STATES OF JERSEY

Health, Social Service and Housing Scrutiny Panel
Health White Paper Review

MONDAY, 30th JULY 2012

Panel:
Deputy J.A. Hilton of St. Helier (Vice Chairman)
Deputy J.G. Reed of St. Ouen
Mr. M. Gleeson (Panel Adviser)
Mr. G. Wistow (Panel Adviser)

Witnesses:
Managing Director, Community and Social Services
Head of Occupational Therapy Services
Service Director for Older People

Also Present:
Ms. K. Boydens (Scrutiny Officer)

[11:02]

Deputy J.A. Hilton of St. Helier (Vice Chairman):

Welcome to the hearing of the Health, Social Security and Housing Panel into the Health White Paper Review. If I could draw everyone's attention to the code of behaviour for members of the public that is displayed on the wall and in particular to the following: all electronic devices, including mobile phones, should be switched to silent, the taking of visual images or audio recordings by the public will not be permitted, if you wish to eat or drink, please leave the room. Finally I would also ask that members of the public do not interfere in the proceedings and as soon as the hearing is closed, please leave quietly. Members and witnesses may wish to make themselves available afterwards but any communication should take place outside of the building. For the sake of the witnesses, may I confirm that you have read and understand the witness statement that is in front of you? Thank you. For the tape, if we could all identify ourselves. Starting with myself, I am Deputy Jackie Hilton, the Vice Chair of this panel.

Deputy J.G. Reed of St. Ouen:

Deputy James Reed, a panel member.

Mr. G. Wistow (Panel Adviser):
Gerald Wistow, an adviser to the panel.

Mr. M. Gleeson (Panel Adviser):
Mike Gleeson, adviser to the panel.

Ms. K. Boydens (Scrutiny Officer):
Kellie Boydens, Scrutiny Officer.

Head of Occupational Therapy Services:
Gill Rattle, Health and Social Services, Head of Occupational Therapy Services.

Managing Director, Community and Social Services:
Richard Jouault, Health and Social Services, Managing Director of Community and Social Services.

Service Director for Older People:
Ian Dyer, Health and Social Services, Service Director for Older People.

Deputy J.A. Hilton:
Thank you very much and welcome here this morning. How would you describe the current working relationship between the Health Department, G.P.s (General Practitioners) and other providers?

Managing Director, Community and Social Services:
Okay, I would describe the working relationship at this current time as better than I recall it at any other point. So I think there is a developing close working relationship between primary care, secondary care and the third sector, however what we would all recognise is that the structures that underpin that relationship need developing and that has always been a barrier to the way in which they work, but I think from my perspective it is essentially very good.

Deputy J.A. Hilton:
Okay. Can you explain a little bit more of what you believe needs to happen in order that the other providers, the Health Department can deliver the services that are outlined in the White Paper in a timely fashion?

Managing Director, Community and Social Services:

Okay, the first element of that would be around co-ordination, so that means that the primary care body needs better co-ordination about how it works and how it delivers its care. The third sector similarly needs better co-ordination and integration with Health and Social Services, and Health and Social Services itself needs to develop a more robust commissioning function so that it can commission services from the third sector and from primary care as a body in a more efficient way.

The Deputy of St. Ouen:

Because at the moment can you just describe how arrangements are generally made?

Managing Director, Community and Social Services:

I suppose historically we have moved from a position where many voluntary agencies and third sector agencies have received grants from Health and Social Services and those grants have developed into service level agreements and those service level agreements are developing into contracts for service. So that is a significant move from grant to contract for service with a shift in focus from inputs in terms of money and resources required by those third sector providers to outcomes and outputs so measuring what the public expects to receive for that money. With regard to primary care, there has always been difficulties for both primary care and secondary care to operate in a fully integrated fashion as a result of the way in which the money flows through the system. So you will have heard from our G.P. colleagues and from consultants, I am sure, about some of the perverse incentives that operate through the system that leaves the user of the service and the provider of the service to not necessarily operate in the most efficient way. So a lot of what the White Paper is about is about trying to remove some of those perverse incentives and make the money flow in such a way that it incentivises people to do the right things.

The Deputy of St. Ouen:

Why have improved arrangements not been put in place before now? Why do we have to wait for the White Paper to see these improvements? What have been the barriers?

Managing Director, Community and Social Services:

Okay, I think barriers are around the fact that it requires more than one States Department to make this work. Obviously primary care is funded by the Social Security Department. So it has been a long journey from ... we were just talking on the way here, about the long journey, the strategic long journey, from when one list was writing about getting upstream in terms of healthcare to the work of New Directions, to where we are now with the White Paper. But there is a complete line of sight from that piece of work. It has taken maybe a decade for us to get to this position now but it is the right journey and I think everyone is coming to the right place at the right time.

Deputy J.A. Hilton:

Can you tell us exactly what work has been undertaken at the current time to address the issue about primary care being funded by the Social Security Department and how you feel that ... what sort of timescales are we talking about that the G.P.s ... because care in the community, I presume, will focus around G.P. surgeries as such. How you feel that we are going to get to a point where those funding mechanisms are going to be overcome or are going to be addressed?

Managing Director, Community and Social Services:

I think the first thing to say is I am not the expert in that area. That is not particularly my primary area of knowledge but from the perspective of managing community and social services, what I can see happening in primary care is a significant reorganisation of the way in which they operate, both in terms of their delivery of information services around their G.P. net, to revalidation in terms of how they are revalidated with the G.M.C. (General Medical Council) to how they are organised from the primary care body with the Medical Director for primary care, so significant amounts of reorganisation which will mean, as a body, they will be able to interact more successfully with other parts of the community.

Deputy J.A. Hilton:

Are you satisfied that the current arrangements, or the negotiations that are going on, are happening in a timely fashion and that you, as Director of Community and Social Services, will be in a position to deliver some of those services that are outlined in the White Paper?

Managing Director, Community and Social Services:

Yes.

Deputy J.A. Hilton:
You are. Thank you.

The Deputy of St. Ouen:
What, I would like to ask, can you point to in the White Paper that makes the difference and enables that better relationship to develop, which is key to delivering the services, especially within the community?

Managing Director, Community and Social Services:
I can think of several but I am trying to think of a single example where there might be a good illustration. The development of intermediate care, if you look to the intermediate care outline business case it talks to mechanisms whereby care will be provided in the person's own home to avoid admission to the general hospital and also timely discharge to ensure that care is provided back in the person's own home in a timely fashion. To do that you need to have a growth in our community resource, and Gill can talk to that as more of an expert than I, around reablement. We have spoken about that before. But you also need to be able to provide G.P. ... you need a medic to be able to co-ordinate some of that care to ensure that an individual does not then fall upon the secondary system. There are obviously issues currently around a G.P. could provide a significant number of home visits without incurring a significant amount of cost on the individual. So if we are seeking to have an episode of care provided in the individual's own home, supported by a community team, perhaps 24/7 for a period of time, there will need to be some co-ordination by the G.P. and the G.P. will need to attend to that patient in their own home. The only way we can do that is making sure that the individual themselves is not hit with, let us say, 8 G.P. visits at home which would be close to £1,000 potentially. So we need to create funding mechanisms that will enable a G.P. to receive that money otherwise the person will end up in the hospital. So it talks to that about how we might commission G.P.s to be able to provide that kind of care.

The Deputy of St. Ouen:
When you speak about ... I fully agree with you, if you want to change from the present system to a new one there are certain key elements that need to be adjusted and you rightly point to the G.P.s and how they are funded. But in any event I would presume that that is all part and parcel of what one would class as an improved service. What do you see as the difficulties in achieving those changes knowing

obviously the experience that we have had in the past with regards to encouraging G.P.s to be more involved?

Managing Director, Community and Social Services:

I will turn to Ian and Gill in a moment, because they might have other views, but from my perspective I think to be entirely candid, the issue that we ... nothing that we are suggesting here is leading edge, it is the right and appropriate way to deliver care and it is demonstrated across the world that such mechanisms are the right things to do. I suppose whenever you are making significant shifts in systems the bit that you do not know about is the bit that you do not know about. In other words, we do not know what we do not know so sometimes systems create perverse incentives that you cannot see when you set them out. So, for example, the current system as you read in the White Paper encourages people to turn up to emergency care rather than see their primary physician. When you change systems sometimes there are blind spots. Now, creating a system whereby you are commissioning general practitioners to provide care for the individual in their own home and provide an aspect care in that way may create different perverse incentives that I do not know yet. So we have to guard and watch for that.

The Deputy of St. Ouen:

Ian, how do you see G.P.s impacting on the changes in services.

Service Director for Older People:

I suppose if we start from where we are at the moment. Where we are at the moment is if the G.P. goes to someone's home at 2.00 a.m. and has concerns about that person's ability to manage until 9.00 a.m. the following morning, they have one option and that option is to make a referral to the A. and E. (Accident and Emergency) Department for hospital admission. What we are looking to do is to change it so that at 2.00 a.m. the G.P. can go to that person's home and can pick up the phone and ask for someone to come out and stay with that person until 9.00 a.m. the next morning or until the Monday morning when the multi-disciplinary team can look at the whole person, the whole needs of that individual, with a view to seeing what is best for them.

[11:15]

So they are kept safe in their own environment, in their own home, for a period of time and then on the Monday morning a professional therapist might come along and say: "Well, what we need here is grab bars or some form of technology to support the person." We might turn around and say: "We need some physio for a period of time." It might be the G.P. can introduce a course of antibiotics within the home and we can have someone, a healthcare support worker, staying with the individual to keep them in their own home for that period of time. So what we have at the moment is, I suppose, 2 options. One is the G.P. walks away concerned that the individual is still at home or the G.P. makes a referral to the hospital. What we need to do is to introduce a cluster of options that can be provided in the middle of the night, can be provided during the weekends, at any time, so there is more options that we can draw on. That is where we are moving from and to. Now, the model of challenge for that, will there be perverse incentives? We have still got to dot the "i"s and cross the "t"s in the 4 business cases to ensure that we prepare for that as best we can. At the same time I would be really concerned that we did not start moving towards that now because in my mind we should have been doing it a while back.

Mr. M. Gleeson:

What do you mean? You would be concerned if we do not start doing it now because we should have been doing it while back, could you enlarge on that?

Service Director for Older People:

What I mean is I would be concerned that we do not wait for everything ... the whole model to be in place and not have any risks about whether or not perverse incentives are going to be reintroduced in a different way by saying: "Right, until we get all our soldiers in line, we do not do anything." What I am really excited about is the fact that we have got the opportunity with this White Paper to move forward to services that can prepare and support people in their own homes. We are not letting go of the skills that we have got at the General Hospital. At the moment we are too much of one trick pony.

The Deputy of St. Ouen:

Do you see G.P.s being, in many cases, key to helping to deliver the improved services within the community?

Head of Occupational Therapy Services:

In parts of it. What I would be thinking is that we will not be surprised in this crisis management sort of way, as Ian was describing a 2.00 a.m. call, if we can develop these services that the White Paper is recommending we will have a number of people on our books who we will be aware of, who are being supported out in the community with a whole range of services that are not possible at the moment because of funding issues and it is not just Health and Social Services providing them, there will agencies such as Family Nursing, private care agencies. All of these people, though, we will be aware of. We want to centralise the records so that we can really support these people in future and the G.P.s and the Family Nursing are aware of what everybody else is doing. At the moment there is all these gaps in communication that the G.P. might know one bit of information, Family Nursing knows something else, you do not tie it together and that is where the person falls between all of this and then they present at A. and E. because they might have a community alarm, pendant alarm, it is activated and the ambulance takes them into hospital. Once you take somebody in hospital they really quickly become deskilled. They are in an unfamiliar hospital ward, they do not have their own things with them, really hard to get a person discharged, particularly frail elderly. So this new funding will achieve that, we will be able to connect people together through the centralised record system that we are wanting to fund, that we will have a centralised stock control system so we can quickly get equipment into support someone in their own home, they might be needing a specialised bed, mattress, et cetera. The staff themselves will be totally aware of what is going on, including the G.P., so when we say is the G.P. key, they are just as key as everybody else in this team approach and that includes the relatives too, so they will be aware of is going on. What we developed a few years ago was the client held notes. Family Nursing use them, you might have seen them. But everybody now contributes to those who visit that person in their own home. Keeps everybody else up to date and that includes the family and the person themselves, the patient so that they feel more empowered and they can communicate better at what they would like to see happen. It is not always the most expensive thing. Often it is a low cost sensible solution that we can come up with on a one to one basis. Those are the sorts of things that we will be able to achieve through the White Paper.

Deputy J.A. Hilton:

Can I just ask you a question around providers? Is the plan for third sector providers to provide that sort of care assistant role in the home or is it going to be a combined service with the Health Department and third sector providers?

Head of Occupational Therapy Services:

Well, I foresee a mixture. We will need to have specialists from Health and Social Services, they might be physio assistants, rehab assistants, who might not have a professional qualification but they have done N.V.Q.s (National Vocational Qualifications) et cetera and they are skilled in providing the sort of care we are talking about. When I say "care" it is not deskilling the person, it is keeping their performance and their abilities up as much as we can in their own home, and then we will have people in the third sector who might be providing more of the care element. That is the traditional role of Family Nursing. They themselves are skilled in providing that. Also some of the private care agencies who are increasingly able to provide additional care and an approach that Family Nursing has not traditionally provided, often for younger disabled people.

Deputy J.A. Hilton:

Have you got any idea of the cost of an elderly person staying in hospital at the moment because the services are not in place to assist them at home? Have you any idea at all what the cost is?

Managing Director, Community and Social Services:

There is a unit cost for a bed day. I think it is quoted in the document.

Mr. M. Gleeson:

£400.

Managing Director, Community and Social Services:

£400, is it? £400 per bed, something like that.

Deputy J.A. Hilton:

Okay, that is a lot.

Mr. M. Gleeson:

On that basis, have you any idea what the multi-disciplinary force that is going to assist the patient to stay in their own home is costing on a daily basis as well? Can you compare the funding in terms of cost containment?

Service Director for Older People:

We can in certain areas. If we take dementia, I suppose, as the area we have a bit more background in. It is suggested in U.K. (United Kingdom) general hospitals that 25 per cent of the adult population in the U.K. general hospitals have dementia. So if we were to equate that to the general hospital here, the 200 adult beds that we have at the hospital, 50 of them would be people in there with some form of dementia. That might be mild to the severe stage. What we also know is people going into hospital who have a dementia are likely to be in there about twice as long as people without a dementia. They do not know their way around, they are confused, they do not know how to use toilets, they become more dependent rather than independent. So for people with dementia going into hospital, it might be lifesaving and might be imperative that they go in there but at times it might be that it puts back their ... what we try to do at the moment with people with dementia is to delay the onset of the stages of dementia. When you go into hospital it can speed up the onset of the stages of dementia. So to compare a day's hospitalisation to a day's home care is not quite looking at the right picture. Because if you can invest in 3 weeks' home care, which means someone has to go to hospital just for the 2 or 3 days for the urgent, you might be delaying the onset of more severe levels of dementia. Now, I have waffled a bit and I do not know if I have exactly answered the question.

Managing Director, Community and Social Services:
No, I think you have answered the question. I know where you are going, Mike, with this, it is the issue of is community care cheaper than hospital care? No, not necessarily. It can be, is not always, should not always be.

Mr. M. Gleeson:
We feel that the cost containment argument is not proven really.

Managing Director, Community and Social Services:
Not necessarily and it is only part of the argument of why you do it. Certainly sometimes we do not provide the best care that we can for an individual in a hospital. Sometimes hospital care is absolutely essential but I think dementia is a very good example whereby we are not geared within a district general hospital to provide good holistic for patients with dementia. They become very confused in that environment and therefore their stay can be overly long. But it is not the reason to do community care, because it is cheaper than hospital care. It is because it provides better care for the patient and the second thing is sometimes it is not cheaper. Sometimes it is and sometimes it is not.

The Deputy of St. Ouen:

You speak about improved services within a community and the need for co-ordination, sharing of data and so on and so forth, who will be primarily responsible for ensuring that there is that co-ordination, would it be the G.P.?

Head of Occupational Therapy Services:

No, I do not think it will be the G.P. I think the G.P. is going to have a key part to play but we are going to be initiating this new development of the service and we will involve the G.P.s, I do not think it could be centred on the G.P. because the G.P. tends to be working with someone when they have got to an acute phase, well that is the part that we always have them play, and what we are trying to do is preventative. If we can keep the person well and as able as possible with the work that we are going to be developing then, yes, they will still see their G.P. on occasion but it should not be centred around the G.P.

The Deputy of St. Ouen:

So it will be the Health Department staff or additional staff that will be ultimately co-ordinating and responsible for the services ...

Head of Occupational Therapy Services:

In partnership with other agencies such as Family Nursing because they will be providing some of the manpower and their expertise, their managerial expertise. So it is not just one body to doing everything, there will be ...

Managing Director, Community and Social Services:

The communication needs to be both physical in terms of written communication and face-to-face communication, but also in terms of the integration of the information systems that they all have. So they have a variety of different systems in a variety of different setting ...

The Deputy of St. Ouen:

I am just thinking that you speak about this comprehensive wraparound type care and we have heard a lot about it within the discussions we have had with all sorts of different groups, I am just trying to work out who ensures that that wraparound care is provided? Who determines the type of care? If you are saying that you expect the G.P. to be more involved, and he had the medical experience, yes, I fully understand

that Family Nursing care are required and will provide support and care but I just wanted to know which body that one could point to to say ...

Managing Director, Community and Social Services:

No, I do not think you can appoint a single body because you will end up with case managers for single cases. It is dependent on the type and condition of the service user to determine who that case manager is. So, for example, if you have somebody with chronic obstructive pulmonary disease in the community you might - chest condition - well end up with a C.O.P.D. (Chronic Obstructive Pulmonary Disease) nurse or a physiotherapist who is the co-ordinating point for all teams for that individual. So Mr. Smith has C.O.P.D. I see them the most regularly, I will liaise with the G.P., I will liaise with O.T. (Occupational Therapy) services, and I will liaise with the secondary physician consultant around these issues. That is not going to be the same in every case, it is going to be the person who has the most contact with individuals, and it might be a third sector agency such as F.N.H.C. (Family Nursing and Home Care) or it might be the G.P. dependent on the individual but somebody will be identified as the sort of responsible officer for that client to ensure that there is a co-ordinator of all the services around the individual.

The Deputy of St. Ouen:

Who does the primary identification? Who initially says: "Right, you are responsible?"

Managing Director, Community and Social Services:

That comes from the M.D.T. (Multi-Disciplinary Team) working together and identifying who is the most appropriate. This happens now. This is not something new we are working on. This is how we work now.

The Deputy of St. Ouen:

Excuse my ignorance.

Head of Occupational Therapy Services:

If I can give an example, we might have a person who is in their 60s and they have had a stroke. When they first have the stroke they will be admitted to hospital. It might only be for a really short period of time because of their abilities may come back quite spontaneously so it varies enormously but the community stroke team get involved, they are already in existence, but they are very small team, and they rely on

their links with G.P.s, very strong links to G.P., Stroke Association who do a lot of the background work supporting the relatives, and the occupational therapist who might put in the equipment. Links with the employer. So there is all of these different connections depending on the person's lifestyle, what they were doing beforehand, their family, their dependents. That would be ongoing though because the person might need a period of rehabilitation where they are in their own home but they are still requiring a lot of physio perhaps, equipment put in, and just getting them back into this different state of health that they had previously, before they had the stroke. So that is an ongoing thing and what Richard is describing is that is just one individual who you wrap the care or you do not wrap it around, because within a fortnight they might have made quite a spontaneous recovery, be able to go back to work, supported by their G.P. perhaps who might be monitoring their blood pressure. So there will be various things going on.

Managing Director, Community and Social Services:
The Stroke Association might end up being the closest point to the client because their need is the Stroke Association. In fact, if there is an exacerbation or something they need, it might be the Stroke Association that comes back to the rehab centre and say they need to re-engage.

Head of Occupational Therapy Services:
Things we do not have at the moment are all of the gaps in between and the White Paper funding will allow us to do that. There is a lot of people who we just do not have the resources to be doing preventative stuff to stop them coming in, that is particularly older people who have fallen and they fracture before we ever get to see them and by the time we have seen them, they are in hospital, they have had their fracture, they are very debilitated because they have had a hospital stay, or they have dementia as well as the fracture and it is really time consuming and a lot of input to get the person back to where they were before they came in.

[11:30]

We cannot do that. We discharge them and then they pop back in again with something else because they have not had the reablement. Reablement being when you have an intensive period, it might be a few weeks, a month, where you have daily visits, maybe several, of the team that can go in and keep that person going to get them back. Restore them to how they were before.

Deputy J.A. Hilton:

Can I just ask you about the role of the consultant physician in the community. Is that a new post or is that a post that has been transferred? How is that going to work exactly? In the White Paper: "Services of a consultant physician working in the community."

Managing Director, Community and Social Services:

In that line there is so much. You will have different things occurring here. We will have secondary consultants who will be backfilled to enable him to move into primary care to support their primary care colleagues in the development of care pathways, so C.O.P.D. is an example, where we currently have secondary care consultants such as Andy Lankshear(?), Peter Bates and Andy Mitchell, that is cardiology, diabetes and chest, respiratory. They currently have an interface, an interaction with G.P.s but what we are developing in the White Paper is mechanisms whereby they can be liberated to provide more support to their primary care physicians and spend some time with their G.P. colleagues, perhaps maybe in a joint consultation where necessary. So there is that part.

Deputy J.A. Hilton:

Can I stop you there, does that mean that those consultants in those roles who are providing more help to the G.P.s, who is going to be doing their work in the hospital?

Managing Director, Community and Social Services:

There will be mechanisms to backfill them, so it might be via a locum or it might be by ...

Deputy J.A. Hilton:

That is very expensive, is it not?

Managing Director, Community and Social Services:

Not necessarily. Not necessarily, depending on how we do it. Can be if you do it as an emergency, yes, but not necessarily. So there are 2 elements to this. One is about secondary care consultants operating more into primary care, and then secondly there is the issue about the development of community based consultants. So we have a community paediatrician and we have our community geriatrician in Mike Richardson, but it is about providing more of that service. Again, because both

those are heavily tied into providing secondary care has enabled more resources if need be.

Deputy J.A. Hilton:

Coming back to the cost of locum consultants, is that what you are proposing then, the backfilling of posts by locum consultants?

Head of Occupational Therapy Services:

They are not necessarily locum consultants. I think it is looking at the various skill mix, is it not, within the hospital because if you have got one post it tends to be a consultant because it has to be someone who has the know-how, if there was an investment funding-wise to develop a community service, that does 2 things. First of all you might reduce the admission rate of people that have got chronic diseases because you are providing better support for them in the community, and educating community providers to look after them differently. Also there would be educational opportunities for people within the hospital. Nurses, other disciplines, to be taking up some of the areas that traditionally might have been done by the hospital doctor.

Deputy J.A. Hilton:

There is just something else that has just popped into my mind. If these posts are being backfilled because you have got consultants concentrating more on primary care, is that going to be a temporary situation or a permanent situation? How is that going to be addressed and the costs associated with that?

Managing Director, Community and Social Services:

The first thing to say about that is the workforce bands in terms of the detail are still being worked up but as an outline stage it would be a permanent thing, it would be whereby, for example, in C.O.P.D. the intention is that the physician with regard to C.O.P.D. would be out there with primary care physicians for a period of time during the week developing pathways, developing and understanding them, and jointly perhaps as a working way, and once those become developed then they are no longer providing that necessarily. It is about bringing up the pathways with certain disease courses in primary care. Now, that model does not necessarily have to run across for all chronic conditions. The diabetic model we currently have is having a provision up at Overdale Hospital and that model may continue because that may be exactly how it works well. It does depend on where the services are currently and the most optimal ...

Deputy J.A. Hilton:
Okay, so at the moment you are still working on that. How you are going ... so that is work in progress?

Managing Director, Community and Social Services:
It is work in progress.

Service Director for Older People:
There will be different models, I think, because the C.O.P.D. for example will have a slightly model to community geriatrician.

Mr. M. Gleeson:
So they use the community geriatrician, are you going to appoint one or are you not?

Service Director for Older People:
The plan is yes.

Mr. M. Gleeson:
You are?

Service Director for Older People:
The plan is June 2013.

Mr. M. Gleeson:
That would help in the co-ordination and possibly contribute to the leadership of the community service.

Service Director for Older People:
I think that is right.

Mr. M. Gleeson:
Because the G.P. is not always going to be around to leave his surgery practice and go and address the multi-disciplinary team and participate in process.

Managing Director, Community and Social Services:

I think what I wanted to stress is the answer is not just one or the other, it is not just we are going to recruit consultants in the community or we are only going to use outreach, the reality is both things will exist. As Ian says, there are plans in there to appoint a community geriatrician in 2014. There are also plans in 2013 to be looking at existing consultants providing more and more time into primary care and to the community.

Deputy J.A. Hilton:

Can I just ask you a question around waiting lists, because we talked about consultants providing more support in a primary care situation and I know waiting lists, waiting times have been a big issue. I do not know what they are like for people presenting with diabetes, for instance. But do you think we might get to a situation where these temporary backfiller posts might become permanent just to make an impact on waiting times?

Managing Director, Community and Social Services:

I do not think so.

Deputy J.A. Hilton:

What is your view? Do you feel that the waiting lists at the moment are acceptable?

Managing Director, Community and Social Services:

I think that waiting times eventually would come down. There is a significant number of drivers that are working in different directions here, which we have to lay out and understand. So obviously we have an ageing population which means there is going to be increased demand for a range of different services. We have a system that is designed to tip everything into secondary care at the moment, so a system that is designed, following an acute episode, to put somebody on an outpatient waiting list rather than provide an alternative way. We currently have a system that does not provide much opportunity for preventative proactive work and is much more reactive so all of those features are driving up waiting lists, driving demand for services. If we get upstream of that and try and address some of these issues before they occur, if we provide more service in the community, if we remove the incentives to tip into secondary care then waiting times should come down or at least remain sustainable.

Service Director for Older People:

The important thing, if you think at the moment of the waiting lists that we have, if the projection of the number of older people we are going to have over 65 by 2014 is 95 per cent, what we have now we know that older people use services more than younger people, there are challenges and what we need to do is to make sure that, coming back to the issue about G.P.s, that people when they have had their period of secondary healthcare can go back to their G.P. to be monitored and not remain within secondary healthcare. At the moment there is perverse incentives that stop people from doing that. If we take the issue of mental health, people often or may have a diagnosis that they lack insight into, they do not want necessarily to take the medication that is felt best for them and they definitely do not want to pay for it. So we have a perverse incentive where they stay within mental health services because to go back primary care services is costly for them and often people in mental health do not have employment. You know, they are one of the groups of people that, to be quite honest, are discriminated against in the Employment Bill. So we need to look at, within a unique service, how we can best provide for the physical and mental health care needs of people with that chronic condition and support them back into primary care land. Those are the sort of issues that we have been looking at within our resources and one of the things that we have been doing is having health clinics for people with long-term mental health problems run by secondary care services. It would be ideal at some stage in the future to hand that over to the primary care services and make sure we have the systems in place for that happen.

Deputy J.A. Hilton:

Can I ask you what your vision is for mental health services in Jersey over the next 5 to 10 years, how you see mental health services being developed? Are you planning on moving or closing Orchard House on the St. Saviour site, where might you move that facility, and just give us a general idea?

Service Director for Older People:

I will firstly give just a little bit of a health warning and the reason being that people are aware that within Social Services there has been organisational changes. Where before I used to be Manager for Mental Health Services which included children, adults, older adults and alcohol, drugs and psychology, that organisational structure has changed now, so now I am responsible for older people services, which includes the old age psychiatry services. My colleague, Chris, who is responsible for adult services, including adult mental health and alcohol and drug services is on leave this week so I will try and answer the best I can, but he is leading that area. Effectively if

we look at the White Paper one of the key areas from a mental health perspective is supporting older people. The King's Fund did a really good document in 2007 called *Paying the Price* which looks at the cost of mental health care into 2026, and effectively says that most of mental health services go up on a reasonably normal line whereas dementia care goes up significantly greater. What I would say is that we are starting from the back foot. We have not had investment in mental health care in Jersey as they have had in England over the last 10 years, so we are starting from a more difficult starting point. The issue about Orchard House, what we are looking at in 2013 is a feasibility study for what can be developed on the Overdale site and that will be to look at the move of Orchard House and having a purpose built acute unit for adults with mental health conditions. I think that is in the melting pot. The actual model I know Chris is leading on the I.A.P.T. (Improving Access to Psychological Therapies), which is the psychological therapy, early psychological therapies for common mental health conditions such as anxiety and depression. That is looking very important, particularly with keeping people in employment, because what we need to do ... you mentioned about waiting lists, the quicker we can respond and support people who have had the mild to moderate common mental health conditions back into employment the better for them, the better for society, the better for the local economy. So that is a significant piece of work. The other areas within the transition document are looking at things like improving the crisis resolution service. We are thin on the ground with staff being able to respond in a crisis to people with mental health problems and so there are plans to support those areas in the transition document.

Deputy J.A. Hilton:

In the White Paper.

Service Director for Older People:

No, that would be in phase 2. So the White Paper takes to the medium term to ...

Managing Director, Community and Social Services:

It will be in the transition plans.

Service Director for Older People:

Then the transition plan you will be seeing.

Deputy J.A. Hilton:

So you talked about people then, you mentioned people with acute mental illness and you were saying we are a bit thin on the ground with staff to deal with those situations?

Service Director for Older People:
Sorry, there are 2 areas. The first was the I.A.P.T. so the psychotherapies, the 3 year period in the White Paper.

Deputy J.A. Hilton:
Yes, I understand that. It was your second comment.

Service Director for Older People:
The second comment then would be about crisis resolution.

Deputy J.A. Hilton:
Crisis resolution, yes. Okay, did I understand you correctly, did you say that we were a little bit thin on the ground with resources to deal with people, individuals, who are in crisis?

Service Director for Older People:
Yes.

Deputy J.A. Hilton:
Why are we leaving that to later on as a second or third tranche of this work? If it is a difficulty now, if it is an issue now, why is it not being dealt with?

Managing Director, Community and Social Services:
I think that is because everything is being lumped on to the resources that provide that. It is about separating that stuff off. If I go back to your original question, maybe that will answer it. I think the big difference with regard to mental health in 2020, let us say, from where we are today, why it will be different on the ground in Jersey is 3 things. The first thing is around destigmatisation of mental health conditions. So one of the issues around I.A.P.T. and providing that care with the G.P. is about not going to a facility which has mental health services but is your G.P. That is an important issue that we will see over this decade. Destigmatisation, people will be happy to talk about it and therefore there will be a change in the way in which it is treated.

One of the biggest pieces of work, and Ian is the expert, is around the changes in legislation.

[11:45]

We have a group that has just met at a political level to talk about the development of new mental health legislation. Again the destigmatisation of mental health legislation by separating out mental capacity legislation from legislation around mental disorder defenders law. So that they are dealt with by different laws, because one is about criminal justice and one is about healthcare. So changes in legislation, changes in the way which people think and act about mental health and also changes in the estate so by 2020 we will be off the St. Saviour site broadly speaking and the bits that remain on site, on the Rosewood House side of it, will be much more fit for purpose. We have had some investment in Rosewood House. We have just now emptied out Clinique Pinel so we can significantly refurbish those areas. By then we will have a new provision for acute psychiatric provision currently provided by Orchard House that will have moved to a new site. So those are the 3 things for me that you will see differently in a decade.

Deputy J.A. Hilton:
You mentioned people who have been convicted of offences who are mentally ill. I think they have been treated very poorly by society in the past, what help are those people who face a merry-go-round of offending, prison, back out again, offending, prison. What do you think there is in this White Paper that is going to address the issues of those people, that they get the help that they need? What is going to change? You said there are going to be changes to the mental health law so I am very interested to know what is going to change, that that cycle is going to be broken?

Service Director for Older People:
The politicians can answer that rather than myself. I can advise and I have been for the last number of years. But let us be quite clear, what we have in England is a Mental Health Law that is a civil law and a Mentally Disordered Offender's Law in different parts. What we are advising here, or what has been suggested here, is that those 2 parts of one law get separated off and one goes to the criminal justice system because it's a mentally disordered offender's component under the criminal justice and the civil part of the mental health law sits within Health and Social

Services. The third part of the legislation is the Mental Capacity Law that was introduced in England in 2005 which looked at people's capacity to make decisions for themselves, whether it be because they have got mental health issues or because they have got a special need learning disability or because they are unconscious when they go through to A. and E. So it is those 3 parts of the law. The key one that has been the focus for the courts and the politicians locally is the mentally disordered offender's law. That will allow courts to remand people for assessment or treatment pre trial and to sentence people to hospital orders post trial in different levels of courts and different levels of assessment and treatment orders. The reality is that we are never going to be able to replicate what they can do in England in Jersey. Mental health provisioning in England includes an acute assessment unit, which are normally open wards where people will be detained under mental health law, the civil part of the law, they have attached to them psychiatric intensive care units where people who are particularly high risk to themselves or others may be nursed for short periods of time. Then you go into what we class as the forensic area which is low secure, medium secure and high secure. The high secure being the Broadmoor and Ashworth Hospitals. Within that you have low, medium and high secure for people with personality disorder, for women's mental health issues, for psychosis, for learning disabilities, special needs, and in some areas for brain injury. Now, there is no way we are ever going to be able to replicate that in Jersey. We could have a law that says exactly as it says in England but then the courts are going to want somewhere to sentence people to. Traditionally in Jersey the courts have been very reluctant to remand people off Island because they do not want to lose jurisdiction. So if someone is charged with an offence and there is a question of whether or not they were mentally disordered at the time of committing that offence, if they go off Island to a specialist service as previously described, it might well be that the doctors there, or the Mental Health Review Tribunal in England would say, no, that person is not fit to return to court and the courts locally would not have been, in the past, happy to lose jurisdiction. So we have had to make do with what we have got, which includes either increased mental health services to the prison during that period of time or someone coming into the acute unit and prison officers coming with them. So it is complex. Where we are is looking at moving forward with the law and if we move forward with the law, which is separate to the White Paper because it goes through the legislation process, there will be resource implications both from a capital and a ...

Managing Director, Community and Social Services:

What you will see in the transition plan, though, which is the bit which will sit within the broad proposition, which talks about where we are now to what this looks like at the end of the decade is reference to the legislation timetable. That has to be in place to enable these pieces of work ...

Deputy J.A. Hilton:

Can I move to telecare and telehealth? We are very interested to hear how and when this is going to be implemented. Are we going to run a pilot scheme before you go ... I just really would like to hear your thoughts on these.

Managing Director, Community and Social Services:

Of course we already have some excellent telecare provisions and Gill will be able to talk to those. Some of the things are about developing those services and some are new ones.

Head of Occupational Therapy Services:

So at the moment you are probably aware, are you, that we have pendant alarms in the community. There is about 2,000 people, mainly older people, and the occupational therapy services will assess somebody if they are referred. Because in the past people would just be given a pendant alarm and if they had an element of dementia they would forget to put the thing around their neck so it was worse than having nothing because people from outside would assume the person was now rendered safe by being issued with one. So we are all now used to seeing them out in the community, an increasing number of course because, as Ian was saying, with the demographic changes in the Island there will be more people who are living on their own or they are living with an equally dependent spouse, and this will mean that they have key holders, relatives or friends, who can be contacted if the person activates the pendant. On to that system which we got about 3 years ago, we can bolt on other assisted technology. Things like motion sensors. So if somebody fell to the ground and they fractured their hip, for instance, that would be detected by the fact that there was no movement in the area they were living for a period of time. There are things like bath water sensors, if a person is a bit memory impaired and starts running the bath and forgets to turn the taps off. Lots and lots of things that are very individualised for the person and because of the new funding, different teams approach, some of it will be stuff that is within the person's own home that we will be fitting, some of it will be connected to the bigger network that we already have the community alarm system. We have not been in a position to do that in the past

because the only bit that we have been able to use is the pendant alarm which is managed by the ambulance service and they have not got the capacity to expand on their call centre, nor would we want them to. We would want the team to be based at Overdale where all of the other services are going to be connecting for this particular group of people living in their own homes in the community. So we will be serving them in their own homes primarily with the telecare. Telehealth is a different thing. I do not know as much about telehealth. These are the systems that support people in their own homes who might have a chronic condition such as diabetes and people are able to use particular pieces of equipment to detect, for instance, their blood sugar on a daily basis - sometimes more than that - and go through a mobile phone system into a database and a team in a hospital setting perhaps or a G.P. setting. So you would have certain people on your books who have got diabetes and they would be self-monitoring. So they would not need to be going in and using clinic time, they would be taking more responsibility for managing their own conditions.

Deputy J.A. Hilton:

I understand we have telecare now in the Island operating, and that can be expanded. So telehealth is not happening now, is that correct?

Head of Occupational Therapy Services:

Not at present, no.

Deputy J.A. Hilton:

So I understand it is planned to roll out that service by 2015.

Head of Occupational Therapy Services:

Yes, the diabetic service is very keen to develop that. Dr Bates says that he has a very, very busy clinic, he has an increasing number of people requiring support and he would still be supporting the people that are at the heavy end, as it were, but for younger people just being diagnosed who are adept at using mobile phones, et cetera, they would be able to start using pieces of equipment that ... they could be out, they could be off Island even and using the various pieces of equipment that we are going to start developing.

Deputy J.A. Hilton:

So if you were not on the Island, it could work if you were away travelling?

Head of Occupational Therapy Services:

Yes, it could. There is already technology.

Deputy J.A. Hilton:

What evidence is there out there, wherever telehealth is being used, that this is a cost effective efficient way of doing things?

Head of Occupational Therapy Services:

Well, it may not be cost effective in the first place if you have to purchase the equipment, however the long-term benefits are that somebody remains better than they would have been because they are not waiting for their regular clinic appointments where their condition can worsen. It is not being picked up because they have had to have been admitted to hospital, perhaps because they have not been managing the diabetes as well as they could have done. They take more responsibility for their lifestyle management. So fatigue, good diet, et cetera, because they have the tools at their fingertips to be able to be looking at it a couple of times a day.

Managing Director, Community and Social Services:

These technologies are not necessarily separate technologies. If you think about it, there is something in the C.O.P.D. business plan which talks to providing clients with significant respiratory problems with alerts by their telephones to say: "The weather conditions are such that ..." "You need to think about taking your medication because ..." Jersey has been doing this for about a decade with regard the memory clinic. We sending text messages to our clients to remind them when to take their mediation at the memory clinic for, it must be, about a decade. So it is not necessarily all futuristic technology. It is very simple ways in which we can use telecare and telehealth to help individuals manage their own health better.

Mr. M. Gleeson:

I think what has upset quite a lot of doctors in the United Kingdom, who are a bit equivocal about telehealth and so on is it was claimed it was going to produce a 45 per cent reduction in mortality. Patients who are being monitored with those controls who did not receive monitoring, which can be interpreted as saying that it is highly dangerous to go into hospital because you are likely to die but if you have got telehealth you are okay, which is ridiculous really, is it not? I mean, it was introduced a bit prematurely ...

Managing Director, Community and Social Services:

I think it is another piece of weaponry in your armoury to provide holistic good quality care and it has to be part of a good system of care. It does not replace ...

Mr. M. Gleeson:

In the White Paper it does quote that 45 per cent reduction in morality, which is really not proven at all.

Service Director for Older People:

Another thing, and you are going to ask me to quote it and I cannot remember the authors, there was a recent paper that came out that questioned the benefits of telecare.

Mr. M. Gleeson:

Yes. It was in the *B.M.J.* (*British Medical Journal*).

Service Director for Older People:

I think, as Richard said, the important thing is that if you make claims that one thing is going to make this difference we know within healthcare it is just that complex it is never going to be one thing. If you take telecare, if you take telehealth or if you take a service where we provide 24-hour support where you have got the right people in the right place assessing the right individuals at the right time when you have got care co-ordinators - and we mentioned earlier on about who was going to co-ordinate, so the idea would be you would have a care co-ordinator who would go out and sort of put in the other relevant professionals or support workers at the appropriate time - put it all together and you improve the services, but one thing on its own is not going to be the panacea. If the White Paper gave that impression it did not intend to.

Deputy J.A. Hilton:

Thank you for that. Gerald?

Mr. G. Wistow:

Thanks. Can I just go back to an earlier part of the discussion, which was about the early identification of people at risk, and there is a section in the White Paper that talks about a single point of access. I am still not absolutely clear how you are going

to identify how and who is going to carry out this process of identifying people who are at high risk of potentially developing a condition.

Managing Director, Community and Social Services
Unfortunately the answer to that again is different depending on the different circumstances.

Mr. G. Wistow:
No, that is fine. That is not unfortunate, that is probably fortunate.

Managing Director, Community and Social Services
So there is a significant amount of reorganisation with our service to make the structures and processes work so that you are creating single front doors for certain client groups. So we have got to do a lot of that work, but also within specific conditions. If we again return to C.O.P.D., we talk in the outline business case of case finding, and that is something for the G.P.s to do. It is about saying: "Looking across your caseload, how many of them fit these criteria and therefore bring them in and provide this kind of assessment."

[12:00]

So that was an example of case management from a G.P. perspective and that is the early identification on that one.

Service Director for Older People:
I think it is important to mention as well that at the moment there is probably something like about 20-odd routes into Community and Social Services, whether it be to psychiatry, psychology, to hearing resource centres, to occupational therapy, to social work. What we are looking at, and it is a piece of work that is being looked at at the moment, is seeing how you could perhaps have a centre where you would have the referrals coming in through a knowledgeable administrative centre who would then be able to book appointments, read this referral, seeing that it responds to the memory clinic, and they will have the diary of the memory clinic staff and when the next available slot is and they would book that in and the information would go there. So then if you are care co-ordinator and you need a week's respite for someone, rather than the care co-ordinator, who might be a well-paid social worker or a nurse or whatever, making all the telephone calls, they would go back to this

central point and say: “Can you book for Mrs. Bloggs a week’s respite this week?” So you have got people that are doing it on a regular basis managing that. There is a model similar to that in Northern Ireland. Interestingly, it is not as complex in Northern Ireland as it is in Jersey because in Northern Ireland the mental health trust, for example, is outside of that group. But I think it is a piece of work that the new workplace planner, co-ordinator, is looking at and having discussions across the board within Community and Social Services and we would be keen for that to work. So that would be the ideal single point of entry. It would not exclude the emergency entry.

Mr. G. Wistow:

So it is a virtual single point of entry?

Head of Occupational Therapy Services:

Plus these people will not be new to us. They are people we already know of because they are quite heavy users of the service one way or another, so co-ordinating it better and having a single point of access will create efficiencies because we will not have 3 or 4 different members of staff knocking on their door getting involved. We would be prioritising who it was that was most appropriate.

Mr. G. Wistow:

That is not always the case, is it? When in the U.K. they did the work on the so-called frequent flyers they found that at least half of them were not accessing services.

Head of Occupational Therapy Services:

Yes, it can work both ways.

Managing Director, Community and Social Services

There are significant cohorts of the community who really struggle to access, like the homeless, those with addictions and such like, so you are right. But I would say beyond the White Paper, other aspects of our services are also moving towards this either virtual or physical single point of entry. So we are developing multiagency safeguarding hubs for children for safeguarding with police and housing so we have one place of referral for them.

Mr. G. Wistow:

Can I ask about the community wellbeing. You talk about a community wellbeing centre and also a similar centre for older adults. Is that part of the same model?

Service Director for Older People:

The active ageing centre, the aim there is rather than having, for example, somewhere where people go for incontinence advice or falls advice or a dementia hub, there would be an active ageing centre. Now, in my view this would be run by the third sector. We would go out to the third sector. They would run it, they would co-ordinate it, but I could go in there as a carer with mother or father who has particular ageing issues and from there an appointment could be co-ordinated to get the advice and information from the right person. That might be a community psychiatric nurse it might be a social worker, it might be an occupational therapist, but that can be co-ordinated from there. The important thing as well is to have it as a hub and spoke so although there would be a centre, which the aim would be somewhere in town, we would go out to parishes and link in to them. So, for example, we might have particular people working from St. Ouen on Friday afternoons or Thursday mornings and St. Martin and so on, so the local people then can come in. The key thing, if we look at dementia and the ageing population, what they are looking at is that people want to be part of society and so it is as important to have the opportunity for carers to get together and to be supported, whether that be organised for the carers or them being able to say: "I do not want this. I have a bridge club down the road that I get involved with", by providing the right respite at the right time for the people they are caring for.

Mr. G. Wistow:

Who is going to be doing the community development work at the sort of parish level? These kinds of activities I think are brilliant, they provide a very useful purpose, but they do not always arise spontaneously.

Service Director for Older People:

What we are looking at again, a lot of it sits within the 2 key areas, the dementia outline business case and the intermediate care. Within the dementia we are talking about having an active ageing centre where there is 3 staff would be attached to that. I would not see that they would just be attached to the active ageing centre. They would be going out and working

Mr. G. Wistow:

They would be doing the development work?

Service Director for Older People:

They would be some of the development work as well. The carer support worker would be going out supporting carers and you have got the Admiral nurse would be developing for carers as well. So in total over a period of time as the demographic increases so the number of people working in the third sector, supporting in the third sector and having those links with health and social services providers, increases. The other thing I think which is really important to look at, although we are talking by 2040 of having a 90 per cent increase in people over the age of 65, the numbers of people by 2040 that it is predicted in Jersey who will have dementia will be a 154 per cent increase. So the fact that the ageing demographic goes up like that, the people with dementia goes up even more steeply.

Managing Director, Community and Social Services

That is because the reality of an ageing ... you can be sort of boring when you talk about an ageing demographic but then you realise what a massive issue it is in terms of the really interesting part of it is they are very old. That is the area that is increasing. If you look year by year at the numbers of over 100 years of age that is where it becomes really fascinating.

Mr. G. Wistow:

Can I ask just one very last question, which is when we were talking about who would be responsible for care co-ordinator and we talked about a number of roles, you did not mention the care navigators and I wondered if you could tell us something about who they would be, what sort of background they would be. I see that you do talk about them ensuring these assessments are completed and individual care plans are produced, so they would have some kind of case management role, I imagine.

Service Director for Older People:

I suppose it is language. Care navigator to one person is care co-ordinator to another. With my background in mental health, I have always seen the care co-ordinator coming from the C.P.A. (care programme approach) as being a nurse or a social worker or professional in that area. The care navigator I think is probably new language that has come on since C.P.A. but the same type of role.

Mr. G. Wistow:

Right, because also in some places care navigator means a person from the community rather than somebody from a formal service.

Service Director for Older People:

This was an interesting discussion I had just last week with colleagues who I work very closely with where we had been talking about care co-ordination, one coming from a social services perspective and one coming from a mental health perspective and having slightly different views on what care co-ordination was. I think what we need to do is come up with a glossary so whatever language we use everyone is clear that we are using the same language. But my understanding of a care navigator would be the equivalent of a C.P.A. care co-ordinator which will be someone who is proficient and skilled in the area, whether it be C.O.P.D. or whether it be mental health or whether it be O.T., and they would then navigate the person through the services or co-ordinate the person through the services. Does that answer the question?

Mr. G. Wistow:

Yes. It is very helpful to make the point that different terms are used to cover the same thing and the same service but there are differences, so that is very helpful. I had understood care navigators in a slightly different way, so thank you.

Deputy J.A. Hilton:

I know we have run over time but I believe Deputy Reed has a question that he would like to ask you if you are agreeable to staying a bit longer.

Managing Director, Community and Social Services:

Certainly.

The Deputy of St. Ouen:

Thank you. It is really about the transition phase. Obviously you quite rightly point to it is a 10-year plan and it is going to be delivered over a period of 3 stages. A simple question: what in your view would be the effect of not having access to all the necessary funding required to deliver the overall plan?

Managing Director, Community and Social Services

The result of that would be reprioritisation which would result in probably some O.B.C.s (outline business cases) being delayed, I imagine, and then you would therefore not have the full benefit. It would be an interesting reprioritisation. Obviously to get to the position where we have 8 outline cases there was a significant amount of prioritisation to say: "That is going to wait, that is a piece of work that ..." So you have already done that process significantly but you would just do it again and there would be winners and losers in that process in terms of service users.

The Deputy of St. Ouen:

You do not see it as having necessarily a particularly negative impact?

Managing Director, Community and Social Services

I think it is pretty negative for the people who are the losers.

Service Director for Older People:

The same thing happened with the Kathie Bull, did it not? We had a very expensive report came from Kathie Bull and it was prioritised and we said: "Right, well, this is how much money we need. Actually we will give you I think a quarter." Then 5 years later we are saying: "Why did you not do what we told you you needed to do from Kathie Bull?" Then we had Williamson, and we were told we needed £5 million for Williamson and we got £3.5 million for Williamson and the same questions are being asked now about services. So, what will happen if we do not get what has been costed in the White Paper you will not get what is suggested are the outcomes from the White Paper and people will prioritise.

Managing Director, Community and Social Services

There are some plans which are all or nothing; if you take a bit of money the whole thing collapses. I do not think it is like that. It would be a case that you would have to reprioritise and say, as they have done with Williamson and Kathie Bull: "These are the priorities. Therefore we will put the resources to those priorities and these things, by the way, are the bits that are not going to happen and we will have to live with the consequences of that."

The Deputy of St. Ouen:

Gill, would you like to add anything?

Head of Occupational Therapy Services:

No, I would agree with that. I think it would be a very sad day if we were not able to acquire all of the funding because it is all knitted together and we already have had to prioritise and prioritise again. So if we are told: "Well, you will not get the full funding" there is going to be time spent on having to reprioritise and that is time wasted when we could be supporting people.

The Deputy of St. Ouen:

Thank you.

Deputy J.A. Hilton:

Thank you very much indeed. It has been very useful and very informative. So thank you for coming today and I would like to close the meeting.

[12:12]