STATES OF JERSEY

Health, Social Security and Housing Panel
Long-Term Care of the Elderly

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:
Dr. M. Richardson (Consultant Physician with responsibility for the elderly)
Dr. L. Wilson (Consultant Old Age Psychiatrist)
Ms. G. Rattle (Head of Occupational Therapy)
Mr. I. Dyer (Directorate Manager for Mental Health
Ms. M. Hutt (Senior Nurse Manager for Elderly Care)
Mr. J. Cox (Service Manager, Adult Social Work)
Mr. J. Le Feuvre (New Directions Programme Director)
Ms. T. Fullerton (Assistant Director, Corporate Planning and Performance Management)

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

I would like to welcome you all here. We will make the introductions first and then I will -- some of you know the guilty -- then we will get down to the details. 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.

Deputy R.G. Le Hérissier:
Julien is the adviser from L.S.E. (The London School of Economics and Political Science) and the University of Kent.

Mr. C. Ahier:
Charlie Ahier.

Mr. M. Orbell:
Malcolm Orbell.

Deputy R.G. Le Hérissier:
We will have slow and clear enunciation of introductions. So, if you could give your name, your number and your job description because we have quite a variety of positions represented here.

Ms. M. Hutt (Senior Nurse Manager for Elderly Care):
I am Mair Hutt. I am a senior nurse manager for elderly care responsible for Sandybrook and The Limes, day centres, resident care and the elderly care.

Deputy J.A. Martin:
You are not being picked up on the microphone. Move in a bit.

Ms. M. Hutt:
I will move in a bit. How did you know that?

Deputy J.A. Martin:
Because the lady over there told me [**Laughter**]. We have a signal.

Deputy R.G. Le Hérissier:
It had nothing to do with the quality of what you are telling us.

Ms. M. Hutt:

All right. Do you need me to say it all again?

Deputy J.A. Martin:
No.

Mr. J. Le Feuvre (New Directions Programme Director):
James Le Feuvre, Programme Director of New Directions.

Ms. G. Rattle (Head of Occupational Therapy):
Gill Rattle, Head of Occupational Therapy.

Dr. M. Richardson (Consultant Physician with responsibility for the elderly):
Mike Richardson, Consultant Physician with responsibility for the elderly.

Dr. L. Wilson (Consultant Old Age Psychiatrist):
Lesley Wilson, Consultant Old Age Psychiatrist.

Mr. I. Dyer (Directorate Manager for Mental Health):
Ian Dyer, Directorate Manager for Mental Health.

Mr. J. Cox (Service Manager, Adult Social Work):
John Cox, Service Manager, Adult Social Worker.

Ms. T. Fullerton (Assistant Director, Corporate Planning and Performance Management):
Tracey Fullerton, Assistant Director at Corporate Planning and Performance Management.

Deputy R.G. Le Hérissier:
Thank you. I would like to thank you all for coming. Those of you who have been here before, you may be aware of the formal notice we used to read out. Essentially, what it does is, it gives you privilege while you are here. As long as you do not say anything of a libellous or unsupportable nature about individuals. So, you do have that privilege. Obviously, there are a lot of people here and we may not be exact in

who we call upon. So, if that were to be the case, I imagine that our 2 colleagues in the middle who will be the key witnesses, so to speak, or the star witnesses, even and Ian, who has joined us. Sorry, I forget plus an able supporting cast, so to speak, and Ms. Rattle also, who has joined us. So, if for any reason one of us misdirects a question or whatever, could you please jump in if we have asked it to the wrong person or if you feel you have a contribution to make other than the person who is answering the question. We would be most obliged. To give you the background because some people are confused about this stuff, including myself but, anyway, that is slightly beside the point. To give you the background, there was gong to be a major study on New Directions and although some excellent work has been done in the background, we have been stalled on that because it has not the political sort of say-so yet. What the intention of this panel was to do New Directions and then to drill down deeply on one or 2 aspects of New Directions. One of the areas we did identify was this one. But because New Directions has not gone forward and had full approval as yet, we decided to go ahead with this one. So, there are existing policies. We are examining existing policies but, clearly, we are also examining policies for the future. So, having said that, I will ask Dr. Richardson or Dr. Wilson, and/or Ian, the first question. First of all, can you tell us what particular roles you play? Give us a very brief assessment of the policies you deal with, and what do you see as some of the pressure points that are emerging in the services for which are responsible. So, who would like to start of the threesome?

Dr. M. Richardson:

I have a fairly wide remit but in terms of what you are interested in, in elderly care, basically, I am responsible for, you could say, the physical care of elderly people on the Island and Lesley would be responsible for the mental care of elderly people on the Island. So, if you do have any rough split, you could say Lesley is above the neck and I am below the neck. My bit is bigger. [**Laughter**] My responsibility is particularly looking after acute physical illness. So, my responsibility will be usually older people in hospital who are ill or who are referred for outpatient rehabilitation or rehabilitation services. Having said that, obviously a fair amount of those people will also require some kind of residential care or continuing care, which is the particular aspect that you are interested in. The system that we run at the moment is pretty -- it has kind of just built up over the years. You will have heard from other people

already that the system we have in place at the moment is very strange and disparate and varies from group to group and what is really needed in terms of funding is a very clear, organised system of what people get and who is responsible for that which is I suppose partly why we are here talking about. In terms of pressure points, the population is ageing. The population which was a population pyramid is becoming a population rectangle. So, the number of elderly people is increasing. The number of very elderly people is increasing phenomenally. That is happening not just in Jersey or in the western world but across the entire world and, clearly, with that remit in place you will be acquiring more and more people who are increasingly dependent and requiring care. That is because people, as they become older, often get frailer and they develop muscular skeletal problems primarily which is what limits their ability to look after themselves. So, you will end up with a lot of people requiring care. So, no matter how hard you try at the medical end, you are still going to have a large bunch of people who require care. They are just likely to be older and frailer. The concept of what we do, I suppose, if you want to put it in a nutshell, is I am trying to compress the morbidity. So, rather than spend 10 years having lots of illnesses, I would rather you have them in the last 6 months of your life so the first 9.5 you felt quite fine and you lived independently. If you think about it, we are not going to reduce the amount of ill health or problems or dependency. We are just trying to compress it and often that means slightly more complicated because it means you are often turning over a person from living independently to living in a nursing home very quickly. It may just take a fractured hip or a fall or another episode and suddenly you have someone who cannot be rehabilitated. So, probably in the future, the rehabilitation population shrinks a bit and the long-stay population rises. I have probably said enough for the moment.

Deputy R.G. Le Hérissier:
Okay. That is very succinct.

Dr. L. Wilson:
Do bear in mind that most of the mental health needs of the whole population and not just older adults is in primary care, i.e., general practitioners. I see our only a small proportion of the psychiatric mobility that is out there. We will see any episode of psychiatric disorder arising in late life for the first time. We will see people with

progressive dementia at any age. The youngest one I have had so far was 48. We also take some patients from the general psychiatric service, that so-called graduate population which can be a difficult group to look after. They tend to be people with very serious long-term psychotic illness. They are often people who it is difficult to place in a non-hospital setting. So, I have a small group of long-stay patients who are not demented, who often have very considerable needs for physical, hands-on care but who are too mentally unwell to be in a conventional nursing or residential care home. Which brings me to people with dementia, which is the big scary one because as the total number -- as Mike said, as the proportion of the population who are senior citizens, and some of them are very elderly, goes up the number of people with dementia that we are going to be looking after is going to go up and we are living with it, ladies and gentlemen. This is not something that is going to happen in 10 years' time. This is something that is happening now. Our patients are stacked up in the community and in the general hospital who need to come to one of my assessment beds and they cannot. Lots of interesting stuff going on in terms of research looking at prevention of dementia and, indeed, treatment of dementia and that will help, certainly. That will mitigate but it will not get rid of the problem. We have an Active Memory Clinic which aims at seeing people early on in their dementia illness, assessing, making diagnoses, providing medications, providing education and support to sufferers and to their friends and family, and also using the anti-dementia drugs and, I think, successfully and I believe cost effectively in that we have people who have been attending the Memory Clinic for a very, very long time who are still living independently or who are living in residential homes. In other words, they have not needed to come into specialist psychiatric services.

Deputy A. Breckon:

I just wanted to ask you both, how far your role extends to community involvement, if you like, where people would not be in, say, a hospital bed or --

Dr. L. Wilson:

Most of my patients are in the community.

Deputy A. Breckon:

They are in the community?

Dr. L. Wilson:

Yes. We do a lot of our initial assessments in people's own homes. The majority of them.

Deputy A. Breckon:

Would you say in the circumstances that you have an increasing trend there that is putting a lot of pressure on your services?

Dr. L. Wilson:

Well, they are busy, yes. We have had growth in our communities recently in terms of community nurses. But, yes, they are busy. They are carrying large caseloads, working with patients and their families in their own homes.

Deputy A. Breckon:

And you work with care institutions for things like referrals? You have places where you can nominate people if required?

Dr. L. Wilson:

What? For people to go and live in?

Deputy A. Breckon:

Yes.

Dr. L. Wilson:

Well, Mike has commented on the somewhat haphazard way in which placements are identified and until recently have been funded. Yes, we would look wherever possible if someone has got to the stage where their needs for care cannot safely be met in the community, we would look -- we look more to the residential sector than Mike does. I mean, by the time his patients need long-term care, you are looking at a nursing bed in the vast majority of cases. Many of my patients can go into residential beds. Those placements, however, do not always work. Not all of my patients with dementia are, to use a jargon phrase, pleasantly confused. If you look at the difference between the sort of institutions that Mair has mentioned, like The Limes

and Sandybrook, and my long-stay beds which are in Rosewood House. You are more likely to be thumped in Rosewood House and people like that will not do in the independent sector. People who are noisy, people who are physically aggressive, people who are otherwise have socially unacceptable behaviours, they will end up in a long-stay bed with me. We access the independent residential sector relatively little and when we do we go through Mair. But most of my patients who need a long-term nursing bed cannot fund it themselves and very few people can fund long-term nursing beds themselves. The independent sector is very, very expensive and they will end up in one of my 52 long-stay beds.

Deputy A. Breckon:
What about your role in that, Mike? For people in the community, do you support people living in the community as well as those being --

Dr. M. Richardson:
I suppose it is in a way different because the service needs are set up different. Lesley does old age psychiatry only and has a C.P.N. (Community Psychiatric Nursing) service or community service that works with her. Geriatrics is probably about a quarter, if that, of my role and our community service would be Family Nursing. So, Family Nursing is a separate service which runs itself separately. There is no service level agreement so we cannot ask Family Nursing to do what needs to be done. We have to let Family Nursing decide what they would like to do.

Ms. G. Rattle:
There is also the community rehab teams with people going out visiting people at homes.

Dr. M. Richardson:
There is but they are fairly small and specific compared with the generality of what is out there.

Deputy A. Breckon:

Then in general terms, you have a sort of client-case conference do you, where people come together and if you have got shared needs then they are referred and then allocation of a care plan happens for the individual? Is that how it comes together?

Dr. M. Richardson:

Yes.

Deputy A. Breckon:

You would use an agency like Family Nursing to support what level of care that may be.

Dr. M. Richardson:

That is right.

Deputy A. Breckon:

Is funding an issue or is it a pressure on where you are?

Dr. M. Richardson:

I suppose the difficulty is trying to have the right package for the right individual and you are left with maybe 3 or 4 pigeon holes and you have to try and slot the person into a pigeon hole. If someone is going to go home, and to live at home they are going to have a maximum of maybe 2 to 3 Family Nursing visits. That means that they have to be able to move around their home independently without falling over. So, they have to be able to go to the bathroom and back again otherwise they cannot really manage on their own. If they need any other help in addition to that, they either have to pay for it or they need unpaid family help. So, my usual approach to families in these situations is either you need pots more money or 6 unmarried daughters that live in the same Parish. If you have that choice, you can manage. If you have both, it is great and some people do have pots of money and some of these packages at home will cost them tens of thousands of pounds a year. They are very expensive and the alternative is, generally, a nursing home environment which is far more cost effective but not easily available for people and we are certainly capped in terms of finances, in terms of what we can offer patients.

Deputy A. Breckon:

Can I ask you both if, in your opinion, the extended family in that support is on the decline?

Dr. L. Wilson:

Yes.

Deputy A. Breckon:

Is that is generally how it is?

Dr. L. Wilson:

Yes.

Deputy A. Breckon:

In some cases it would not be family at all?

Dr. L. Wilson:

You have a variety of social pressures. You have more women in paid work. You have more mobility. People are less likely to stay where they were born and brought up. The other thing you need to bear in mind that some of the family is very old themselves. You are talking about patients in their late 80s, early 90s. You can speculate as to the age of their kids. They are retired people themselves. They may well have other responsibilities like care of grandchildren and so on and so on.

Dr. M. Richardson:

The problems are exacerbated here for exactly the reasons Lesley said. You often have people who may have retired to Jersey many years ago. Expats who have come from the Far East or wherever who live here, plus people that live here but the children have moved away. It is not unusual to see people with 2 or 3 children all living on different continents, never mind different countries. So, it is a problem that you see everywhere but for various reasons it is worse here than it is elsewhere.

Deputy A. Breckon:

In your assessment, would you look at people's financial circumstances as well or do you look at it very clinically?

Dr. M. Richardson:

Personally, it is a clinical assessment but I do make it clear to people that if they have more money it will oil the wheels in terms of the kind of care that they need or in terms of the choice because if someone needs to be placed in a home, the system we seem to have at the moment is that if you do not wish to spend your money, you will be placed eventually in the home of our choice. If you wish to go to the home of your choice at the time of your choosing, then you pay for that yourself.

Professor J. Forder:

I just want to pick up on one of the points you made earlier on. I was not quite clear the extent to which Family Nursing provide packaging -- they do not provide the more intensive home care packages that you might see in England? So, not even close to 24 hour ---

Dr. L. Wilson:

No.

Dr. M. Richardson:

Absolutely not.

Dr. L. Wilson:

You have use of up until 3 times a day. I must admit I am very surprised too. A visit to get you up, get you dressed, get you breakfast, and a twilight service and you have to be fairly needy to get that.

Mr. I. Dyer:

Just to clarify that within the mental health side, within Lesley's team, the community team able to provide a more comprehensive package for people in their home but it is not a 24 hour service.

Dr. L. Wilson:

No. We have our own home care support workers who are directly employed by us. So, they are nothing to do with Family Nursing and Home Care whose work is supervised by one of the community psychiatric nurses. Now, we only have a small number of them and they do tend to be working with some of our more challenging and difficult to engage patients. Ian is right. We can have them in there for longer during the day but no, I still do not think that it would compare with the sorts of services that might be offered certainly in some way on the mainland.

Deputy R.G. Le Hérissier:
I wonder if I can switch to Ian? Can you give us your analysis, Ian? What you do, basically, and give us your analysis of where you think the service is at?

Mr. I. Dyer:
I am Director of Mental Health so I am responsible for mental health services which include adult mental health which is basically 16 to 18 through to 65; old age psychiatry which is over the age of 65 that Lesley has clinical responsibility for; child and adolescent mental health services which are young people under the age of 16 to 18. We do not have a sort of a clear demarcation such as they would in the U.K. (United Kingdom) Psychology services and alcohol and drug services. Obviously, looking at the long-term care needs and specifically old age psychiatry, we provide a significantly different type of service to what is currently being provided in England in so much as a lot of the beds in England that were originally managed by the Health Services have gone over to either private sector or Social Services and are been funded by Social Services. In Jersey, at the moment, as Lesley said, we still have 52 beds for continuing care for people who have severe mental health and often physical health needs at the latter stages of their life but it has been brought about that the main component, the trigger, has been some form of dementia, normally. Alzheimer's. Of those 52 beds, it is about roughly 98 per cent bed occupancy. As someone dies, which is normally the way they move on from that service, there is always someone else waiting to come into the service. I believe it is quite a high standard of care they provide there. They provide, for example, a good quality palliative care where they link in with the hospice. So, if someone has a cancer, for example, and is dying because of the cancer, they will continue to be nursed within Rosewood House and not have to be transferred across to either the general hospital, other than for diagnosis

and for initial treatment, or to the hospice for the end of life issues. The day-to-day medical care is provided by G.P. (general practitioner) practice and we commission with them which allows Lesley and her team more time to work within the community and within the assessment areas, the assessment wards. Some of the problems that we are facing at the moment is staff recruitment. Recruiting for qualified nurses for old age psychiatry is becoming more problematic. That is being addressed, to some degree, with a Work Force Planning Review for the nursing workforce. That is being led by the Director of Nursing, Rose Naylor. So, we are looking at those issues across Health and Social Services. We move then to Clinique Pinel, which is the other inpatient area for old age psychiatry. That provides assessment for 2 types of patient. One is the functional people, people with functional mental health problems which include anxiety, depression, there could be a psychotic element and normally it is a period of assessment, treatment, and hopefully, then back into the community to their own homes. The other assessment unit is for people with organic dementias. The third element of that area is, as Lesley described, people with a graduate mental health problem. To be honest, people that have become institutionalised from the way mental health services were provided in the past.

Dr. L. Wilson:

Excuse my butting in for a second. They are not all graduates. Some of them are new long-stay, they are people who have developed mental health problems in later life and who we cannot fix.

Mr. I. Dyer:

So it is an 11 bedded unit for people who more often than not would try to work within residential care, the private sector residential care, or in other aspects of our own residential portfolios, and it has not worked either because they have not accepted being in the community or the community have found it quite difficult to accept some of their behaviours. So they are being cared for at Lavender Unit, Clinique Pinel. I think Lesley has given a quite good detail about the community team for old age psychiatry. Our ethos is to try and treat people in the least restrictive environment and to provide services within the community. Like we have increased the number of nurses within old age psychiatry but we had to do that by reshaping the services, it has not been through growth money. The reality is, I think, over the last 3

or 4 years with all the work that has been done in New Directions we are hopeful that if New Directions is seen, heard, listened to and approved, that is where the investment for future long-term care is going to be. I am sure Professor Forder mentioned the recent documents that came out earlier this year from the Kings Fund, which is entitled "paying the price", which is looking at mental health care, has gone into quite a bit of detail about the cost of dementia care projecting to 2026 where it is suggesting that if we continue to provide dementia care the way we are currently providing it or, more specifically, the way England is currently providing it, the cost then will increase by 111 per cent. That is purely because of the ageing demographic, people living longer. I think, Lesley, you know the figures better than I do, but if you are over 90 there is a one in 6 chance --

Dr. L. Wilson:

No, that is over 80. If you are over 90 that is getting more towards one in 3, 95 is one in 2.

Mr. I. Dyer:

Chance of having dementia.

Dr. L. Wilson:

A significant chance.

Mr. I. Dyer:

A significant chance so --

Dr. L. Wilson:

It does, the line does not go straight up unless you plot it logarithmically --

Mr. I. Dyer:

So within the Kings Fund they are looking at, projecting to 2026, providing services at the current rate in England for the current services. I think what we are trying to do within New Directions is to say: "Well, if we have a number of prongs to try and tackle this, the idea will be sort of early investment for longer term gain" so try to keep people safe in their own homes longer. A lot of that is going to depend on who

is there to care for them from family and loved ones and what sort of packages of care that the State can provide them with.

Deputy R.G. Le Hérissier:

Okay. Gill, can you update us on your service and pressures?

Ms. G. Rattle:

Yes, well my service is quite diverse but the main initiatives are to keep people in their own homes as long as possible, keep them safe and independent. If they do have to come into hospital with a medical problem to put together a package of care that is going to - whether the discipline is not with family nursing or other health workers - to help to get people home and working with the relatives to think of ways individually that would help that person stay at home for as long as possible. Then it extends, of course, when someone cannot stay at home. That is why there is some gaps over there, there are not the choice of sheltered environments that you might have in the U.K. The current assisted housing where someone can live independently but they have got some support during the day. The 24/7 warden. We do not have anything like that here at the moment, it is either you stay in your own home or take the jump into residential care. So in the meantime we would look at some of the assisted technology that is available. Again, we could do far more over here but it means that although we have machinery and technology it does not run on its own, you have to have staff who can support that technology and we have not got that sort of back up at the moment. So although we have got a community alarm service we have not got the manpower to expand it further. One of the concerns about the community alarm service, there is a misunderstanding for a lot of people that once you have the pendant around your neck and you depress it the ambulance comes with its flashing light down the road, and that is not actually the case. The understanding is that if you sign up for this, and Jersey Telecom are in involved in this, that if you activate your alarm a relative or neighbour will come and see if you have fallen, whether you need the assistance, and then if you do they will then contact the ambulance. There are less and less friends and neighbours able to perform this duty so we are finding that although somebody has been referred for an alarm, when you try and find somebody to be the 2 key holders that we require we cannot find anyone. There are no relatives who are prepared -- sometimes there are relatives but they are

not prepared to be contacted 24 hours a day. No neighbours that are young enough themselves to be able to perform the duty, they themselves are often in their 80s and that means we then have a dilemma of can we safely give this person an alarm. We sometimes put a key box outside that they have got someone who will come along and will get the front door key and go in but they will not be prepared to hold the front door key themselves. But it is getting more and more difficult and the ambulance service cannot be expected to be key holders for the whole population. In the U.K. the local council will employ wardens or there is a separate company that will run the service, over here it is growing like topsy, it started off as being very small and now we have over 1,000 people with alarms. The service was never, ever supposed to be for more than 300 people maximum. We have got one part time assistant running it so it is one of these things that is going to be needed more and, of course, we cannot bolt on all the additional bits for assisted technology that we could use with the hardware we have got, which are things like motion sensors, water sensors, gas sensors. There are a number of different things you can put into somebody's home that helps keep them safe but someone has got to monitor it.

Deputy R.G. Le Hérissier:
You are very involved, Gill, and we did ask this of the previous delegation who surprisingly have turned up as the current delegation, the whole issue -- there has been a lot of discussion in the States about over 55 housing and it has sort of been loosely hung on the issue of sheltered housing, although it is very difficult, it is a moving target that. How closely have you been involved in the design of the different provisions under the rubric of sheltered housing?

Ms. G. Rattle:
It is variable. The Dandara development down at L'Hermitage, we were initially involved and we put down our proposals, we worked closely with the Planning Department but they got tweaked at a later stage so some of these supposedly disabled friendly flats in the main building had the joists turned around so you now cannot put the ceiling track hoist in the way we wanted if we needed them. Or the walls that we said needed to be load bearing to put rails on in the bathroom, for instance, are not load bearing so we are then challenged with what sort of equipment we can help somebody with. Because the other part of the service is the community equipment

that we loan to people free of charge, and that varies from very low tech, low cost stuff that we do not recycle to something that is very complex that we need to have service agreements with a local company and that will help somebody look after a loved one in their own home for a length of time, like a hoist for instance. So, in answer to your questions, there are anomalies. Love it to be far more that we should -- we must have more robust relationships with anything that is being developed and I know there was some Parish homes developed and that seems to be patchy. Sometimes we are involved rather too late in the day when the bricks and mortar are done and you cannot start to change around things that are going on.

Deputy R.G. Le Hérissier:
Of course, as you know, this programme has now been put through for all this housing for the over 55s, including a very big development at St. Saviour. You were not asked to advise on that, were you?

Ms. G. Rattle:
No.

Deputy R.G. Le Hérissier:
On the mix that there should be and ...?

Ms. G. Rattle:
No, the last one that we were involved in was the Bon Air development, as was, and now is called Highlands Luxury Care Homes.

Deputy R.G. Le Hérissier:
I know you are very involved and obviously it is excellent with ideas like load bearing walls and so forth, what about the whole concept and the whole kind of social support built in. Very admiringly people talk about the Rowntree development near York, have you been involved in that kind of planning?

Ms. G. Rattle:
Yes, I have visited there, yes. I have seen it.

Deputy R.G. Le Hérissier:

Has that planning applied, or that kind of thinking applied over here?

Ms. G. Rattle:

It would be marvellous to have something like that over here, we have not got that far yet because unfortunately land is very precious over here and the best we ever get is something like Dandara which unfortunately is not bungalows which they have got at Hartrigg Oaks. Ideally you want something on level ground for an older person, you want to dispense with the stairs but property is very pricey over here so they try and build them --

Deputy J.A. Martin of St. Helier:

Sorry, can I --

Deputy R.G. Le Hérissier:

Just, Ian, first.

Deputy J.A. Martin:

It was on accommodation, where would you class -- you said no sheltered housing, what would you class the Willows as behind the line? I mean, they are independent, I have been in and they have got hoists where people can get themselves out. They are independent living but there is people --

Ms. G. Rattle:

Yes, but they do not have warden, though, do they? What I think of as sheltered housing is that the people live very independently, they have got their own front door, they have got a well designed home that is smart so as they get older things like switches are at the right height, things that will make their lives as easy as possible. But they have got someone within reach that they can ask to help them if they require that help so that it does not increase the --

Female Speaker:

Around the clock?

Ms. G. Rattle:

Yes, around the clock.

Deputy J.A. Martin:

Yes, from England. To me the nearest I would have said we have got to sheltered housing over here was the Willows and the Willows has been there a few years. As you say there is no warden but there is a community dining area, I mean I go in --

Ms. G. Rattle:

I do not think so any more. I think they are separate flats now. They may have had that at one time and I think you are right when Maison Le Pape closed and the chaps moved from there, I think at that point it was more of a communal living area but now I think it has become a number of flats with front doors and people are provided with those flats just like they would anywhere within States housing.

Dr. M. Richardson:

That was originally staff accommodation. It was Health and Social Services general staff accommodation. The Willows were individual flats managed by Housing, nothing to do with Health and Social Services. Then that accommodation was taken over when Maison Le Pape closed. They put in a few semi-independent men until they were not longer able to manage and then they were all managed into residential care as their numbers declined. That is probably the accommodation that you are talking about.

Ms. M. Hutt:

That has gone back to accommodation now.

Ms. G. Rattle:

States housing are now responsible for that. I know there is a number of people in there that are older, some of them are wheelchair users but they do not have any warden or support 24/7, even Victoria Cottage Homes is in the same situation. At one time they had a warden now States housing look after it and they have somebody there during the day who is not a warden, they are a member of staff that is doing different duties out in the community but they will be on site at a certain time of the

day. We provide the people who live at Victoria Cottage Homes - just like anyone in their own homes - with a community alarm, they have to have key holders. That is an example of how difficult it is. You cannot ask your neighbour who lives next door to be your key holder when they are older than you are.

Deputy J.A. Martin:

So now there is no communities, there is no bingo going on down on 2 nights a week and all that, the community part that was at Victoria?

Ms. G. Rattle:

No, not like there used to be.

Deputy J.A. Martin:

That, it would be seem to me, to be a backward step.

Ms. G. Rattle:

Not unless the residents themselves --

Deputy J.A. Martin:

Yes, I know the residents were very involved before, I did not realise that. I know Housing had taken it over because it was running 2 things but I did not realise it had gone --

Ms. G. Rattle:

If it is sorted out by the residents, Housing support it but they do not have the member of staff --

Deputy J.A. Martin:

Oh yes, I am not knocking it, I just was surprised about that. Okay.

Deputy G.P. Southern:

Ian, sorry.

Mr. I. Dyer:

Just to clarify, you mentioned about the plans for St. Saviour, the retirement venture or village area there. It must have been about 4 years ago myself and Richard Jouault - were you involved, Lesley? But the planners at the time, or I think the architects at the time, asked an opinion based on sort of the high level statement of was that type of facility needed and such like. So there was some early input from officers of Health and Social Services. To my knowledge I do not know where that has developed, where it is in the building --

Dr. L. Wilson:
No one has contacted me since that --

Ms. M. Hutt:
Can I just add something here? I kind of know a bit about that because Richard Jouault used to be the Director of Elderly Services before we had kind of restructured, we would often have private developers come and talk to us, and talk to doctors, about what they might want to do but we had no track of what was in the pipeline so something could go into Planning and there could be 10 applications to Planning but we would not know and when we asked Planning how they tracked it, they did not track it in a way it was helpful to us. But I believe that Mike Pollard now has that level of contact in the Planning Department is better as Richard Jouault is now working in the Planning Department, so we do now have knowledge that we did not have 4 years ago when they might have come and talked to us then and then kind of drifted off, somebody at a high level in Health and Social Services would now know what was going on.

Deputy J.A. Martin:
Is that because it is in a structure or just because you have got somebody -- I do not mean that in a -- it has got to be structured.

Ms. M. Hutt:
It is helpful having Richard there now but prior to that Mike Pollard had made contact with the previous chief officer and had regular contact with him about what was going on.

Ms. G. Rattle:

Could I just say a little bit about the community as well? What I have found over here is that it is a really challenging place to have old people living in because Jersey, although a small Island, is very hilly and a lot of the housing that people select when they are classed as young/old, in their 50s and 60s when they are maybe downsizing is about the most unsuitable that you could ever imagine. They culturally do not think about the future, the fact that they might not be able to use stairs and they decide to buy something that is a bit like a lighthouse and then they ask us to give them a piece of equipment that will render them independent again and it is a real concern because you think: "Why did you buy this last year when your husband had had a stroke." We do have to start thinking about not just the possible sheltered accommodation we are talking about but generally educating people to think about the future, not saying: "Well you all have to live in bungalows" but do consider what the difficulties might be in the future because that is going to impact on your quality of life when you need to look after one another.

Dr. L. Wilson:

I was out seeing a new gentleman a couple of weeks ago and the G.P. in his referral letter said: "Lives on a headland in St. Ouen" and when we pulled into the drive I could not believe it. If you wanted to design a location that was totally inappropriate for a very elderly couple, one of who was ill, to live, because it is miles from anywhere, it would take them a half hour to walk to the bus, and my guess is that if the lights do not go on in that house at night no one will know because the house is just not overlooked.

Deputy R.G. Le Hérissier:

Very good points. On that issue - and that is why we are quite keen on housing and --

Dr. L. Wilson:

Affordable housing. Developments like Dandara are lovely but you have got to be reasonably well heeled to be able to access them, places like Avalon, Oaklands, these are all private developments.

Deputy R.G. Le Hérissier:

That is a very good point. In terms of research into the elderly, particularly on the mental side, is there some merit in having these large villages where people congregate, hopefully under the right physical conditions, and there is all kinds of support, or do you try and keep -- because Senator Le Main had this great thing about people wanting to go back to the Parish of their origin so there had to be these little satellite settlements built in the various parishes. The counter argument was that people particularly who lived in town, they liked the urban environment, provided support, it provided more casual social interaction and they had rebuilt their lives. They did not want to go back necessarily to the people with whom they were children or whatever.

Dr. L. Wilson:

Horses for courses, Sir. Some people would say: "Where do you live?" and they will say" "St. Mary" and in fact they have not lived in St. Mary for 40 years but I would not -- one of the big drawbacks of some of the more rural parishes is that when people cannot drive it really, really -- it is a disaster for them. Now, it is my belief that certainly the older population of Jersey believe that the right to a driving licence is right up there with life, liberty and the pursuit of happiness and the responses we get when we suggest to people - I think one this week was 95 - that possibly the time has come for them to consider not driving any more, you would think that I had suggested that I take chainsaw to their legs. I do not think all older people want to live in big retirement villages. I think it suits some people. Once you have an established dementia a move to a new form of independent living is not on the cards, people will not adapt, they will not learn their way around their new environment, they will not learn to use new appliances.

Ms. G. Rattle:

We found problems even if you take out rugs, do we not, that it does not look like their room any more? So you have to keep the familiarity of the environment stable.

Mr. I. Dyer:

I think coming back to talking about Parish -- I suppose everyone has an opinion. We had quite a bit of debate in early 2000-2001 about where the acute adult mental health services should be situated because they should be near town so no one would have to

travel too far. I think we need to put things in context, I mean Jersey is 9 by 6, if you lived in Somerset you would be travelling 30 miles to your nearest acute ward, you know, so it is really looking at where is the most appropriate place for people to get the most appropriate care where their loved ones can most appropriately get to them. You are not going to be able to do it by servicing everyone's needs, but looking at the best benefit for the majority. My thoughts about the retirement village, when we originally spoke about St. Saviour and my understanding and recollection of that, they were talking about people over the age 55 being able to buy sort of 2 bedroom or one bedroom accommodation, then there would be residential accommodation on site and then there would be nursing home site, they would have a bowling green, a chemist and a shop and entertainment facilities, et cetera. Not everyone is going to want that but a lot of people might. The fact is a colleague of mine has just left the N.H.S. (National Health Service) to go and work with his brother who has developed these villages in southern Ireland. It is a private venture and people are paying lots of money to go and live in them. So the fact that, you know, a private venture can make a profit doing this because some people -- it suits what they want. But I think as well we look at what is coming out of the -- being discussed at Westminster at the moment about the people being separated after 50 or 60 or 70 years of marriage because of someone having dementia and at the moment the options we have in Jersey is you live at home with perhaps high risk or with whatever care we can provide, as a couple or you live separately in residential or nursing care and at home.

Ms. M. Hutt:

Can I just add something to that? Not wanting to contradict you entirely but slightly, inasmuch as the dual registered homes have aided the cause of that. Not all -- Lesley alluded earlier to the fact that she deals with the more complex people with dementia and this is a very big population of people with dementia that are dealt with by other arms of the service, and we now have 3 dual registered homes and we have had 2 incidents recently where we have been able to place a couple together in the same home because the home is able to take nursing people and dementia people. They do not have like a little flatlet and they do not have shared rooms but then clinically shared rooms might not be a good idea anyway. But we have been able to come to an accommodation with the home managers to do that and the dual registered homes have really added to our portfolio of choice, if you like, in that respect.

Mr. I. Dyer:

What I think we need is services that provide -- as good possible services for the majority, about having options.

Ms. M. Hutt:

I genuinely do not know of a couple that have both wanted to go into care that we have had to split up, certainly in recent years I genuinely do not think we have had to do that.

Dr. L. Wilson:

The problem is when you have got a couple with very, very disparate needs.

Deputy R.G. Le Hérissier:

Yes, that is a good point.

Ms. M. Hutt:

If one wants to stay at home, yes.

Dr. M. Richardson:

Can I just mention a couple of things on the subject of retirement villages. There are various issues with that but there is also things that a very unique to Jersey because of its size. My understanding of over 50s or over 55s accommodation is a private developer taking the enormous amount of equity you get from selling your house and taking it all off you to give you a very small box instead. So they are not usually cost effective from the point of view of the investor. The retirement idea is so that the developer maximises his profit because he has bunged a lot of boxes on one small site and you might get a bowling green and a small swimming pool, that is an idea of what you are getting. So I have got a problem with the principle in terms of who is developing and how they are being sold. But the issues for Jersey specifically as well are, one, for land and housing you have got limited space, if you are maintaining people in their own houses then that is housing stock that is not available for somebody else. So you have got to remember that. So if you are supporting a 95 year-old lady in a 6 bedroomed detached house, that is a 6 bedroomed detached house

that is not available for someone else to come in and use. So that is an issue in terms of how you are going to manage your entire housing stock. So if you plucked all the elderly out of their house at 65 and put them in a village you would probably solve your housing crisis. The other thing you have got to bear in mind is that from that imagine 2035 Jersey has probably the highest amount of women in work proportionately of possibly any other country in the developed world. Take into account the majority of professional carers are going to be women you, no matter how hard you try, are not going to have enough carers so one of the issues, apart from where they would like to be - and you have of course got to think about where is the most cost effective way to manage people, but it is also human resources efficient as well because if you are going to import labour, because these are very low paid jobs, you are going to import non-English speaking people. You know, you can afford to have someone making a bed in a hotel or digging potatoes whose command of English is not very good but you do not want someone in that situation looking after elderly people. You know, they want to be able to communicate in their own language. So there issues that are not immediately apparent but are fairly important for a place like Jersey because you have got imported labour, you have got land, there are other issues that make it a little bit more complicated than the mainland.

Deputy R.G. Le Hérissier:

Yes, I think those are valid points. Just - and I will come back to Dr. Richardson - to bring you up to date with St. Saviour, the latest we heard was there is going to be a dementia unit on site. It has certainly got the seal of approval from your then Health Minister, Senator Syvret, when there was as meeting about 2-3 years ago. No funding. The other issue is the managing agents were going to be Methodist Homes for the Aged U.K., not the Jersey branch because they do run a home at La Corderie, I think. There are 2 - one at St. Aubin. So that is where it was at. Now, it has just been given the green light in general terms so we will now wait to see whether the detail is fleshed out as per those particular promises. Back to Drs. Richardson and Wilson, one of the issues we are aware is a possible elephant in the room is the role of G.P.s under New Directions and there are some fairly high hopes that the role of G.P.s will be refashioned or differently incentivised and group practices will emerge and practice nurses will play different roles and so forth and so on. What is your view of

the plan, of the aspirations, laid out for G.P.s and do you think they will make your work - were these plans to come to fruition - easier, would it help your work?

Dr. L. Wilson:

From my point of view if G.P.s are incentivised to employ directly practice staff in disciplines other than medicine, the benefit from my point of view is that that may reduce some of the pressure on the Clinical Psychology Department, it probably would reduce my workload somewhat, or rather my nursing colleagues workload somewhat but if they can employ counselling staff, for instance, it may reduce the waiting times for people to be seen by the Clinical Psychology Department. Whether or not they would be more successful in picking up people up early in their dementia I do not know. Certainly we still, despite the sterling efforts made in the local media to raise the profile of dementia, you know: "It is okay to say you have got it, chaps." I have to say *J.E.P. (Jersey Evening Post)* and Radio Jersey are very supportive of our service and annually the Alzheimer's Society has an Alzheimer's Awareness Week and they usually cover that very well. I have been on the radio and they have been smashing. But we still are getting people who at the time we first see them have a moderate to severe dementia. I think some of those are patients who have refused a referral, where the G.P. has been aware that there is a problem but the patient has said: "No, I am not going. I do not have a problem. There is nothing the matter with me." I do not think all of them are. So whether or not if there were ancillary staff attached to the practices we would get some of those people earlier, and we are very keen to engage with families as early in the illness as we possibly can. Certainly in terms of use of the anti-dementia drugs when they work, and they do not work in most patients. When they do work we will get a better result if you start taking them early on in your illness. One of the reasons we are not following the N.I.C.E. (National Institution of Clinical Excellence) guidelines, which is to say to the patients: "Yes, you have got dementia, please go away and come back in 12 months' time when you need help wiping your bottom." It does not make sense to me.

Professor J. Forder:

Can I jump in at this point, if you do not mind? One of the things I picked up on was this issue about prevention, there is a lot of talk about the role -- maybe not so much

drug therapies but other lower level interventions, early interventions, and whether this really does have a meaningful impact on the course of someone's illness or not?

Dr. L. Wilson:
I think it is very difficult to be certain. I mean, we have got lower level interventions, we have got a group running for people earlier in the course of their illness looking at ways they handle things, getting into good habits. You made the observation about the routine and a place for everything and everything in its place, that sort of thing, use of memory aids, use of notice boards, use of diaries. Those sorts of things. Certainly if do get people earlier and they can establish those sorts of habits, they do seem to benefit. We are not doing double blind control trials on that obviously.

Professor J. Forder:
No, sure. But this is --

Dr. L. Wilson:
But also very helpful for families in terms of how they assist their husband, wife, mum, dad, whatever, in dealing with their incurrence as they progress.

Professor J. Forder:
Yes, well of course there is some things that N.I.C.E. does not cover, looking at wider impacts of these, going back to the drugs issue. Also just to follow that up, if I may, what are the lifestyle risks? I mean what are the sorts of things that can be done --

Dr. L. Wilson:
Vascular, vascular risk factors.

Professor J. Forder:
Vascular risk are the biggest ones, yes.

Dr. L. Wilson:
Not just for vascular dementia, vascular dementia being stroke-related dementia. This increasing body of work suggests if people can identify and control vascular risk factors in people in their 40s and 50s you reduce the risk of them developing

significant dementia in later life. So blood pressure, cholesterol, pack in the fags, do not drink too much, take regular exercise --

Deputy R.G. Le Hérissier:

Lead a totally virtuous life. **[Laughter]** We are very virtuous on this side of the table.

Professor J. Forder:

A long and dull life. **[Laughter]**

Dr. L. Wilson:

There is a study quoted on the BBC website today saying that one group of workers have found that if you are on a statin you have got the risk of dementia halved. Now, that has not been duplicated. In fact, just to really, really confuse you there was something on the BBC website either last week or the week before suggesting that the theoretical risk of taking a statin will increase your risk of dementia. So we will wait and see if this study is replicated. But certainly in terms of primary care by and large men in their 40s and 50s do not go to their G.P. unless they are ill. You know the vast majority of consultations that general practitioners do are women and children. But if we could encourage them to screen for abnormal blood lipids, hypotension, smoking advice, then yes you might save the Island some bucks.

Deputy R.G. Le Hérissier:

Yes, okay.

Professor J. Forder:

You do not have a cause and outcomes framework here? The incentive mechanism, the points mechanism, that G.P.s in England have --

Dr. L. Wilson:

We do not have Q.O.F. (Quality and Outcomes Framework).

Deputy R.G. Le Hérissier:

Dr. Richardson, the role of G.P.s and whether they are optimising the work you are doing or whether you are optimising the work they are doing --

Dr. M. Richardson:
General practice does not work, seeing as I am protected in this room. **[Laughter]** The problem here is people have to pay to see the doctor. So they have to be ill if they want to go and see the doctor and you soon realise the difficulties here, apart from -- for a G.P. to maximise his income he needs middle or upper income patients who are prepared to be turned into patients to return regularly for routine but probably unnecessary appointments. People who are lower income, and that is the group who end up in residential care is lower income groups, those are the groups that do not go to the doctor, apart from the ones we mentioned, the middle aged vascular risk, which is a key group for reducing dependency in later life. A lot of the other issues for people as they are getting older are often seen as inevitable problems rather than reversible problems. Your 4 biggest factors in terms of ending up in a residential home or nursing home is your diet, smoking, alcohol, exercise. It is the same old story. If you do the right things you do not need a residential home, if you do the wrong things --

Dr. L. Wilson:
You are less likely to.

Dr. M. Richardson:
Much less likely. But the differences are astronomical. So, you know, if you really want to cut down the people in residential care in future years then it is a public health initiative, it is not a doctor initiative. All you are hopefully doing is going to compress morbidity and reduce the length of time before they are going to be there. They are going to end up there, they are just going to end up there for a shorter period is what you are hoping for.

Professor J. Forder:
But with more intensive needs.

Dr. M. Richardson:

Yes, more intensive needs. But in terms of general practice, I think what you have is a system that really does not work because people have to pay. You are not going to pay unless you are really ill and that tends to be the problem. The lower your income bracket, the higher your risks and the less likely you are to go to the G.P. We are recognising this more and more now with the abolition of the prescription payments, believe it or not. Because now people do not have to pay for their drugs but they do have to pay to see their G.P. So they now do not want to get their drugs from the G.P. because the drugs are free but they have to pay for the doctor. So they now ask us incidentally when they see us: "By the way, I have run out of my drugs for blood pressure, can you just give me a prescription for those?" How good is it for their health when they have maybe spent the last week without their blood pressure medication because they did not want to go and get a new prescription. Now, that is the tip of the iceberg. You know, that stuff goes on all the time. So the current system, as far as I am concerned, is untenable, unworkable, and should not happen.

Deputy R.G. Le Hérissier:
Okay, Alan.

Deputy A. Breckon:
Can I ask both you doctors the trends that you are picking up from the community of the level of care and the numbers really from say 5 years ago for dementia and how do you see it now and where is it in 5 years' time? What do you see the trend in the stress on the service that you are able to provide with other professionals, and the same from the health point of view for the ageing community, if you like?

Dr. M. Richardson:
I think from my point of view I feel that we are already seeing the compression. If you look at say 20 years' ago, for example, when I was a junior doctor, you could see men in hospital in their 50s with a heart attack or an ulcer, they then might be in hospital at 60 or 70 with a stroke perhaps, and then they might be dead by 75, and that was your average in patient. So that was spread over several years. Nowadays people turn up to hospital in their late 80s or 90s for the first time with multiple problems that are usually by this time unfixable. So they come in from living at home independently, and you can imagine that a typical maybe widow, very thin, high risk

of falls, starting to get a bit of dementia, falls over, breaks hip, ends up in hospital. You have now got someone who does not have the power or the strength to get up again. The dementia is exacerbated because they are in hospital and ultimately that person is going to need to likely be placed, and more often than not you find their rehabilitation needs are minimal because they are beyond that. So when we used to have 30 rehabilitation beds at St. Mary, we have now have 20 and struggle and to fill those with appropriate patients, because the patients that you get often have very complex prolonged needs, but the actual rehabilitation they are having is often minimal. What they are having is a very complex care package assembled and it takes a long time to do it. So what you see is that over time you are getting -- so instead of having someone come into hospital with an event and going out again and they are a bit worse, and 3 or 4 years later they are coming to hospital with another event and they are going out and they are a bit worse. It is all just compressed right up at the end. So for a lot of people -- we have seen people in the last few months or years or so of their life --

Deputy A. Breckon:
Needing intensive care and support?

Dr. M. Richardson:
-- that need intensive care. But those patients may need varied intensive care and support and that can include, you know, transfer to England for heart investigations and treatment, rehabilitation. Cancer treatments as well for people who are elderly and frail are often done on the mainland. So it is not just the complexity but the geography and the arranging of the treatment for these patients so as well as thinking what would be the best thing to do you have also got to take a pragmatic approach of can you actually physically do it? Can you send someone of 83 over for 6 weeks of radiotherapy? You know, a lot of the time the answer is no you cannot, that will kill them anyway. So these things get more and more complicated and more and more concentrated in a shorter period of time. So we do see that already.

Ms. G. Rattle:
Also there are relatives' expectations, are there not? They want the person to stay at home and over here because property is often kept in families there is this expectation

that you can somehow do a miracle cure and the person can return home. When, in fact, it is not safe for them to do so. In other circumstances they would go into care. It is not realistic because there is not the 24/7 package that you can provide for that person who will be living alone. They are not going to be having anyone with them.

Dr. L. Wilson:

Indeed, sometimes are not living alone but the situation that we see not infrequently is that offspring have returned to - or in some cases never left - the parental home, are trying to combine care of their elderly and - in terms of the people that I see - demented parent with childcare and working, and mum or dad will go into care over their dead body because it may mean that they lose their home. Because if they need residential care and they have an asset the expectation is that that asset will be realised to fund their care.

Deputy R.G. Le Hérissier:

We have spoken about that around the social insurance model.

Deputy J.A. Martin:

I just want to ask Dr. Richardson something. You said about the men between the ages 40 and 50 not going to the doctor here because there is a cost for everybody here and it is not cheap. But is that not really fair to say it is a man thing that even if it is free --

Dr. M. Richardson:

I did not say that bit. Yes, that is a man thing. What I recognise here is from the patients I see, going to their G.P. it is a financial burden and for the vast majority of patients it is a financial burden and it has to be budgeted with everything else and often that is the thing that goes, and in the main most of the patients that I see are very, very reluctant to spend that money on their G.P. G.P.s here work, as you know, in very different ways, there are different practices, there are different ways in which they work, individuals work in different ways, some people can have an old fashioned system which can be quite generous, other people can be very fixed. You can have people going in spending £2 on a repeat prescription, some other practices or G.P.s may charge £30 for a repeat prescription and that is required every month. You will

have people who need to go to the G.P. every month for medication, the G.P. could prescribe the medication for 3 months. So you have a system that works very, very differently and all I can say to patients is that if you do not like it find a different G.P. with a system that you do like, because they are running their own businesses, they are not running their own practices.

Mr. I. Dyer:

I think coming back to what you were saying there, Judy, as well, I think I am right in saying that some preventative care in England, G.P.s are incentivised to invite people to come to --

Dr. L. Wilson:

That is what the Professor was referring to.

Mr. I. Dyer:

So if the G.P.s will get however much to remind me to come and have my health check at the age of 50, and they get an extra payment for that, there is value for them doing that. Of course here it is almost -- it is perverse incentive, they are not incentivised but I am -- you know, double whammy, one, I do not want to go and see them but (2) if I do go and see them it is going to cost me £25-30 or whatever it is for that appointment. So there is the opposite --

Dr. M. Richardson:

Can I just say the other side of the coin is the middle class businessman who goes to the G.P. for his annual health check, who has all his bloods checked by the G.P., most of them unnecessary and irrelevant, they are checked at the hospital's expense, because the G.P. does not have to pay for those blood tests. The patient is paying the G.P. for the privilege of having all the tests free on the hospital. It is a health check in all but name.

Deputy A. Breckon:

Dementia numbers and trends, would you like to comment on that?

Dr. L. Wilson:

I think I have probably been a consultant a bit longer than you, Mike. I have been a consultant for 19 and a half years.

Dr. M. Richardson:
You are nearly ready for retirement then.

Dr. L. Wilson:
Six years to go, and it suits me. When I started as a consultant, which was not here, it was in London, it was quite unusual to get a referral in respect of a patient who was 90 plus. It is now not uncommon to have a week when all the referrals are in respect of patients who are 90 plus, and I would underline strongly what Dr. Richardson has said about the complexity of needs. When I was training we were taught about something called Ockham's Razor, the theory whereby if someone is presenting with more than one symptom the chances are it is actually caused by a single disorder, which may well be true if you are seeing a patient in his or her 40s, and will not be true if you are seeing a patient in his or her 90s where multiple pathology is the norm and the patients will all have dicky kidneys, dicky livers, many of them will have a chronic chest disorder, many of them will have a degree of heart failure, many of them will have a bit of peptic ulceration or hiatus hernia, and an awful lot of them will have significant cognitive impairment. Now, some of these are people who have been in -- and again I stress the difference between patients that Mike sees and patients that I see, I see a lot of patients who are established in residential care, often they have gone in because of physical health needs. Sometimes they possibly could have been supported at home but never mind they were not and they are now in residential care. They are nigh on 93 and they are very complicated, and they are very complicated in terms of their physical health and sometimes they are very complicated in terms of their psychological health. The homes are struggling. The residential sector, would you say, is sometimes struggling to meet the needs of their residents. Often residents that they have known for a very long time and residents whom they would like to keep, which is why it is very useful that a home, for instance such as St. Ewolds on Trinity Hill, has now got registered nursing beds. So they will try and hold on to them but they are complicated and they may need a lot of support from the likes of Gill and the likes of me. That is something that is striking pressure on my assessment beds for people with dementia, which at the moment is pretty much critical. I have

got patients waiting to come into that ward at the moment whom I cannot admit. You asked me about policy, it is my policy wherever possible to have one admission bed on that ward all the time because some of the people we admit there, if they do not come to me they will end up in the general hospital, there is nowhere else within the mental health sector where they safely can be nursed and some of the people who go to me would cause chaos in the general hospital, and I do mean -- you know, I am talking about climbing on furniture to try and escape through the window type behaviour which we will deal with but J.G.H. (Jersey General Hospital) would struggle a bit.

Deputy R.G. Le Hérissier:
You did mention younger dementia patients at an earlier point, do you have issues in bringing the generations together?

Dr. L. Wilson:
We do sometimes. When they are in the earlier stages of their condition, because the numbers are tiny, I am not sure we have got any on the books at the moment who are under 65, when we do they cause anxiety disproportionate to their number. I have to say our colleagues in the general adult mental health community services are very supportive and would allow us to avail ourselves - so long as it is safe and appropriate - of some of their day care facilities. So, for instance, for the gentlemen we have a service in St. Lawrence on a farm where people with significant mental health needs can do meaningful daytime activities and we have been able to tap into that service. I have to say, not just for some our younger patients but some of our older ones as well. But, as I said, only so long as it is safe. They have to be able to be managed safely within a relatively unsupervised setting. So when they get to the stage where they cannot be, then sometimes we struggle because sometimes they do stick out in their own mind like a sore thumb in services for people who are by and large in their late 70s upwards. We have got a patient who is 50-something, eventually they do not mind, which is I suppose terribly sad in some ways but when it happens it is quite a relief for us because we can offer their families the sort of support that they need.

Deputy J.A. Martin:

Just a question, you mentioned earlier about some people will not go but then you reversed it which is what we are looking at as well in the social insurance where you would not need to lose your home. Is there much of that that goes on where absolutely people are refusing the right care or they think they can deliver, have a full time job, look after their own family and people are not availing of some of the packages because they will lose their inheritance basically?

Dr. L. Wilson:
Yes.

Deputy J.A. Martin:
So quite a lot of that does go on, do you think?

Dr. L. Wilson:
I would not say quite a lot --

Deputy J.A. Martin:
But it goes on?

Dr. L. Wilson:
Yes, it goes on. Yes, it goes on.

Deputy J.A. Martin:
There is no way you can overrule that? I mean, when does the --

Dr. L. Wilson:
No, we cannot.

Deputy J.A. Martin:
I am not saying you should be able to, I am just wondering whether --

Dr. L. Wilson:
We can detain patients with dementia using the Jersey Mental Health legislation, and we do. However, if I have someone who is detained whom I want to put into a

residential setting I cannot because you cannot charge a detained patient for where they live. So if some of my long stay patients are detained either on a treatment order or a guardianship order, they are in hospital and whereas informal patients who are over 65 who live in the hospital do pay a contribution towards the hotel costs of their accommodation, detained patients may not be charged so no residential home will take them.

Deputy J.A. Martin:
No.

Deputy A. Breckon:
On numbers where are you from 5 year ago? Are you getting lots more referrals on an annual basis?

Dr. L. Wilson:
Our referrals go up pretty much annually incrementally. I am afraid I could not give you the figure. Put it this way, when I came to Jersey 14 years ago there were 2 doctors working on my unit, there are now 3. We have more staff. Some of it is through new money, some of it, as Ian said, is by his being able cleverly to reconfigure the service so that more money comes in and we have more staff in all disciplines.

Deputy A. Breckon:
Do you manage the budget within your department?

Dr. L. Wilson:
No.

Deputy A. Breckon:
You do not. How do you bid then if you are saying: "Well, we have got this extra pressure on --" If you are going centrally then do you have to argue your case the same as Mike, do you have to say: "We have got these issues and how ...."

Dr. L. Wilson:

Ultimately Ian would argue the case.

Mr. I. Dyer:

Within the directorate what would happen is that the team leaders and the teams, through our functional management team, so adult psychiatry, adult mental health, psychology, within there they would identify the cost pressures and also the growth -- what they would perceive as being the priority growth needs, that would come up to the directorate executive and we would look at the competing demands. The reality, once we get the competing demands, the first thing are the cost pressures. If there is something that we are doing that has grown and it costs more now -- I mean, drug budgets for example are classic. You know, we have been looking at the cost of the drugs and the increase. So first would be the cost pressures and then it would be looking at the risk issues. So what are the risks of not introducing A, B or C? I then take that to the senior management team where we would have the discussions with colleagues from general and acute medicine, surgery, public health --

Dr. L. Wilson:

I have to say, psychiatry is not sexy. Old age psychiatry is deeply, deeply not sexy. When it comes to do we want to fund wonder drug X to treat multiple sclerosis or wonder drug Y to treat cancer in younger people, or do we want to fund Lesley's service? When it comes to do we want to refurbish the general hospital to reduce the risk of hospital acquired infection or do we want to refurbish Rosewood House so that when your old mother needs to come into a specialist service for dementia, for continuing care, she does not have to share a bedroom for the rest of her life with 3 complete strangers? Guess where the money will be spent, in my humble opinion.

Deputy R.G. Le Hérissier:

[Laughter] So really you do fight the good fight but it is an uphill battle. Just one thing, and then we are going to nearly wrap it up, one of the issues that came up with Family Nursing was we were quite intrigued as to how -- we have heard this very lengthy explanation about the service level agreement which has been around for some time, as you know, who fights their corner within the system?

Mr. I. Dyer:

Who fights ...?

Deputy R.G. Le Hérissier:

Who fights in the corner of Family Nursing? Like if you people, as you do, were to conclude that we need this policy but it needs a lot more community support and the people best able to provide that are Family Nursing, therefore we have to increase their grant. Does it happen that way?

Mr. I. Dyer:

It does. I mean, we would have a lead officer that is responsible for the service level agreement with have with family nursing. If we look at all grant aided bodies across Health and Social Services, I think there is something like 20 or 30. Silkworth Lodge is one that I am responsible for, I am lead officer representing Health and Social Services, we would look at the increased cost, the cost pressures that they are facing and ultimately I then have to make a decision within the directorate about arguing for more money for Silkworth or for old age psychiatry or for adult mental health or are they sort of going to get increases, cost of living increases, that come through, bearing in mind that cost of living increases we get for residential type care and such like do not carry the extra 2 per cent G.D.P. (Gross Domestic Product) that they would have in the U.K. for healthcare costs so we do not get the extra on top of that. I am trying to think who is responsible -- is it Rose Naylor that is responsible for the service level agreement with Family Nursing?

Female speaker:

Rose and Russell.

Mr. I. Dyer:

Rose and Russell, so Director of Finance and Director of Nursing and Governance. I think it has been difficult because we have not got the service level agreement yet and there have been occasions where we have identified high cost community packages of care, whereas we said if it was in England it would be the equivalent of family nursing, district nursing and all support teams and such like that would be providing that high level of care into the community where family nursing can identify what they are going to put in rather than necessarily the multiple disciplinary team

identifying what needs to be put in. I mean that is probably a polite way of saying we do not always get what we need.

Deputy R.G. Le Hérissier:

Yes, there was quite a discussion on the commissioning issue --

Dr. L. Wilson:

May I interrupt? John might have something to contribute here because I know I have one, again, younger sufferer, a younger woman with Huntington's Disease who has a fairly extensive package of community care that I believe your department --

Mr. J. Cox:

That is because she is under 65.

Dr. L. Wilson:

Yes.

Mr. J. Cox:

We had this discussion earlier, there is a budget that we manage for under 65s that can pull together packages of care, often involving Family Nursing and Home Care but they are limited in what they can provide for high need cases. So therefore we commission from the independent sector other providers. Unfortunately we do not have access to a budget to do that for older people. We are entirely reliant on Family Nursing and Home Care to provide that care.

Dr. L. Wilson:

May I ask you, John, what would happen -- this lady will not get to 65 in the community because she is -- I think she has just turned 50 but I would be very surprised ... Had she developed her condition 10 years later on in her life than she had, and you had put in a care package for her, what would have happened if she had hit 65?

Mr. J. Cox:

What would have happened is - which has happened in a few cases I think - I would take that case to the -- there is an under 65s panel which approves ultimately the expenditure. Ian sits on it. I would present that as an issue that clearly we cannot withdraw. We would have to have a debate about is that residential/nursing care an appropriate alternative now to the package in the community which involves assessment and wishes and so on. Then the panel would advise on what would be the wise decision to take in that particular case.

Ms. M. Hutt:
Can I add something there? The budget that I manage that pays for buying beds in private sector, not contract beds but the spot purchase beds, that budget is intended to purchase care and purchase beds which could, in theory, be used to purchase care package time. But I am never approached because that is something Family Nursing and Home Care do. Were I to be approached on a regular basis I would have to go off to our Director of Finance and say there is not enough money in this. There is not because all the money is tied up in buying beds. But the theory of that is there but F.N.H.C -- should have to pass over to F.N.H.C.

Dr. L. Wilson:
Family Nursing and Home Care would not be able to. You know the lady I am talking about?

Mr. J. Cox:
Yes, I do. It is fairly general because I think the point has been well made that they can do 3 visits a day in some cases. Some of these complex cases need a heck of a lot more than that and you are setting something up to fail unless you put in what you can do. For the over 65s we are limited because of the way the thing is structured at the moment.

Dr. L. Wilson:
I mean this is obviously is not John’s fault but it is grossly inequitable.

Deputy R.G. Le Hérissier:

Yes, you have drawn attention to a very special issue there. Are there any more questions from the panel? In terms of the group, some of you have remained very quiet, of course you did have in a sense your moment of glory earlier, but if there is anything you wish to contribute or if our speakers wish to contribute anything further, and similarly if you go out of the room and - and Alan and I have a lot of these moments now - say: "Oh, I had forgotten that" and so forth, we would be very pleased to hear from you. We cannot put it in the formal evidence, so to speak, but this is not an adversarial court of law, this is a way of trying to get at your views, at the thinking behind your views and whatever evidence can sustain them.

Mr. I. Dyer:

The only thing is I am assuming you have got most of the documentation you need, sort of national reports and such like, but whether or not the executive summary for payment price would be -- I have brought copies along if it would be beneficial.

Deputy R.G. Le Hérissier:

Yes, that would be excellent. That is very kind of you. Thank you, Ian.

Mr. I. Dyer:

It is looking at mental health, the costs and such like. So I will leave these.

Deputy R.G. Le Hérissier:

So that said, we are very pleased from you. As I said, if there is anything else you wish to say ... I would like to thank you all very much for attending, it has been very enlightening.

Dr. L. Wilson:

Can I just say one thing that you might like to know? We have finally closed Leoville and McKinstry.

Deputy R.G. Le Hérissier:

Excellent. I know it took slightly longer than planned. They were the 2 that were the subject of the Overdale inquiry. But I would like to thank you all. I am not sure you have left us all in a totally optimistic frame of mind.

Ms. M. Hutt:

Very pleased to have had the opportunity.

Deputy R.G. Le Hérissier:

As I said, it has been enormously enlightening for us, so thank you very, very much indeed.