go in nursing care, I am told. Is that your one?

Ms. P. Massey:

Yes, this is exactly the same. The same tool.

Deputy J.A. Martin:

It is a different board though or is it just the same criteria?

Ms. K. Huchet:

Our district nursing team leader was working with Health and Social Security and the team on long-term care placement to do an assessment tool that fitted every organisation so, in actual fact, they are piloting it as a joint initiative.

Deputy J.A. Martin:

Have we seen this? Obviously to me it would not mean anything as a non nurse, but all I am told is it is a vigorous placement tool that they use at Social Security now. Whether that means like if you need X amount of care, you can go into it or not.

Ms. P. Massey:

It is a document and it is a full assessment basically so it looks at the physical, the psychological --

Deputy J.A. Martin:

I am told I have it. I apologise. Okay. I will read it. I am getting there, thank you.

Ms. K. Huchet:

It is a joint agency initiative of which I think Richard Jouault was chairman at one stage. It was a joint initiative of Family Nursing and Home Care, Health, Housing, Social Security, anyone who is involved in the care sector, so it is not an individual agency.

Deputy J.A. Martin:

No, that is fine, yes. Just as long as it is everyone on the Island. Thank you, Karen. Sorry.

Ms. P. Massey:

That is okay. Looking at the physio and occupational therapy function, we also have an equipment store which obviously feeds into that assessment and a delivery of that equipment. Those are the sorts of main elements to the home care service. With child and family services, we have services that we provide care to children that have special needs within the school setting so we have special needs school nurses that will support children in the education environment. We also have a small paediatric team which provide supportive care within the family home and support the family, and we also have a health visiting service which does an awful lot of work with newborn babies that have obviously long-term conditions. I think with the development of the medical world, there are more and more children that are surviving that have a higher degree of need and the health visitors work very closely initially with the families about accessing help and support around those needs. So those are the sort of key areas that we work at supporting long-term conditions within the clinical services.

Deputy R.G. Le Hérissier:

Before we move to the next question, and you have done an excellent job here I should add, it has almost made us redundant but anyway we have to keep steaming on --

Ms. K. Huchet:

We have done it on every Scrutiny Panel because I just think if you have missed something we have said, it is there. I have specified to staff that I wanted it very, very short so, in actual fact, it is quite user friendly but at least you have a reference you can refer to later on. The one thing that we have not mentioned that I think is quite important for Scrutiny and for the Professor is we are unique obviously in relation to being a provider because we do do health and social care under one umbrella with one budget so if clients come to the service, we do not refer them to the Social Services Department. So, everything comes into the organisation and is handled from the nursing side and goes into the social care side as well. We do not have issues which you have often in the U.K. (United Kingdom) about that is not our budget, we will not deliver, you know so, from the point of view from uniqueness, I think in the U.K. I think there are a few areas trying to follow a similar model to get this integrated working.

Deputy R.G. Le Hérissier:

But if somebody does need a social worker, for example, Karen, who makes that assessment? Say that person initially comes to your attention, do you say: "Oh, I think we need Social Services."

Ms. K. Huchet:

Our nursing staff would link in. Basically, anything that we do not deliver, that is not within our service, our staff would liaise automatically with Social Services, Income Support, the Parishes, Housing. They would just automatically bring in the full package for the client so it is pretty good.

Deputy R.G. Le Hérissier:

Just reverting to Pam's description of these services, as I said this is going to be an underlying theme, but could you tell us where the pressures are on your service at the moment and what are the services you would like to be offering that, at the moment, you feel you are not offering?

Ms. P. Massey:

At the moment, from a statistical point of view, we are delivering -- how our slots are divided up are into 15 minute slots of activity regardless whether that be nursing, health visiting or home care. So, we divide our slots into 15 minutes of activity. At the moment we are delivering a total based on 2007 figures: 52,490 episodes of care from a district nursing point of view, and we looked at analysis of the age groups really and over the 2006/2007 period, the age group that we were delivering over the age of 65 was 996 clients that were on our books. Now, that correlates with the 12,330 people on the Island that were over the age of 65 and hopefully there are a lot of people over the age of 65 that will not need any care whatsoever. So, it is just to give you a balance of the pressure on care delivery really. We are looking at more complex and complicated packages of care so it is not huge numbers. We cannot say that the numbers have increased significantly, but the complexity of care has increased and I think that has to be flagged up as a pressure. So, it is the complex needs of patients that we are looking to. Patients that are coming out with very high complicated medical interventions that are needing highly skilled nurses and also the

pressure on people doing a lot of proactive work around trying to retain their chronic disease at a state that is enabling them to stay within their own home.

Deputy R.G. Le Hérissier:
Are you aware, Pam - and I am off script as I keep saying - of people who are in the community but you just have not resources to work with and are, therefore, having to end up in residential/nursing homes?

Ms. P. Massey:
I think if we look at the placement tool that you have already referred to, that is a really good way of benchmarking the complexity of need. The problem being with that placement tool is the funding is for a nursing bed in a nursing home and that funding does not continue to follow the patient where they want to be. So, we have high complex care which needs to be funded and we have a choice, it is a nursing home or it is not funded and I think that causes quite a lot of problems.

Deputy R.G. Le Hérissier:
Absolutely.

Ms. P. Massey:
If we were able to have that amount of funding within the community setting for more clients, then we would be able to develop those services. We certainly do not have a 24 hour nursing service on the Island, at this moment in time, in the community, and if you look at care of the dying, that is something that is essential when you are looking at care for people right at the end of their lives. We look at the demographics and that would suggest that we are going to have a huge increase in people dying on the Island and we need to look at patient choice of where they want to be. There is certainly a lot of information from the U.K. about standards of care that we need to be reaching when we are looking at care of the dying and there are some gaps within that service on the Island at this moment in time.

Deputy R.G. Le Hérissier:
Just slightly back and I will truly move on, you mentioned very politely that conditions in the home were, when it came to the question Alan raised about supports

and wet baths, less than optimum I think was your view. Is that because the money is not available or because some parts of housing like social housing have not been properly converted? What is the reason that it is less than optimum?

Ms. P. Massey:

I think it is multi-faceted. I think you are quite right there. I think it is around investment into States housing, I think it is around the cost and there are some extremely wealthy people if you look at their housing where they live, but they are not cash rich. It is maintenance of that too. Also we have problems with people with alcohol and substance misuse that obviously fall very short, in terms of maintenance of a house would become very low priority for them. So, I think it is multi-faceted.

Ms. J. Hinks:

And individual choice. Because our perception of need is not always the client's perception of need and so they will just say no.

Deputy R.G. Le Hérissier:

Yes, yes, good point.

Ms. P. Massey:

Can I just add one thing that I am desperate to get over really is the growing need with our children with long-term care as well? We have identified within our service that we have a shortfall in trying to support those children in special needs schools, particularly in the paediatric, around ensuring that they get the support and care that is needed to deliver education and home support within those services too.

Ms. K. Huchet:

Can I just go back to the question you originally asked? You asked about what the gaps were. If you go into question 3 in our response, we have flagged up that currently 74 per cent of our budget is obtained from States of Jersey. So, 26 per cent of Family Nursing and Home Care's budget comes from the charitable side of the organisation. We cannot expand basically as an organisation to key essential areas such as rapid response schemes, hospital at home, intermediary care and any other initiatives and basic service provision. We can only deliver at the moment and cope

with what we are currently delivering. So any expansion into any of the areas that we want to do is currently, at the moment, coming from the charitable side of the organisation. So, we are only addressing current issues, not development of services for long-term needs. We have also mentioned that within home care services flexibility of service, which Pam has already mentioned, needs to be addressed for the service to offer real choices to patients and clients. I think as 3 of the panel members saw, Jean did an excellent presentation at our A.G.M. (Annual General Meeting) on the social care pilot which, in fact, you have copies of the presentation in your pack. Basically it looks at the fact that we need to look at changes in social care, remodelling services, to cope with demand. So, we are trying to address the demographics and the issues, but at the present moment in time the funding is not coming from Health and Social Services or the States of Jersey to address the major demands in community care. I think that is a crucial point for us in relation to everything we are doing. We are only just dealing with current issues rather than any major service initiatives. I think that is around New Directions as well. Is that all right?

Deputy R.G. Le Hérissier:
Okay, thank you. Yes, no that is excellent.

Deputy A. Breckon:
For the benefit of the tape, if you want to finish your bit about home care and get the statistics on the record there because we have a copy, but you did not get as far as that and the reason I say that it is relevant is because one of the issues about where this does care stop and start is supporting people in the community and that is relevant to that, so I wonder if you could finish that bit first and then come back?

Ms. P. Massey:
The statistical information that we have around the home care level 1, number of clients that we saw - and that is 2006/2007 information - is 951 clients; for home care level 2, it is 1,063 clients; and for home care twilight service it was 224. Now, some of these clients may be receiving all 3 types of care and the total number of visits that were provided to these clients was 109,952. The total visits for physio and O.T. visits were 2,117. For the child and family services, the statistical information is that the

school nurse special needs activity was 6,387 and the total paediatric team visits was 1,411. The health visiting activities was 7,369 and we estimate that about 10 per cent of their activities centre around long-term care needs. The total school nursing and special needs activity was 15,605. So, that was the sort of statistical information about our activity. Thank you.

Deputy A. Breckon:
I wonder from that if you could say how predictable the demand is for your services? I mean, is it just a case next week is different from last week and sometimes you have been asked to do things really which is putting a tremendous strain on the service you provide?

Ms. K. Huchet:
I think one of the things you see in the paper is that one of the things we were asking for as an organisation is improvement of the strategic planning in the Island. So, in actual fact, if there is improvement in commissioning and strategic planning, then we would be planning for our service delivery and any demands. Our difficulty for the staff is that they often get new initiatives coming in that have been changed by another department which then impact on the organisation so, for example, moving staff out of Queen's House into the community means that, in actual fact, our staff get increased demand for other services, nursing or home care, and there has not been a planning or an implementation plan put in place. So, I think a lot of our issues, as you go through the questions, are around some kind of commission body for the Island and strategic planning so all agencies are working to the same strategy and, therefore, not just for States departments but also for the charitable sector, that we are not duplicating and so we are all working in the most efficient manner so we do not waste resources.

Deputy A. Breckon:
You are not suggesting we have joined-up government, are you?

Ms. K. Huchet:
That is for you to decide, is it not? But the importance is, and it is for every agency, if you work in isolation the danger is another charity will set something up similar to

Family Nursing, another States department set up the same and I think we are going to face not just demographics, but budgetary constraints which means we all have to look at what we are all delivering and is the right person the key deliverer? I think that is our question. It should be the person who is the right agency for the job rather than just a case of well, we think we fancy doing that service.

Deputy A. Breckon:
Can you maybe expand on that bit? How good would you say then the assessment process is for the clients in the multi-agency approach, whether it is States, whether it is an institution, whether it is yourselves? Is everybody singing off the same hymn sheet here?

Ms. K. Huchet:
I think within any organisation, as you go down to the operational or the clinical staff level, it is excellent. I think the vast majority of staff know who they are working with and they will do their best to ensure that the client has the right care delivery. I think the difficulties are happening as you go up the budgetary or the financial ladder and the strategic ladder, that is when you get issues around the joined-up thinking in relation to what is happening. I think that you will always have some issues around you could do things better or you could address services, but I would say overall, at operational level, staff will link together if there is a problem to see how can we do it better.

Ms. J. Hinks:
Yes, I agree with that.

Deputy A. Breckon:
Is there a lead from below if you like and a lag from policy and funding? Is that about where it is?

Ms. K. Huchet:
I think it is around strategy, policy and you will see as you go through our paper one of the key issues for ourselves is that the commissioning of Health and Social Services, it is very difficult to have a Health and Social Services Committee that is a

commissioner, a regulator and provider and I think that creates difficulties in structuring policy and I think also it creates difficulties in partnership working because the fact that you are working with someone who is a provider, if we get into discussions about how I want things to change, it is always seen as --

Deputy A. Breckon:

You are stepping on their toes.

Ms. K. Huchet:

-- political conflict really. Whereas, in actual fact, if it was independent commissioner and obviously providers, I think all agencies could communicate and work together on improvements without it being seen as you are crossing into a political territory. I think that is a major issue as we go through and also the tendering process. I mean one of our things is around having a transparent tendering process and through commissioning that if we, as an independent, put forward a proposal or if someone in the department did, it would be seen as transparent, independent and looked at as who was the best provider and the best value for money rather than just it is an expected way of practice.

Professor J. Forder:

Can I just pick up on that? Are you suggesting, therefore, you need a greater separation between the commissioning role and the providing role?

Ms. K. Huchet:

I think that is the general feeling. The budget at the moment comes from the States of Jersey into Health and Social Services Department who, in actual fact, are primarily acute service providers. Therefore, that will always create difficulties because their priorities obviously with acute sector will always absorb the other side and I think, to be honest, for every part of the delivery, and I think for Health and Social Services as well, I think dealing with the commissioning side would make it much easier for people to communicate in a fair and transparent way because then you do not get the tensions or the dynamics or the budget issues which is what always causes problems in health and social care. So, I think that is across the board in Family Nursing. I

think from all levels, it is around strategy, policy, what do we work towards, agencies having clear ideas of the boundaries and what they are providing and why.

Deputy J.A. Martin:

Have you spoken to any of the politicians who could do this, like the Minister for Health or Social Security and their feelings on it?

Ms. K. Huchet:

It comes up at our committee meetings and has been brought up in discussions with the Chief Officer of Health and Social Services and with various ministers. It is in our A.G.M. report again. It is the one thing every year. It is the final part that I think we tend to agree is that until you sort out the commissioning of health and social care there will be difficulties in how the services are provided and how you can monitor those services and what is happening and have value for money. If the commissioning was correct and the strategy and the policy, then I think a lot of things just fall into it. I suppose that is a bit idealistic but I think it is a good start that you all know what your terms of reference are.

Professor J. Forder:

Yes, definitely.

Deputy R.G. Le Hérissier:

Back to your question of commissioning and tendering, Karen - and I am sorry I am off script again but we will come back - of course with the constraints, for example, on immigration into the Island and, therefore, constraints on how you can expand your workforce, obviously you cannot contemplate a possibility where there would be an alternative tenderer to yourself. Is that correct? We are asking for a tender in a monopoly situation. Is that correct?

Ms. K. Huchet:

Yes, I think as you go through the paper, I think what we are saying -- the question was: "Would we have difficulty in Family Nursing and Home Care seeing other providers in the market?" and the answer was no. I mean, from our point, it should be the best provider for that service, best value for money around governance, training,

education and hopefully we are, so even there was other competition it would be a case that we are delivering an excellent service, but I do not think we would see any difficulties at all in relation to -- because it is an monopoly. I mean it is a monopoly market at the moment and in relation to staff coming into the Island to Family Nursing, you will see that we do not have major, major recruitment issues especially in home care. Very, very positive from Jean's service in which nearly all her home care staff are local employees and 52 per cent of our service is health care assistants so the vast majority of our service is around social care.

Ms. J. Hinks:
We are seen to be a quite good employer for all sorts of reasons but terms and conditions particularly because we give a salary. We are salaried. The employees are salaried, whereas if you look at most private agencies, and that includes the U.K., they are not salaried so you only get paid if you work, and pensions and sickness pay, annual leave but as an employer we do not do that so the staff are salaried. So, although there is a cohort of people, in fact we attract them. We have a very good inductional training programme and that follows straight through to N.V.Q. (National Vocational Qualification) level 2 in care and level 3 in care so we have a workforce at 90 per cent qualified N.V.Q level 2 and I do not think there is any private agency, even in the U.K., would match those figures.

Deputy R.G. Le Hérissier:
Yes, of course.

Ms. K. Huchet:
I think also because of the charitable status, again which is quite positive, we have really good relationships with Regulations of Undertaking and, in actual fact from our point of view, as I said 92 per cent of the workforce are locally employed. We tend to go to the U.K. only for our specialist nursing staff. I would say there we probably are facing some shortfalls because of a lack of availability in paediatric nursing specialists and school nursing. But health visiting, district nursing and home care, no, I mean basically we could expand. I mean we would need the systems and structures in place, but we could expand as an organisation to deliver other initiatives. Pam has been working on the new pilot project which we are doing around almost a mini rapid

response scheme and that is in response to the hospital and the major bed refurbishment. So, there are initiatives coming through, but they are very low cost initiatives that we are getting the opportunity to develop.

Deputy R.G. Le Hérissier:

Thank you. I will come back to script now. Under question 4, we have covered assessment but just as Alan would say, to put it on the record, I will ask you the question and then you can fill in any gaps and then you can answer the classic thing about what the strains in the system and what could be improved? So, who assesses potential clients, how do you make your assessments and, very importantly, because you have already raised this issue, how does this work in relation to any Health and Social Service Department assessments?

Ms. P. Massey:

The referrals come in from a selection of routes and we did analyse this from January to March of this year and the overall outcome really suggested that 50 per cent came from G.P. (general practitioner) practices, 40 per cent from the acute hospital and 10 per cent from other and that 10 per cent included people that had visited the G.P. who had told them to refer directly into us. So, that was the sort of split. The referrals are logged as they come in and they are assessed and then fed through to the appropriate team. That is the sort of assessment process. The clients are assessed by registered nurses or therapists or the health visitors and a plan of care is discussed with the client and the family and that care plan is then implemented by the appropriate staff within the teams. The plan of care is regularly evaluated and any significant changes obviously will be addressed. That information is written into patient held records which remain within their own homes and the patients can take those to the G.P. or to an appointment at the acute hospital so that we can record those visits. I have to say that does not happen very often, but it is something that we are pressing that people do take them with them and they become quite user friendly. The other things that we have in the process are we have a liaison and district nursing sister who works with our acute colleagues in the hospital and her work is particularly centred around discharge planning and discharge processing. We have meetings twice a week looking at discharge planning. The hospital are very focused now on their discharge planning process because of the reduction of beds. She then brings back the key

complex cases that are likely to be discharged and discusses those with the individual nurses that will be taking care of their care when they come home. We also do case conferencing when the district nurses will go into the hospital and discuss it with the family, social worker, in a multi disciplinary team approach about what care is needed and what care can be provided and if it cannot be provided with us, then we look at sourcing other agencies to fill those gaps for them. So, there is quite a lot of work centred around the discharge planning process. Regarding the children, our paediatric team have regular meetings with the Robin Ward, which is the paediatric ward in the hospital, and liaison is centred around that process. Again with the health visitors, they link with maternity services and the special care unit so we do have quite good links on the ground.

Ms. J. Hinks:
The liaison sister meets weekly with the social workers as well from the adult team.

Ms. P. Massey:
So that process is being developed significantly. I think the focus probably around the reduction of beds in the hospital has made everybody focus on that discharge planning process which has been one of the positives that has come out of it.

Ms. K. Huchet:
I wonder if it would be useful though, obviously because 3 members saw Jean's presentation at the A.G.M. on the new way of social care and assessments. I do not know if it would be useful for Jean just to take you through how we are doing the new way.

Deputy R.G. Le Hérissier:
Yes. If we could though, Karen, I will just finish with Pam. What I was going to ask you, Pam, and Karen has raised this issue, if they are discharging people earlier from the hospital, that must be putting a lot of pressure on your organisation, but is there a funding mechanism where the hospital says that you are now picking up people at an earlier stage, we are now having to hold more planning meetings about these people thereby putting more pressure on our organisation. There is no system at the moment where funds can be shifted to you to deal with that?

Ms. P. Massey:

We are still finalising our service level agreement with Health and Social Services for service delivery so until -- well, it is very positive because our new scheme on the pilot rapid response which is around a system with the bed refurbishment we have a small S.L.A. (Service Level Agreement) in place. We have got the first one. But the baseline foundation S.L.A. for what should be provided by the States of Jersey as core services and sourced to Family Nursing, and what we provide from our charitable status, we are still finalising with Health and Social Services. It is moving, but obviously I think there are other initiatives that have unfortunately got in the way of the priorities, but I think until we have that, it is extremely difficult for them to then start and reallocate funds into new initiatives. We need our baseline first and then we can start and look at -- you know, we are taking on a development, therefore, you need to create funds to come with that. So, it is really still linked into the service level agreement.

Deputy R.G. Le Hérissier:

Okay. On the issue of assessment which we have discussed earlier, Pam, and Alan mentioned joined-up government, would it be fair to say or would it be over optimistic to say that you and Health or the Social Services component of Health, you are all singing from the same hymn sheet? You all understand what assessment mode you are using?

Ms. P. Massey:

Yes, I think that is true, particularly in the elderly. I think it has to be developed further for the younger sick, but certainly for the elderly, yes, that is the agreed tool. I think, like you say, the funding that matches that tool still has some blocks really to delivering the care where people want it to be delivered.

Deputy R.G. Le Hérissier:

Would it be fair to say that the funding is simply focused on the different levels of residential/nursing care and it has not really moved into assessing the units of community care?

Ms. P. Massey:

Absolutely.

Ms. K. Huchet:

Or reallocate them to the client to use it as they feel they -- I mean I think the one thing we have not covered in fairness to our Health and Social Services colleagues is that a lot of the proposals for long-term care of the elderly we totally support the overview here in relation to the fact that, you know, public and private division of services, new proposals, new funding models, new initiatives, the unified assessment, F.N.H.C (Family Nursing and Home Care) totally support the work that Health have been undertaking in joint decisions with ourselves. I think we have to get that somewhere in the hearing that people are all working very hard to try and resolve the issue.

Deputy R.G. Le Hérissier:

The service level agreement, as you said, Karen, this has been going on for many years?

Ms. K. Huchet:

1996.

Deputy R.G. Le Hérissier:

1996. Oh, well, perhaps in Jersey terms that is fairly fast.

Ms. K. Huchet:

We are getting there. We are getting there. Yes, well, you heard at the A.G.M. it will be in by 2009.

Deputy R.G. Le Hérissier:

Yes, it is a qualitative as well as a quantative measure. Is that correct?

Ms. K. Huchet:

It is both. It is both, yes. Obviously it is the funding, it is around the types of services we deliver, it is around performance indicators, it is around governance, it is around

risk assessments and how the organisation runs, but primarily I think the discussions, obviously the detail, that we struggle on is basically deciding, because of the breadth of services we provide, and we do believe we do deliver an extremely high quality service in the organisation because of the charitable status. It is that decision about what would be provided by the States as outsource services and what the charge -- so, it is the negotiations that I think always get complicated. But now we have a guarantee. I spoke to the Director of Finance at the A.G.M. and yes, we have a guarantee in the minutes of the A.G.M. that 2009 we will see definitely clear guidelines about obviously what is being paid for by the States of Jersey.

Deputy R.G. Le Hérissier:
Will it involve another level of bureaucracy to manage it or will it be fairly self-managing?

Ms. K. Huchet:
Well, we are quite a flat structure. I mean, on our side, no, I think we would not do bureaucracy because most of our funds go to front line services. We may have to look at reshaping some of our division around the commission side and the measurement but that would be a margin with an excess to resources. We would just look at people doing an extension of roles or a development. But the main thing is going to be around the monitoring, the evaluation, performance indicators and the governance side of it. On the Health side, I do not know. I do not know. They do not have a commission department so I think, for them as well, if you look at the third sector and the charitable sector, there is an issue about how they will bring in this new way of working because there is no point doing the commission if you are not monitoring it and evaluating what your quality is.

Deputy R.G. Le Hérissier:
Yes, quite.

Ms. K. Huchet:
We would hope to do it by reshaping or with the aims we have within the organisation and ideally with some involvement of nursing and social care staff. Our staff do have the knowledge base, so it is a huge advantage if you are doing a commission.

Deputy R.G. Le Hérissier:

Yes, okay. Thank you.

Professor J. Forder:

Can I just on behalf of the panel really? This links back to your point about strategic commissioning and the allocation of resources overall between the acute end of the care spectrum and then across to community health and social care and the fact that without a standalone commissioning function, then decisions about where funds are allocated may follow the way that services have been traditionally provided and it may not necessarily mean the best allocation of resources given the spectrum of needs that you see on the Island. Is that a fair summary?

Ms. K. Huchet:

The decisions tend to be made at the moment on operational crisis, I would say. So, if something happens within the service or there is a change in working or there is a change in demand, then often it is a reflex reaction to the fact that you have that pressure rather than planning in what you would need to address your long-term needs. Yes, definitely. Yes.

Deputy R.G. Le Hérissier:

Well, having cruelly stopped Jean in her tracks, would you like to briefly explain the relevance of your initiative?

Ms. J. Hinks:

Yes, if you do not mind me going to question 8, because it sort of follows on.

Deputy R.G. Le Hérissier:

Okay, we seem to be jumping everywhere so that is par for the course.

Ms. J. Hinks:

It is about the expectation that demand of the services would change and that is how the new project was got through. So, we do know that we have an ageing population. We do know even if the ageing population is to be a well population, there will be the

natural frailty of old age, but we also know that that will bring on people with long-term conditions who will live longer and long-term conditions mean that there will be more than one disease process happening at the same time, so it was how do we best meet the needs for these people who primarily will want to be cared for their own home. So, that is why we were looking at the project really. We know that in the UK they grasped the nettle, as I said at the A.G.M., back in 1991 and part of the Community Care Act was that they would look at nursing care and social care and begin the separation of the 2 and that social care, the person would have to pay for whereas nursing care was still free at the point of delivery. So, we were looking at how nursing and social care are devolved at Family Nursing and Home Care and, as you know, it was the bringing together of 3 independent caring services and as the evolution had happened in the U.K., it happened over here that nursing and care assistant work was closely integrated but the separation happened in the UK. The separation had not happened here and we have to be careful how we do the separation because we want a very safe, effective and cost effective service so we want to be very careful about how we manage the change. But it is cascading down from what would have been traditionally a district nursing, a sister's role, through down to our social care nurses who are at staff nurse level and then when the comprehensive needs assessment is complete, with all the risk assessment, environment health assessment, falls prevention, nutritional screening, the whole package of care, when that has been done, then with safety, the patient or client will then go through to our senior health care assistant and that is a brand new role. So, the brand new role of the senior health care assistant will have a little caseload. That will be monitored and evaluated but the supervision of the care that is delivered, so the quality control of the care that is delivery, the assessment, re-assessment of the client, once it has come through to her care, that will be under the responsibility of the health care assistant which we have not had before. I am very excited about it and we have talented, skilled people who are eager and ready to develop so that is the way the project will go.

Deputy R.G. Le Hérissier:
Excellent. Judy, any questions about the project?

Deputy J.A. Martin:
No, no.

Deputy R.G. Le Hérissier:

One of the underlying foundations of New Directions - and you remember New Directions, we are all trying to get there - one of it has been that essentially people will live longer. If New Directions kicks in we will all live healthier lives, just pass a bit of fruit, we will all live healthier lives and there will be what I think the Chief Officer has called that horrible - but I do not think we found a substitute - phrase, compressed morbidity, where the illnesses, the conditions, they will be put in a fairly short period at the end of life. Is that one of the assumptions?

Ms. J. Hinks:

I think the estimation is that it is around the last 7 years of life that we will all need help so even if we have never smoked, we drink moderately, we take lots of exercise, potentially we are going to live to be 95, 100 which would not be an extreme, particularly here on the Island, there will be a period of time, and some of the estimates are that it will be about the last 7 years of life, you will be in care. I mean one of our aims, and we have talked a lot about vision, is trying to, and Pam eluded to it earlier, put the person at the centre of what we try to deliver and then we will not have Utopia but try and match the services to what that person needs. One of the aims particularly for the social care pilot is that we keep the service going in early so that we meet the needs as soon as the person requires help to try to stop that extended period of time with fractured femurs and things like that that could happen if we do not put the help in quickly.

Ms. K. Huchet:

I think what we are already seeing this in occupational therapy and physio. We are already seeing the pattern though that a huge amount of their workload is around over 85s.

Deputy R.G. Le Hérissier:

Sorry, Karen, is around what?

Ms. K. Huchet:

Our occupational therapists and physios are already seeing the trend that the vast amount of their caseload is over 85 year old clients, so we are starting to see it coming through in relation to the pattern.

Ms. J. Hinks:

If you extrapolate some of the information from the U.K. from documents like Our Health, Our Care, Our Say and the Wanless Report, those sorts of documents, I mean their annual increase, their expectation for their annual increase of people with long-term conditions will be about 6.6 per cent per year and they have a really scary estimate about the workforce and how that will need to grow. Over the next 20 years they say the workforce, the caring workforce, will need to increase by 80 per cent so the figures, I do not know if Professor Forder --

Professor J. Forder:

No, no, that sounds about right.

Ms. J. Hinks:

So, we have to be looking at, we have to do that as Karen was saying, the strategic planning and how that care is going to be delivered. We need to be thinking about that now.

Ms. K. Huchet:

I think 2012 is meant to always the black hole about the nursing and the specialist nursing. We know about 50 per cent of our workforce in Family Nursing is 40 years and upwards. All of our senior nurses, with expertise and knowledge, are coming towards retirement which is why if you go in the document we think we will have to reshape and remodel services around using the younger staff coming in, health care assistants, to find a different way of working rather than just concentrating on the way we have always worked before because I am not sure we are going to have the workforce. We have also not mentioned yet obviously pressure on carers because we will see more pressure on carers, obviously on those who are employed to look after ageing relatives so I think there is a major issue about succession planning, workforces and how we deliver the patterns of care. It is not just around capacity, it is about remodelling and restructuring services to maximise it.

Deputy R.G. Le Hérissier:

Given your service, Karen, is very people intensive and we discussed the issue, for example, of the twilight service of people trying to get mutually acceptable times to go to bed and so forth which obviously puts a lot of pressure on your service, really your service is people dependent, is it not, so there is only an extent to which you can remodel the service to make the use of your staff more efficient? Is that the case?

Ms. K. Huchet:

I think you are going to be looking at more support workers. I think definitely looking forward is it would be around support work services and probably reducing down the number of specialist staff. Going back to your point obviously the T.V. and other bits, we do try our utmost if it is a special request, but it does not matter how many staff we have or what services we deliver, you will never be able to fit it according to a fixed time delivery. I think that would be extremely -- I think it is around need versus want, is it not, really with the clients but we will do our best if people want to go out to a function or there is a special need? We have not mentioned yet, we do have a sitting service. So, we have a day sitting service and a night sitting service where we can support carers again, so if they need some freedom of flexibility, but at the moment it is limited. It is limited, yes.

Deputy R.G. Le Hérissier:

I think and I will rely on Alan, Judy and Julien and the officers to inform me, I think we have covered most of the areas. I am sorry we have not quite followed the sequence of your questioning, but I get the feeling that we have moved through most of the major areas that we identified in our questions and which you have so excellently answered both in your written document and your verbal answers. Are there any areas you feel we have not covered properly or that you would wish to draw our attention to?

Ms. K. Huchet:

There is just a mention of number 10 which is around the recruitment of staff.

Deputy R.G. Le Hérissier:

Yes, which you have just alluded to.

Ms. K. Huchet:

There is still the issue on Island across the board the issue of police checks. Obviously in relation to checking new staff coming in because there is still currently - for all agencies, and obviously it is no one's fault, but it could be improved - about a 10 week wait in relation to the police clearance which obviously affects any quick initiatives you are trying to bring in. I have put in the paper, but you have the A.G.M. report, where all our funding comes from so you obviously have that. I have also mentioned when you talk about the insurance scheme, we do see it as a positive but we do think that, obviously being very biased, Family Nursing's membership, our membership of the organisation, could be encouraged in the short term until the insurance scheme comes in because obviously our membership is, in fact, an insurance scheme in itself.

Deputy R.G. Le Hérissier:

Absolutely.

Ms. K. Huchet:

That pays for future care initiatives. So, we have mentioned, yes, very positive, but in the short term until New Directions is addressed, it would be great to see people signing up for membership and investing into -- because we could deliver more. There is no question of what we could do as an organisation.

Ms. J. Hinks:

Can I just say the Green Paper is not about regulation? As an organisation we are very for the regulation of domiciliary care, the regulation and inspection which CSky do in the U.K.

Deputy J.A. Martin:

I think to answer your point, as you say, interim investing and joining Family Nursing and I think why we are looking into it, long-term care and insurance is because we have waited for so long for New Directions and think it is such a big thing on its own that it needs to be coming forward very quickly, as you say. We are hitting the people

now who do not really want to leave their own homes. You are doing your best. If there was more money out there put aside, directed and not, as you say, just depending on what is going on down the hospital and how many people need to be -- there is a completely new review. We are lucky, we have got Julien and I know the health service probably have the equivalent, we hope, and it is very new even going back to what Julien has told us from the bigger countries in 1994, 1995 and then Guernsey have done it, but it does give, providing what you are doing, the people who have got the money -- and it is paying you to come out at different times, would be through an agency or whatever, but I think we need to get it off the ground and this is to push the Ministers to look at every side of it.

Ms. K. Huchet:

Obviously we do not have the luxuries in organisation. We have never had big money. I mean whatever we have we have to do the best we do with it. I think that is why we need some strategic planning because I think even if we were meeting in a strategic forum, there are short term initiatives that we could be working together on to reallocate resources because I think we are waiting for this major new initiative which is around big investment but, as professionals, we should be using every opportunity to reshape services and, for example, we could be doing it in partnership with someone else, it could be someone else reallocate some of their staff to us. I think it is about being creative as well as always having to wait for the big guns.

Deputy J.A. Martin:

New Directions is a lovely, fluffy warm feeling document and my personal feeling is if we do not smoke, drink and never sort of cross the road, we will live. It is good, it is good, but this is something, as you say, it needs taking out, it needs putting aside with all the people involved on it and if we cannot get it right in an island of 90,000 people, the U.K. has no chance really, but I mean we have got the 4 or 5 good on bad examples that we have been given and we can pick, we are in a position to pick all the best bits and keep people in their homes, if they want to go in residential, if they want to go in nursing and things like that. You have got to hope people buy into it.

Ms. K. Huchet:

The thing about Scrutiny is this. It is also about not always criticising the States and the States departments. This is around if you have strategic planning and commissioning, this has got charitable organisations, public sector, Parish, everyone knowing exactly what to work together on to solve some of the issues. I think it is that communication and the discussions that we need at the senior level because I do believe this, I do. The staff at operational level will be having discussions and sorting out the individual problems. It is the bigger picture, is it not, really?

Ms. P. Massey:
There is lots and lots of work to be done and we need to do this --

Deputy J.A. Martin:
I am not saying it is a small job, that is what I am saying. This part of it needs to be taken out of it and worked through. That is our opinion. We hope and we think, and we are meeting with Social Security and Health, they will tell us where they are. We are coming at it the wrong way round, according to them. But if it gives them a steer in the right direction, I do not think we can do anything wrong.

Ms. K. Huchet:
Yes. Well, unfortunately, the world does not stop if patients do not stop in relation to a big strategic plan. So we have got to keep going.

Deputy J.A. Martin:
No. They need to step aside and have a look at it. We can only suggest -- talk to the people on the ground, talk to the Ministers and then we will do a report and make some suggestions, which will probably be along the lines that they are going anyway, because they cannot reinvent the wheel, you know. But it has to happen before New Directions.

Deputy A. Breckon:
General question: how much is dementia an issue? Is this emerging?

Ms. P. Massey:
Yes.

Deputy A. Breckon:

Is it getting more serious?

Ms. P. Massey:

Yes. It is a growing concern, I have to say. It is very, very complex to keep somebody that is acutely confused in a normal home without proper services and it is an issue. There is an issue about getting patients assessed in the community. We, as family nurses -- so the nursing service cannot ring up directly and request a referral to our community psychiatric colleagues. We have to go via a G.P. or an acute medic. So that sometimes can be a delay and that has been flagged up and we are trying to work through with our colleagues in mental health around the referral process.

Deputy A. Breckon:

Would you say that perhaps there are people who are vulnerable, who are still living in their community because of dementia?

Ms. P. Massey:

Pardon, sorry?

Deputy A. Breckon:

Are there people living in the community who are getting support that you may consider as being vulnerable?

Ms. P. Massey:

Yes. I mean, I think it is about clinical risk and risk assessment and there are people that choose, with their families, to maintain people in their own home with dementia. But there is a degree of risk in that.

Ms. K. Huchet:

I think in general you go back to the question of the need and the times of service. If we felt as an organisation there is a clinical risk and we felt that we could not professionally deliver a service, we would have a case conference with the family and the members and explain the risks involved. We do that. So it is not just about

dementia. There are vulnerable clients in the community, who, as Jean said, do not always accept what the professional assessment is. So I think you would work with the G.P.s and everyone to look at managing the risk and then decide whether you can continue to deliver care because that is the cut-off point for ourselves: is it still safe to deliver a service for the staff involved? That is around aggression, it is around -- we have not done anything on obviously patient conflict and other things, behavioural difficulties as well, with staff. You have to support your staff as well and what is safe for your staff to deliver.

Deputy A. Breckon:
Another issue: I wonder if you could comment on whether we have any sheltered housing because, as you know, we are building in fields for people over 55 and I should declare an interest here. We found in Guernsey that they have a needs assessment panel and one of the things for an allocation for sheltered housing is that people have a requirement of at least 4 hours of personal care. In your experience, do we have anything equivalent here or are we just building fields with developers? How does it work here for people who might need that level of care?

Ms. K. Huchet:
We are consulted in relation to planning and housing. We do get from the States departments all the documents in relation to our opinion on it. I think in relation to -- it is all over at the moment, is it, Jean?

Ms. J. Hinks:
I think we do not have a panel.

Ms. K. Huchet:
Panel, no, no.

Deputy A. Breckon:
You do not have anything so it is a bit of a free for all, is it?

Ms. K. Huchet:

Again, it is back to your risk assessment and your plan. It is around the whole process. We have had discussions around, obviously, building our care into developments. So, that is like in the UK they have lots of settings whereby you have got packages built in, homes built in where community care would be built into your housing requirement. Because I think that is an expansion --

Deputy J.A. Martin:
We need to get our head around what sheltered housing is. We have not seen a good example what I have seen in the UK and can be delivered in tower blocks, even. But, as you say, it has got the nursing care there.

Ms. K. Huchet:
Built in, yes.

Deputy J.A. Martin:
Community, yes, it is safe. It is secure.

Ms. K. Huchet:
There is a lot of different models in it. A lot of it is around the level of care, as you go into that, would increase as you deteriorate. Then for us, as well, as you have mentioned earlier, because we do not have step-down beds, which we have asked for for Family Nursing, we would appreciate some rehabilitation beds where our patients who deteriorate short term, we could man some way, take them in from the community, rehabilitate them straight back out. So there are ways that we could continue to support clients so that they do not go into a residential setting.

Ms. P. Massey:
Or take an acute bed

Ms. K. Huchet:
Bed, yes.

Ms. P. Massey:
Because that is what happens at the moment.

Professor J. Forder:

The acute bed is something I wanted to pick up. As you were talking earlier on I was thinking: "Well, what about the prevention role or ability or low-level support in the community to be able to mitigate against some of the demand you might see from more acute end care." I think this goes back to the point you were making about allocation of resources between high end and low end.

Ms. K. Huchet:

We did a rapid response pilot scheme. I think it was in 2003. We have put one in for 3 months. We felt it was well evaluated and was successful. The funding did not follow the scheme. So it stopped. We are now into a position where we are dealing with a much smaller pilot because of the hospital refurbishment. But our goal was that if clients became short-term ill or carers became ill, then we would use a rapid response scheme so they would not go into an acute bed. In reverse, if a client deteriorated and needed to go into a rehabilitation setting, if we had some beds Family Nursing were managing, again, because that is the skills that the staff is keeping people independent, we would take them into the setting that was straight back out into the community in a short-term, rather than get them institutionalised.

Professor J. Forder:

So there is really no intermediate care as such on the Island?

Ms. K. Huchet:

No. That is what we have been asking for is rapid response, step-down beds, hospital at home. We have been putting numerous documents forward saying that in actual fact -- our service basically is quite basic in relation to its care in the home. But we have the ability and the staff have the ability, knowledge and expertise to expand into those areas.

Ms. P. Massey:

We do not have respite beds for patients in the community that deteriorate at all unless it was based around the carer breakdown.

Professor J. Forder:

Right. Okay.

Ms. P. Massey:

So it is not based on clients; it is based on the carers. So we have access to nursing respite care based around the carers' needs but not the clients' needs.

Professor J. Forder:

If you had extra funding, is that where you would allocate it or would you allocate it somewhere else?

Ms. K. Huchet:

Rapid response we would definitely do. That is definitely for rapid response. We have beds as well. I believe that some of senior staff -- because obviously district nursing is quite intensive, we have staff who could go and work in a rehab setting and have the skills to run that. The respite, I think it is a question of who would be right person to deliver the respite care. But that package of what is needed, I think needs to be worked on outside probably New Directions because New Directions is the real high level. New Directions, I do not believe, as yet, has addressed the care in the community side of it in the document. It is not addressed what is primary care and what are we physically going to do about these issues, really. So, yes. To be honest, I do not think on the funding side -- I think we have to try a small-scale initiative, see if it works, pilot it and monitor it. It if were successful go back to long-term funding.

Professor J. Forder:

Yes. Just as a matter of interest, you might want to know that we are involved in a 3-year evaluation of so-called reablement, homecare reablement services in the UK. We are very happy to share information.

Ms. K. Huchet:

That would be fantastic, thank you, yes, thank you.

Deputy R.G. Le Hérissier:

Okay. Well, we have covered an awful lot. Are there still any final points there?

Ms. K. Huchet:

No, I think just that we would like to put across, obviously because we do not meet again, positive steps for Health and Social Services to be looking at the long-term issue. Everybody from -- I think it is very positive that there is involvement.

Deputy R.G. Le Hérissier:

It certainly seems to be one of the findings emerging. Whether we will make it officially, who knows, but one of the findings emerging is that you need to be plugged in much more to the whole strategic and operational planning process in health and that when this S.L.A. is resolved, hopefully more time and focus will come.

Ms. K. Huchet:

Yes. I think also just because obviously my big passion is the third sector. But I think it is third sector agencies across the board because I think if you look worldwide from the U.K., major, major transformation of how they are working with the charitable or voluntary sector because of their efficiencies. I think it is not around just Family Nursing. It is around other providers in the Island. Hospice and others who could also be strategic players.

Deputy R.G. Le Hérissier:

Putting the last leading question, do you think one of the real issues is in a way you are beholden to the Health Department because they obviously provide the bulk of your funding, you have become, to some extent, and some people would wish this to be formalised, one of their major service providers and as a result a tension arises because the role of the third sector to be innovative, to be creative, to break away from all the bureaucracy associated with service level agreements that you described, in a way, are you compromised by the fact you are so dependent on such a major part of your financing?

Ms. K. Huchet:

The funding is a totally separate issue. I think the funding is 74 per cent of our budget, so there is a huge amount we have to raise ourselves. So it is not around the funding. I think it is around the fact that if you had a neutral commissioning body

then any third sector provider or any department could go to the commissioning body independently and privately -- not go to the political arena in relation to tensions about why do you want part of the bigger budget. I think that is what we struggle with is that they are a provider, they have their own budget issues, so then if we go, obviously they have got tensions within their own departments. I have said for a long time I think partnership working would be better for everybody. It would make it a lot more independent, fairer, just easier without the tensions, that we could go and just say to someone: "We would like to develop these services; we are thinking about this; we would like to submit something," without it being a case of acute sector versus community. I think for everybody it would ease a lot of the initiative. So it is not around the funding. It is around the fact that we should be able to politically lobby ministers. We should be able to go in say: "We are concerned about carers. What are we doing?" I think, unfortunately, you often get to a situation where it is seen as "them and us" rather than a case we are all trying to work for the same purpose. So that is client need, is it not, that is client need.

Deputy R.G. Le Hérissier:
Well, they have the same struggle between the hospital and Social Services. That is obviously a major issue in their own department.

Ms. K. Huchet:
But it should be about patient care. Put the patient at the centre. Forget the dynamics and funding. It is about the best provider delivering that service for the best quality for the patient and hopefully leave the politics for others to deal with, really, I think, yes.

Deputy R.G. Le Hérissier:
I will ask the panel. Any other questions?

Deputy J.A. Martin:
I am fine, thank you.

Deputy R.G. Le Hérissier:
Okay. Well, thank you, Pam, Karen and Jean --

Ms. K. Huchet:

You are welcome. Thank you very much.

Deputy R.G. Le Hérissier:

-- for an excellent presentation. I am sorry we slightly went off script. But we do really thank you for all the hard work you did in preparing your submission. Thank you.

Ms. K. Huchet:

Thank you to the staff who prepared it all for me as well. So, yes, thank you very much. We will take up the offer to talk to you at some time.

Deputy R.G. Le Hérissier:

Okay. Thank you.