Social Affairs Scrutiny Panel

OVERDALE SUB PANEL

THURSDAY, 14 SEPTEMBER 2006

Panel:
Deputy A. Pryke of Trinity (Chairman)
Deputy R.G. Le Hérissier of St. Saviour
Deputy S. Power of St. Brelade
Deputy S.C. Ferguson of St. Brelade
Deputy D.W. Mezbourian of St. Lawrence

Witnesses:
Senator S. Syvret (Minister for Health and Social Services)
Mr. M. Pollard (Chief Executive)
Mr. M. Littler (Directorate Manager of Medicine)
Ms. M. Hutt (Senior Nurse, Services for Older People)

Also Present: Mr. W. Millow (Scrutiny Officer)

Deputy A. Pryke of St. Trinity:
Good afternoon to everybody and, in particular, I would like to welcome Senator Syvret, Mike Pollard, Mark Littler and Mair Hutt. I would like to introduce myself; I am Deputy Anne Pryke of St. Trinity who is the chairman of the Sub Panel of the Overdale review. I will ask the other members of the panel to introduce themselves.

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

Deputy S. Power of St. Brelade:
Sean Power, St. Brelade.

Deputy D.W. Mezbourian of St. Lawrence:
Deidre Mezbourian.

Deputy S.C. Ferguson of St. Brelade:
Sarah Ferguson.

The Deputy of Trinity:

William Millow is the Scrutiny Officer. There is certain protocol and I understand that you have seen and read the statements. As discussed with you, Senator Syvret, this part of the hearing is to be held in public and will be recorded and transcribed, and will be available on the website. There are some areas which you have asked to be kept confidential, importantly the contract. When we get to that point the session will be closed and we will ask members of the public, at that point, to leave. The hearing will be continued to be recorded and transcribed but it will not be put on the website, it will be kept confidential. If there are questions in the session that you feel that are confidential I trust that you will tell us and then we will ask them again in closed session. Most of all, I hope that most of the hearing will be open. The purpose of this hearing is to discuss the way that the decision to close McKinstry and Leoville Wards, transfer the patients to the private sector is reached, and when the decision was made and the current situation. There will be other issues that we will want to discuss and when the time is right we will probably ask you to come back to another hearing. If we look at the current situation first; what stage has been reached in the closure of Leoville and McKinstry Wards and the subsequent transfer of patients to the private sector?

Mr. M. Littler:

Where we are, we have reached agreement to transfer 25 continuing care beds to a private sector provider. That is out of 54 beds up at Leoville and McKinstry.

The Deputy of Trinity:

How was that decision reached?

Senator S. Syvret:

The decision ultimately was made by me but I take advice, obviously, constantly in all of these kind of questions pertaining to policy and health and social services. I take advice from the officers, clinicians, whoever is needed under the circumstances. I suppose the build-up to this decision goes back probably as far as 1993 when originally the department first started to look at the possibility of a capital bid which was going to be the Belle Vue site to replace the Leoville Ward facilities. It has been kicking around as an issue ever since then, having varying degrees of success with the capital programme with the States, and, as we know, I think the capital programme of the States will have to get radically re-aligned in order to accommodate the need to find the money to build the Bellozanne incinerator. So it was at that stage our plans to build the Belle Vue Centre fell off the States' capital programme. We were then left with the issue of; is it appropriate for us to continue having for some years people living in the ratty, rather unsatisfactory hospital ward environment, Overdale, when we could - given that we could not provide the capital programme itself - buy high quality beds for them in the private sector. That was the view of the officers of the department, and that was the view that was arrived at, that was the view I accepted and that is the basis of the decision.

Mr. M. Pollard:
I think it is fair to say, also, that Belle Vue was a solution simply for Leoville and, of course, here we are talking about McKinstry and Leoville, and that is something which was an important change since those very, very early days in 1993. This is a bigger solution to a bigger problem.

The Deputy of Trinity:
Just going back as we look further into that. You just said that we have got agreement for 25 beds in a private sector. When do you hope to start transferring?

Mr. M. Littler:
We hope to start transferring beginning of next week, but we will be able to transfer all the patients, subject to their individual needs; we think we can do that over a 2-month period.

The Deputy of Trinity:
Is there any delay in transferring the patients?

Mr. M. Littler:
No, there is a technical term which is connected to the terms of the agreement. Basically within the agreement we said on signing the agreement both parties then will be in a position one week later to start the transfer of patients. So there were some delays in signing the contract because of technicalities, and we wanted to make sure that we had Law Officers' approval and their advice before signing it. So it is one week later after signing the contract.

Mr. M. Pollard:
Moving patients over a period is very good practice. In the 1990s what used to happen in the National Health Service is that wards of this nature transferred wholesale, and there was anything up to a 10 per cent attrition rate - that is the euphemism for death - 10 per cent attrition rate by crude transfers. So by doing the transfer subtly, informed by the individual needs of patients, is the best practice and is the best thing.

Mr. M. Littler:
I think the way it is, the staging of the transfer of patients; Mair, in conjunction with senior nurses and other professionals, they are able to personalise it and put all the support that we have got to transfer them in an appropriate way, make sure they are settled in, and that is why it is going to take at least 2 months to do.

Senator S. Syvret:
Can I point out also; there was a remark I heard on Radio Jersey this morning to the effect that the patients did not want to be moved. Sorry, I do not know where that has come from but it is absolutely

fictitious and 100 per cent wrong. It is simply incorrect. All of the patients who are suitable to go to the private sector homes, such as Silver Springs, want to go.

Ms. M. Hutt:

Can I add something to that? I have personally met with the families of every patient that has been assessed as suitable to go and all those people that I have met with, if they have any reservations then no one has been put under any pressure whatsoever to accept to move. We have not forgotten at any point in this process that we are dealing with people and we have not forgotten that the views of the family are as important as the views of the patients and that they are all linked together. When we have been looking at our assessments and we have been looking at whether people are suited to go, we have not just looked at someone's nursing needs or clinical state. We have done social assessments, we have looked at; is there an elderly spouse that lives closer to this hospital or that ward from the other? We have taken those kind of things into consideration. This has not just been a question of saying: "This person's nursing needs are at this level, never mind how convenient it is for other members of the family or other people that are important to them." So we have worked very hard to work with families on this, in discussing moves. Some families of patients that are staying have expressed preferences or Limes or Sandybrook, we are doing our very best to meet those wishes for people. We are really not into coercing, persuading or doing things against anybody's wishes. Senator Syvret said that nobody that is moving does not want to move, and that is quite true. I have had only 2 families that have said that they would prefer their relative to stay at H and SS (Health and Social Services) and they are staying in H and SS. They cannot stay on at Leoville because we are closing it but they can stay within the H and SS.

The Deputy of Trinity:

So you are saying that the delay in the transfer was due to the Solicitor General?

Ms. M. Hutt:

I am not quite sure what you mean by delay there. From the point the contract was signed, the point we start moving patients, we would never have anticipated moving patients the same day we signed the contract. You cannot move patients without a lot of preparation. We have done assessments on all the patients that we have considered suitable to move during the last 3 to 6 months. They have to be revisited. Because we assessed someone as being suitable 3 or 4 months ago does not mean to say they are still suitable today. We are dealing with old, dependent patients. We have to take another look at everybody, we have to make sure that the assessment we did then is still valid. We also have to have them have a medical examination because there was no point having a medical examination 4 months ago, that has to be current and done the week before they move. We also have to arrange for these patients to be seen by the home because they need to agree that they are suitable for care there as well because this is a partnership of care and we all have to be in agreement that that is a suitable person to go. We never envisaged moving patients on the same day that we signed the contract. We always knew it would take a week or so for us to put these other things into process for the first week's worth of

patients that are going.

The Deputy of Trinity:
But then I understand what you said in answer to the question in the States that the families had been told that they were due to be transferred but then patients were due to be transferred at the end of the June.

Senator Syvret:
Yes, we were hoping to begin the process of transferring patients earlier this year. That is certainly true. Again, it would not have been on an on block situation as Mair's described it, it would be on a case-by-case basis, gradually spread over a period of time. But as is often the way with commercial issues, in negotiating the contract, making sure the service level agreement was correct and agreeable and acceptable to both sides, taking legal advice to make sure that we were doing the right thing. All of that took, unfortunately, longer than we would have liked.

Mr. M. Littler:
Yes, I think when Mair and I met with the vast majority of relatives at Leoville, McKinstry, Limes and Sandybrook, we had to tell them this is what our business case was in terms of what our intentions were and we had to give them timescales. But this was our intent. We said, you know, there had to be a lot of work in order to make sure that everything was in place and all the care and the monitoring would be in place from day one. But we did not say exactly this was the time; this was the intent, and it was quite right that we gave them our intent. So we held nothing back from them.

Ms. M. Hutt:
I think 1st June was mentioned in our outline business case at the beginning. That was revised later then as negotiations took longer.

Deputy S.C. Ferguson:
What criteria did you use for deciding who was suitable to go?

Ms. M. Hutt:
We had a team of professional people; we had nurses, medical staff, we had social workers, occupational therapists, that was the core team. For those patients that we thought it was appropriate we also have people like speech and language therapists, physiotherapists, whoever, the mental health team were involved with some patients. Social workers. Those different professionals did assessments from their own perspective. At the very beginning, throughout caring for these older people, we use a system called MDS which is a shortened version of Minimum Dataset. That is a comprehensive assessment that looks at people's physical, nursing, medical, psycho-social, a whole range of their needs and gives us a base line. We do that on a regular basis. We have been using that system for some 4 years now. So we

knew where we were as a starting point from that perspective. Because of that we were able to exclude some patients quite quickly because we knew that they were the highest end of dependency. All the other patients had assessments from all these professionals and then those professionals met together, as a team, and we looked at their reports for every patient. The criteria really relate to complexity, stability, behaviour. Complexity in relation to are there lots of underlying pathological reasons, diseases, illnesses and what have you, chronic situations, that mean that somebody needs the services of different professionals on a very regular basis. Is someone being seen by physio on a weekly basis? Do OT (Occupational Therapy) have to come once a fortnight to see someone? So anyone that needs lots of services from lots of professionals comes into that kind of complexity side of it. Stability; has somebody got an underlying illness that is not stable? Is there an epileptic that is having fits on a very regular basis that are not controlled? Is there a diabetic whose diabetes is uncontrolled and having hypos and hypers all the time? So stability in those kind of respects. Behaviour-wise; a very large proportion of our patients suffer from dementia to some degree or another. Dementia does not preclude some of them being cared for in the private sector but there are some behaviours associated with dementia that would preclude. So if somebody wanders a lot, if they are very noisy at night, if they hit out when they are being attended to in an aggressive sort of way, that would preclude them leaving our care. It was those issues that were the main criteria around whether someone needs to stay with us. We also considered the people with obvious social needs for staying with us as being excluded immediately. We knew, for instance, that there was one lady whose husband lived opposite the Limes. We would never consider moving her no matter what her condition. There was another lady whose husband lived in Gorey and came on the bus everyday, well, he could never go anywhere else but the Limes because the bus routes would not allow it. So if there were obvious social needs they were excluded for those reasons as well. They were the main exclusions. I mean it is not an exact science. It is something that a team of at least myself, the ward sister, occupational therapist, a social worker, at least 4 people at a minimum discussed each case and very often there were more than 4. There was always debate around aspects. It is not an exact science but they are the main things; complexity, behaviour and stability.

Mr. M. Littler:

I think when we met with the relatives they asked: "How are you going to choose?" and we said: "Well, it is going to be based on a multi-disciplinary team assessment" and they were greatly reassured that we were taking that trouble to have a wide assessment of all their concerns, especially the social not just the nurse and the medical. It has proved to be very, very, good.

The Deputy of Trinity:

Just that we have got a lot of questions to get through so if you could condense your answers it would be appreciated, thank you.

Deputy D.W. Mezbourian:

Going back to what Mr. Pollard said about the Belle Vue having been a solution at the time for the closure of Leoville; what was the solution at that time for McKinstry?

Ms. M. Hutt:
McKinstry did not exist at that time.

Deputy D.W. Mezbourian:
I thought there was --

Ms. M. Hutt:
Sorry, old McKinstry and Secker House you mean? When Belle Vue was proposed for the closure of Leoville - I would need to check on exact dates - but I believe that when Belle Vue first became the plan for Leoville, old McKinstry did not exist because old McKinstry was reopened as a temporary measure because of acute shortages of beds at the General Hospital in 2002, was it? So prior to 2002 there was no McKinstry. It was not there.

Deputy D.W. Mezbourian:
If I may, another question for the Minister. When it was the ministerial decision, you have told us that you have made the decision that patients may be transferred into the private sector, it was a ministerial decision. When was that decision made?

Senator S. Syvret:
I think in March. Yes, the outline decision was taken in March this year, and the decision to sign the contracts and press the button, as it were, was done 2 weeks ago.

Deputy R.G. Le Hérissier:
I will move on to part 2 which is basically how the decision was made, Stuart, so we have started on that. The decision was made, you said, not 2 weeks ago obviously, it was made some time ago.

Senator S. Syvret:
The in principle decision that we would use partnership with the private sector to care for these people, in principle I agreed to that in March sometime this year. All of the work that has taken place since then has been, as I have already mentioned, working on things like the service level agreement, the contracts, all of that kind of thing, getting legal advice, that work was completed about 2 weeks ago and I then made the decision.

Deputy R.G. Le Hérissier:
Recording the official ministerial decision, was that recording made in March or was it made 2 weeks ago?

Senator S. Syvret:
Both. Both are recorded decisions.

Deputy R.G. Le Hérissier:
Both are available?

Senator S. Syvret:
Yes.

Deputy R.G. Le Hérissier:
Then it brings us to the other issue; in the broader sense - not only the immediate crisis you faced with the wards - in the broader sense why was the decision made? I mean, presumably you had all sorts of options going through your mind in terms of how you deal with the elderly.

Senator S. Syvret:
We had options, you know --

Deputy R.G. Le Hérissier:
Give us some of the options you were considering and why you happened upon this one?

Senator S. Syvret:
Belle Vue was the original option to build the third phase of the public sector long term residential care. We have the Limes, we have Sandybrook, and Belle Vue was going to be the third section of that. So States capital build of a new facility was one of the options. Another option was to keep people as they are now in the existing facility. Another option was to use the private sector. All of those options were considered in great detail by a full team of professionals, both administrators and clinicians, and it was decided, I think absolutely correctly, that given the pressing need to move people out of that environment that we would go into a partnership with the private sector.

Mr. M. Pollard:
It is very rare in option documents to find the option with the highest standards that is also the most cost effective option. It is very rare to find. You often end up making compromises in the middle. The document that we had demonstrated that if you ignore the do nothing option, which frankly everybody must surely abandon the do nothing option, then the one option that we chose has got the highest standards, not just best (…inaudible).

Deputy R.G. Le Hérissier:
You chose that option, but what were the other options? We have heard of them generally from Stuart,

what were the other options you had in the back of your mind?

Mr. M. Pollard:
Firstly, do nothing because we have always have to benchmark in business planning terms against the status quo. The second was some minor upgrade which frankly is a smidgen away from the status quo anyway so we say that for completeness sake. The third was the option that we are now talking about. There was then the option of a new build but we do not have any capital anyway so again that is a slightly virtual option. The fifth thing is to buy a hotel and convert it, but again with capital which we knew was not existing anyway. So a clear second option is to test the process but some of them were never realistic. I repeat the status quo was never really a realistic option, and getting massive capital from the States in the short term was never an option. We have to live in the real world and move forward on that basis.

Deputy R.G. Le Hérissier:
We keep hearing about the abandonment of Belle Vue, and there were concerns that it was reflected in the proposition, for example, that was sort of the ghost of the feast from the Constable of St. Helier, his proposition on Belle Vue and the cost of Belle Vue. What about other options like, for example, building in much more community support? Surely during this period the whole approach to handling elderly people, admittedly they are at a certain point on the continue, but the whole approach must have been changing; how did that impact on your thinking?

Senator S. Syvret:
I think the patient cohort we are talking about are people with complex, significant needs and these are people that it has been clinically determined need to be in a cared for environment. Yes, you are absolutely correct, it is our preference and it is our policy to want to maintain people in their own homes in the community as long as possible, and that is absolutely the right way forward. But nevertheless you are always going to have a cohort patient whose degrees of need are such that they are going to need to be in a cared for environment. This group of patients fall into that category.

Mr. M. Pollard:
As Mair has said, through a multi-disciplinary assessment process.

Deputy R.G. Le Hérissier:
When you were making these decisions was there or is there a policy document to which you go to and that, you know, broadly entitled “Care of the Elderly” and it sort of is, for the moment, giving you your direction in how you handle these issues?

Mr. M. Pollard:
There is no formal grand strategy because, as you will see from the strategic plan, one of the

requirements of me to spring forward through the Minister, new options for the redesign of the health and social care system this year, so I am under a bit of pressure on that. That strategy basically deals with 3 big areas, which I realise time is short so I will not go into great detail. But firstly it requires the health population to remain healthy. Secondly, that we deal more effectively with chronic disease management because it is a bit of a dog's breakfast in Jersey; everybody agrees with that. Thirdly, that we maintain people in olden age with a maximum level of independence. The strategy will go along those lines and you and I, Deputy, have talked about that and I know you people support that approach. But notwithstanding within the context of this we always have this cohort of patients who have a high dependency need and would never have been suitable for community care services which are missing in Jersey now.

Deputy S.C. Ferguson:
In effect, you started considering the options presumably when you pulled Belle Vue in the FSR (Fundamental Spending Review) process in March 2005?

Mr. M. Pollard:
Yes, we had to renegotiate the capital plan which was, to me, certainly an important milestone in my first year here because it had allowed us to, in a corporate way, in a partnership way, provide the States with something it desperately needed which was an energy from waste strategy and we had to restructure our capital programme to be able to fund that and departments had to, as I say, undertake their partnership and corporate work. But in restructuring we also got some fantastically big benefits. As you may recall, Deputy, we managed to fully fund something that was not fully funded, which was a new day surgery centre. The complexity of that case meant there was about £1.5 million short, and we needed a new CSSD (that is a Central Supply Sterile Department) based at Five Oaks. That is responsible for removing any contamination and infection from any surgical equipment. Without a unit like that there is no surgery in Jersey and we were able to fully fund that through the kind of negotiations that you will appreciate did take place. Belle Vue was a counter in that negotiating game, so to speak.

Senator S. Syvret:
The day surgery, that is the works that are taking place at the hospital now between the Peter Crill House and the old building. It is going to be more than just a day surgery; there are other facilities as well.

Deputy R.G. Le Hérissier:
I wonder if I can come back to the options. We have had your view that essentially with this group of people it had to be some form of residential care. Now we may have misread the report but we have read a report called "Review of Continuing Care and Respite Care Provision" which I think was compiled by your former director of nursing, as I recall.

Ms. M. Hutt:
Commissioned by, not written by.

Deputy R.G. Le Hérissier:
Commissioned by her, okay. Who wrote it?

Mr. M. Pollard:
Honor Blaine. She is a senior nurse within our department.

Deputy R.G. Le Hérissier:
For example, in looking at option 5 it stated in the report, and I would like some clarity on this, I might have got the wrong end of the stick, but it says: "The development of alternative community continuing care and respite care model in partnership with other stakeholders, for example, family nursing and other independent voluntary agencies." Was this one of the options?

Mr. M. Pollard:
No, I think we are confusing 2 things, with due respect, Deputy. The long term care strategy is an important feed document into the new direction which I talked about when I described these 3 important elements. When we undertook that piece of work it was really around that, that is the strategic issue. We also knew we had a pressing issue at McKinstry and Leoville, so what you might describe in that report is the carving out or the adding into that. How do we deal with this highly specific and important, but urgent, matter as well? The options you have described are the right strategic options for Jersey in the future. But what I might, with due respect, say is that you are confusing those options with the highly specific and technical 5 options I mentioned earlier about what happens to McKinstry and Leoville. At the risk of prejudging new directions those issues are our community care packages with family nursing and other partnerships, that is where we will be putting our money, so to speak. Two things but intrinsically limiting; one strategic, one immediately in operation.

The Deputy of Trinity:
With the new unit at Samares for rehabilitation, why did that take precedent on that rather than inpatient care for the elderly?

Senator S. Syvret:
I think because there was a desperate need for that facility. Basically we had lots and lots of beds in the General Hospital building consumed by people that no longer needed to be in an acute setting but needed to be in a more rehabilitative setting. That is why there is a desperate need for that, not only because it is better at addressing the needs that group of clients had, but also it was freeing up space that was being inappropriately used in the General Hospital for ordinary acute patients. So there was a very high degree of urgency with that project.

The Deputy of Trinity:
Even, would you say, that one floor I understand is just outpatient clinics?

Senator S. Syvret:
Yes.

The Deputy of Trinity:
That was still a high need then?

Senator S. Syvret:
Yes, it was.

The Deputy of Trinity:
That, say, took a higher precedent than care of the elderly and the facilities that --

Senator S. Syvret:
It was because of the impact it has on the facilities and available space in the General Hospital.

The Deputy of Trinity:
Even clinics?

Senator S. Syvret:
Even clinics, yes. Even clinics. Because you will appreciate if you go to the General Hospital that generally speaking the outpatients are very heavily subscribed. There is inadequate space there now really.

Mr. M. Pollard:
The focus of a lot of care is moving now to outpatients who are remaining in hospital for short times through day case surgery, as was mentioned earlier, and by using outpatients. Lots of clinical treatments now take place in outpatients and we have moved a long way from an outpatients being a simple kind of across the desk consultation between a healthcare professional and patient.

Deputy R.G. Le Hérissier:
Just to wrap up, and again try to sort out my thinking between these different plans that are rolling along, what you are doing now in moving this group into the private sector, do you think it is compatible with this long term strategy that you are working on?

Mr. M. Pollard:

Yes. One of the difficulties we have when we have a strategy is that can we dare take any short term action? Because we may take a short term action and there is nothing formal in my strategy, could be wrong every step, however if we leave everything until we work on strategy we leave patients, as we have described today, in dire circumstances and withholding the best possible benefits. There is always a bit of a game to play that. There is a tension in the balance between those 2 issues, so confronted by that what we have to do in our department is say: "This is an important issue. Is there any options in the future that we can possibly contemplate that would not allow us to do Leoville and McKinstry in the way that we have done today? Of all the options that we have to unfold before the States we can still proceed with this without prejudicing in any way whatsoever the strategy for the Island." If I may say, at the risk of pre-judging acceptance of that strategy, a key issue that you have alluded to yourself, is the partnership arrangements with other players. Family Nursing most certainly, other grant aided bodies but also the private sector.

Deputy R.G. Le Hérissier:
Although this will be dealt with later, you are also thinking of the financial implications of what you are doing?

Mr. M. Pollard:
I am indeed thinking about the financial implications.

Deputy S. Power
I would like to focus for a little bit on consultation. One of the reasons I think we are all here today is because there is a great deal of interest in closure of Leoville and McKinstry and the movement of our dearly beloved elderly to new care, new units of care. We have obviously as a panel in the last 4 weeks received a great deal of communication in written correspondence from public and interested groups and my first question would be: are you comfortable with the degree of consultation that has taken place, first of all, with those immediately concerned, families of patients and patients themselves? Do you think if you had a second chance would you have done it slightly different?

Senator S. Syvret:
We have gone specifically, before making these decisions, to the clients and their families and asked them what they thought. So I do not see how we could have done it possibly any better than that. There has been some concern generated in the public, that has to be said, largely by ill-informed and inaccurate political comments that might have stirred up misapprehensions in the part of the public. The statements on Radio Jersey this morning was an example, this kind of grossly inaccurate information that simply might be causing public concern because the public do not know necessarily any better than to take on face value what they hear on the radio. But as far as consulting the clients and their families are concerned, we have done that extensively and, Mair, you might want to --

Ms. M. Hutt:
Mark and I invited to meetings families of every patient in our care leaving McKinstry site and from the Limes and explained what our proposals were and took their views. I also wrote to the families of all the patients that we thought would stay within Health and Social Services to allay their fears from the very outset, and I also met personally with the families of everybody that we thought would be suitable for the private sector. So we have had huge numbers of meetings with individuals.

Deputy S. Power:
I am sure you have and I am not implying for a second that you have not done that. Where I am going is we are reacting to the volume of correspondence that we have which reflects differing views. As regards what the media says, I do not know what they said this morning, but you know well and I know well that the media have a role to play of their own and none of us here have got a direct influence in factoring in how they report a story such as the Overdale story. The second question I have would be: what other parties were consulted during the development of the current reports? For instance, did you talk to groups such as family nursing and organisations like that?

Mr. M. Littler:
Can I just answer by going back? Notwithstanding what we were doing with the specific project of Leoville and McKinstry, in the developing of the continuing care report which was initiated mid-2005, for the first 4 or 5 months Honor Blaine went around not only with a formal questionnaire but to all the external agencies and also relatives and patients and what they wanted. So going into the Leoville McKinstry project we knew formally and also from a consultation process of over 5 months long we had a good idea of what the view of professionals and lay people alike were for continuing care and specifically Leoville, McKinstry, Limes and Sandybrook; so we were not going in blind and just had a few meetings with relatives and patients, it was not that. This was the topic, so to speak. It added to what we already knew and already all the professionals in the field knew. So this is just adding to what we already knew.

Senator S. Syvret:
The work that Mark refers to itself had a foundation, so to speak, in the form of the integrated strategy of an aging society which was a very comprehensive piece of work involving pretty much every conceivable stakeholder around the issue of demographics and caring for older people; that strategic document was defined as the basis upon which this continuing work was undertaken.

Deputy S. Power:
I accept and I understand completely the amount of time that Mair has indicated has taken place in consultation with families and patients, the 2 together. In terms of the external agencies that you also consulted, percentage time-wise, how much time would you say you allocated to the agencies?

Ms. M. Hutt:
As Mark has just explained, I did not personally, at that point, meet with the external agencies. That work was done by Honor Blaine in the preceding months.

Mr. M. Littler:
I can read out some of the people that were consulted which led to Leoville McKinstry. Age Concern, the consultant for our older people, the nursing homes, FNHC (Family Nursing and Home Care), GPs (General Practitioners) and representatives, Jersey Association of Carers, the Registration of Homes, Social Services, and others, and obviously a formal questionnaire for patients and relatives.

Deputy S. Power:
Are you contemplating doing progress reports to inform people as to how your proposal is being implemented? For instance, you have mentioned that you are gradually moving people out in 2s and 3s, and you were very specific, Mr. Pollard, as to why you are doing that. I think also the other side of that equation is the fact that the new unit has got to take up its slack in exactly the same way as you are; so it is a balancing act, in a sense? It is for both organisations really. Are you intending to do progress reports on how --

Ms. M. Hutt:
Can I answer that? I wrote to families - I would need to check the exact date but it was about a couple of months ago - with a progress report. At our last steering group meeting which was a week today, we agreed that my priority now would be to meet with the families again, to meet and talk with the families of people that are moving, but that I would also write a letter just out of courtesy to all the other families to let them know where we were and what was happening. But we also decided that my priority before I send that letter must be the families of people that are moving.

Deputy S. Power:
So the answer, you are.

Mr. M. Littler:
In addition to that, the steering group meets every 2 weeks and it always is an agenda item as where we are with the patients, the relatives and also with the staff and their representatives. An ever present agenda item.

The Deputy of Trinity:
Can I just clarify a couple of points there? So the patients that are moving next week they know they are moving? They and their families know that they are moving next week?

Ms. M. Hutt:

Yes.

The Deputy of Trinity:
When were they informed of that decision?

Ms. M. Hutt:
During this week. Since Monday.

The Deputy of Trinity:
The ones that are going in the following weeks?

Ms. M. Hutt:
No, they do not know because I have not finished the schedule yet. I have to make a schedule that takes into account such things as families being off the Island and on holiday, I have requests in relation to that, so I have not finished that schedule.

The Deputy of Trinity:
But the ones that know they are moving next week do know?

Ms. M. Hutt:
Yes.

Senator S. Syvret:
The only concerns we have had expressed to us are by those who know that the move is planned and want to move and they worry that the move has been put under threat by political attempts to derail it.

The Deputy of Trinity:
As we have said, we have had a lot of submissions but one thing that has come through loud and clear is consultation - lack of consultation. But that is --

Senator S. Syvret:
I am sorry, I have to say that the evidence simply cannot support that allegation because the consultation with the stakeholders throughout this whole process, both this particular move and the introduction of the relevant strategies that are informed prior to moves, has been absolutely comprehensive; and the evidence is absolutely plain to that effect.

Deputy S.C. Ferguson:
It would be helpful to have that evidence.

Deputy R.G. Le Hérissier:
We all know with issues like this of course it depends on perceptions from both sides obviously, and one can do the most perfect job but the other side can feel let down. This is in the nature of management. Perception counts for everything. I wonder now you have had a time to, sort of, take breath, have you reviewed this and have you said: "I would have done this differently" for example? Are there any areas where you have said: "Yes, maybe I should have done it differently"?

Senator S. Syvret:
Ideally would have liked to have done it quicker.

Mr. M. Pollard:
I mean it sounds arrogant to say I think we have done it perfectly. Because these are esteemed front line people who deal with it, and my role is to check the probity, the value for money and all of the things that you would expect me to check on your behalf, and I have to say that some of the work that you will see in part 2 is of the highest possible standard. I have worked in very large organisations elsewhere but I have never seen the level of documentation. When you see it you will be, hopefully, very, very, impressed. There are risk registers which are the very, to my mind, best in Jersey - best I have ever seen. The detail is excellent. The level of intensive one-to-one discussions that we have heard from Mair, that cannot be better. By definition, you cannot do more than meet everybody in person. I believe the consultation has taken place - multi-layered consultations taken place - family nursing and GPs sit at the top table and we are developing a strategy which will be unfolded later this year. They have been involved - as we have heard from Mike, he has listed the stakeholders - and relevant people have been involved in the individual discussions. It may well be that what we need to do a little bit further down the line when we do review and take progress reports that we can take the value of hindsight. At the minute I have to say somewhat conceitedly and somewhat immodestly in a position to say these; I have not come across anything as good as this when I have been in the department. Again, hindsight might contradict that and we will look at that and we will test, because we can always learn. You can always learn more things as to how we can do things better. I will contend to you, and hopefully this will be demonstrated in part 2, this is high standard work, both clinically and managerial.

Deputy S. Power:
Can I just make one last short comment on the consultation problems? I think just so that you understand where we are coming from on the Sub Panel. We are telling you that we have had a degree of correspondence which has surprised us. Some of the correspondence absolutely endorses what you are doing and there is obviously part of the correspondence which is not happy and, you know, life is not a perfect world.

Senator S. Syvret:
Can I just ask; are you saying that the patients themselves and their immediate families are saying that

they have not been consulted? Or is this just general members of the public?

Deputy S. Power:
I am specifically, and I think the chairman is specifically, referring to pieces of correspondence which would suggest that they were surprised at the decision and surprised --

Senator S. Syvret:
Who? Who were surprised? This is a very important point, because if it is just general members of the public you are talking about, yes, they perhaps were not consulted as individuals. If it is the clients, themselves, and their families you are talking about, they were consulted.

Deputy R.G. Le Hérissier:
There were some comments which, in a sense, it is not our role to examine, but there are some people who, of course, have just simply very strong views about the public service buying private services. They have very strong views and although we are not focussed centrally on that particular issue it is an issue and it is one, of course, that you have talked about from time to time. It is an issue that exercises members of the public. Mike knows this issue from the NHS (National Health Service) in England and it is one upon which several members of the public have written in. Rightly or wrongly, they do not feel that the private sector can do better than the public sector, if only we were for the public sector we could do the job so why are we giving -- I am just expressing it. That is the view that has been given to us.

Senator S. Syvret:
We are a client-centred organisation, we have to put the best interests of our clients first. That is what we do. We cannot be deflected from that because of ideological positions held by various sections of society, you know those that are left wing and opposed fundamentally to anything done by the private sector, or indeed the opposite extreme whereby some people might think that everything that the public sector does is rubbish and it can only be done properly by the private sector. We cannot be deflected on doing what is best under the circumstances by our clients by those kind of ideological considerations. With all due respect, if people are writing to you saying they do not like the use of the private sector as a matter of principle I do not think it is of any great relevance to this particular case because what we have to do is what is right for the clients.

The Deputy of Trinity:
Just to finish on a positive note there; just thinking of the submissions that we have had - I did say just on a positive note - they have all praised the nursing care they have all received.

Mr. M. Pollard:
That is absolutely correct. The standard of care and the staff are excellent; second to none. The only reason we are doing this is because the physical environment is wholly unacceptable and we want

people to be in modern private rooms.

Deputy D.W. Mezbourian:
I believe that, Mike, you referred to the stress and anxiety that can be caused to patients and, indeed, their families when moves such as this are made. Indeed, that it can increase mortality rates.

Mr. M. Pollard:
If done wrongly.

Deputy D.W. Mezbourian:
If done wrongly?

Mr. M. Pollard:
Yes.

Deputy D.W. Mezbourian:
Would you like to explain what measures you believe the department has taken to deal with these emotional aspects of the move?

Mr. M. Pollard:
I think what Mair has done is to explain that we have not kind of (…inaudible) crude. We would not do this at Belle Vue but I just put this for demonstration purposes. We would not crudely batch needs, like there is 5 patients in and we think they are all broadly the same. We have seen the level of best spoke, that is what this is about. The best spoke package that Mair has produced, all the best practice suggest that not only do you look at the clinical and pathological issues that are related to the patient, but the socio-economic environment as well, having a carer who is close and can pop in and maintain those relationships. Being on the bus routes as we have heard. Those kind of things. Being in the same Parish are very, very important things for people, and that work has been done. So that level of highly individualised consideration, together with a phased programme we believe will reduce these crude issues of attrition.

Ms. M. Hutt:
Can I add something to that as well? The research suggests that increased morbidity and mortality is also caused by the receiving home not having the time nor the information to care for the patient properly. When there were high rates of morbidity and mortality in the 80s and early 90s it was because large numbers of people moved at the same time. That is why we move in very small numbers at any one time and we are also sending our own nurses as companions for as long as we need to, and the nurses in the home can kind of learn whether turning this way is best or 2 cups of sugar or milk in the tea, those kind of personal details. They are the kind of things that help people get settled in quicker.

Deputy D.W. Mezbourian:
For those patients who are going to be moved next week, has the home had the opportunity to come in and assess them prior to the move?

Ms. M. Hutt:
That is part and parcel of what we have to do with everybody that moves and that is going on this week.

Deputy D.W. Mezbourian:
So it will be done for all of them before they move?

Ms. M. Hutt:
Yes.

Deputy D.W. Mezbourian:
The current policy with regard to eligibility for those with private income to have this sort of care, and I am referring here to the report which is headed "Purchase of Private Nursing Care Placements" which we were provided with by the head of Health and Social Services. I do not know who prepared it, but it is 28th January 2002.

Mr. M. Pollard:
Sounds like the departmental policy rather than anything specifically, well, by definition what they could do with McKinstry and Leoville because it pre-dates that (…several inaudible words).

Deputy D.W. Mezbourian:
If I may just read to you, as you do not have it in front of you, a paragraph: "Historically the committee has provided its own nursing care beds for patients who could not afford to purchase that care privately. Given the States commitment to stimulate the private sector to meet demand for public services wherever possible a shift from a policy of direct provision to that of contracting care from the private sector would be in line with current strategic directives. However, if the committee is to move to a mix of direct provision and contracted beds it will need to consider a number of issues surrounding the latter provision." What we are interested in is the question of eligibility. It does say here the first question on the issue is that of eligibility: "Currently the committee does not debar those with private income sufficient to meet the costs of private nursing care from applying for admission to its own nursing care beds." That is in one of your own reports. Can you tell me now, who is eligible to receive?

Ms. M. Hutt:
This goes into the question of who has a continuing care bed from Health and Social Services and that is decided on clinical need. Most of the patients come through the General Hospital where they are

referred there to one of our consultants for a continuing care bed or they may be referred by their GP from home or they may be referred from a residential home. The question of whether they can afford it is not looked at, at that point. If they clinically need a continuing care bed they are put on the list that I keep, which is a referral waiting list. Once they have been put on to that list then their financial state is looked at and Health and Social Services are obliged and do charge for accommodation, but accommodation only, and that charge is the same whether you are an inpatient or in a private sector purchased bed. It is very slightly less than the private sector but that is an anomaly with the NSS(?) and attendance allowance, but essentially it is the same.

Deputy D.W. Mezbourian:
Is that likely to remain so or …?

Ms. M. Hutt:
That will absolutely remain so, yes.

Senator S. Syvret:
In the short term. In the medium to long term we are looking at completely remodelling how these things are funded and paid for and so on, because the current system has evolved piecemeal over decades and it would not be an exaggeration to describe it as a chaotic mess.

Ms. M. Hutt:
You would not want to make a system up like this.

Mr. M. Pollard:
We are looking at that under one of the new directions projects.

Deputy R.G. Le Hérissier:
There is this very vexed issue of, for example, giving up your house. Where is that at, at the moment? This is something that causes people enormous distress as we well know.

Mr. M. Pollard:
I mentioned earlier the issue about maximum independent living for older people, and that is a major strand of our work and new directions. New directions is not something where we all go away and squirrel away within Health and Social Services. There are many partners involved in this early work. A major partner in the early work is our Department of Social Security and Richard Bell, himself, involved himself in these matters. What we are doing is looking at the minute at the various options that are available to fund not only residential and institutional care but, to take your words earlier, Deputy, to how we can fund the big, big gap in healthcare provision on the Island, which is primary care led community services. I think that we will be, with our colleagues in Social Services, putting forward

proposals. Indeed, the Minister has already kicked off that debate in an article on the front page of the *JP* about 5 or 6 Saturday's ago. Where he started to articulate issues about sustainability of funding for our department and what they are in terms of old age provision.

Deputy R.G. Le Hérissier:
But at the moment you are having to take houses?

Senator S. Syvret:
Indeed.

Ms. M. Hutt:
No, sorry, that is not entirely the case. The Parishes, when people are Parish-funded, they take housing into consideration. So it depends which "we" you talk about. The Parishes will sometimes put a charge on somebody's house but when people are funded by budgets that I manage then we do not. We are not allowed to do that.

Mr. M. Pollard:
It is rough justice and it is an anomaly.

Ms. M. Hutt:
And it is not fair.

Senator S. Syvret:
It is inconsistent and it is unfair. What we are going to be looking at putting in place through the new direction strategy will be something akin to, not necessarily exactly the same, but akin to the system they have in Guernsey whereby there is a compulsory contributory social insurance scheme which generates a source of income to pay for long term care that people need.

Deputy S.C. Ferguson:
That does not take houses into account?

Senator. S. Syvret:
No, it does not.

Mr. M. Pollard:
But the beauty of the Guernsey system, without digressing too far, is - and we talked about this before, Deputy, it is about the most popular tax you can ever think of because what the people in Guernsey see this as, they see it as an insurance policy against the State taking the inheritance which they wish to pass on to generations.

The Deputy of Trinity:
To bring it back; how much do patients pay, as I understand it, just for accommodation?

Ms. M. Hutt:
£394 a week at the moment, but that is due to go up in 1st October.

The Deputy of Trinity:
To?

Ms. M. Hutt:
I do not have the figures yet. They are published --

Mr. M. Pollard:
They are negotiated by the Parishes.

The Deputy of Trinity:
So every patient pays that whether it is funded by the Parish …?

Ms. M. Hutt:
The charge is £394 a week to every patient, whether the patient pays it or not depends on their own particular circumstances. Sometimes the Parish pay it, sometimes the budget I manage pay it.

The Deputy of Trinity:
I do not want to digress too far down the line of if it changes and we are looking at a similar system again to Guernsey; will it be retrospective?

Mr. M. Pollard:
No.

The Deputy of Trinity:
So the patients in care at the present will continue to be funded by you?

Senator S. Syvret:
The system may change so that the circumstances, the payment or otherwise, of existing clients in homes may well change with the introduction of the new system. We do not know for sure yet, but it may well be the case. When you say: "Will it be retrospective? Will it kind of restore people's houses or charges that people have made in the past?" then, no, it will not. It will not do that. I mean if it is going to be effective it will have to, I would have thought, affect all patients currently in or coming into

long term care.

Mr. M. Pollard:
That is work that we are tackling, as we speak. Key questions.

Deputy D.W. Mezbourian:
Are you able to confirm that £394 a week applies to all patients whether they be in Leoville, McKinstry, Sandybrook or the Limes?

Ms. M. Hutt:
Of those patients, yes. The difference is, the patients that are in the private sector beds that we buy, the 30 that we already buy, the 25 that we have accepted contracts for, if they are not financially assisted by us then they pay - and I would have to look at the figures - but it is something like £370 a week. That is because Social Security Department makes some adjustment and do not pay attendance allowance. Essentially it works out the same but the cash is coming from different places. So they pay very slightly less but they cannot pay attendance allowance.

Deputy D.W. Mezbourian:
You said that you will apply to those who move into Silver Springs?

Ms. M. Hutt:
Yes. So really it does not make any difference to our patients from a financial point of view as far as that accommodation charge is concerned.

Deputy D.W. Mezbourian:
I have got one more question which is concerning the staff on Leoville and McKinstry. Really giving you the opportunity to tell us at the hearing what the proposed arrangements for the staff are?

Senator S. Syvret:
The proposed arrangements are the staff have been guaranteed jobs and no loss of terms or conditions of employment. We have been keeping a number of vacancies as they have arisen in other parts of the service, the general hospital and elsewhere. Where the staff are needed we have been using bank and agency staff to fill up those posts on a temporary basis precisely to enable us to keep the posts open in the long term, to have jobs to move our staff into from Leoville and McKinstry. The staff have been kept fully informed of these plans.

Deputy D.W. Mezbourian:
I understand you were going to be creating 2 new posts, the liaison sisters.

Ms. M. Hutt:
We are going to use 2 of the posts that are there - the 2 sisters, one from Leoville and one from McKinstry are going to work as liaison sisters; and we are also using half a post to employ half a social worker to work with them.

Deputy D.W. Mezbourian:
That was going to be my question: are these 2 new posts being filled by people who currently ...?

Ms. M. Hutt:
Yes. It is the current sisters.

Deputy D.W. Mezbourian:
Which makes sense.

Mr. M. Pollard:
We have kept the trade unions informed via our consultative machinery. We have 2 bodies, one called the Manual Workers Department Consultative Committee, because one or 2 manual workers are affected by this, but more particularly by the Nursing and now Nursing and Midwives Departmental Consultative Committee. That has been a standard agenda item since I have been here, really. So, in constitutional terms we have kept the local representatives and, indeed, the fulltime officers fully involved in the nicety of what we are about.

Ms. M. Hutt:
I have also had meetings with the union representatives and individual meetings with every member of staff.

Deputy S.C. Ferguson:
Now, is this a fixed in stone strategy? Is it going to be a long term strategy or perhaps is there a possibility as you develop your general strategy that you might well say: "Hang on a minute. Perhaps we do need to build our own homes".

Senator S. Syvret:
That is entirely feasible. It may well be something that the States would want to do in the future. It is dependant on a lot of factors, such as getting the States capital programme sufficiently available to fund that kind of work. But the reason why it is more than possible - perhaps even probable in the longer term - is because with certain cohorts of patients you have very complex needs and lots of instability in their conditions. You get to a stage where the private sector becomes reluctant to deal with those kinds of patients because of the cost involved in caring for them and the complexities of their needs and the risks involved in caring for patients with that degree of complexity. So, that particular cohort of patients

are not especially attractive to the private sector. So the probability is that some form of State provision will always have to exist.

Deputy S.C. Ferguson:
Right, and at the moment, once patients have been transferred to the private sector, you then have quite a sizeable chunk of very nice land sitting at the corner of Overdale. What are your plans for that? What are you going to do in the short term; what are you going to do in the long term?

Mr. M. Pollard:
Well, the Chief Minister has announced that as part of the property holdings and property strategy of the Island some property of the States has been designated as for disposal; some to be secured; and others to be reviewed. Two of our big properties are subject to the review process, one being St. Saviour, which is the largest State now that it has been centralised. This facility has been centralised down into a small segment of that site in exactly the same position as Overdale. We believe that that review - which will not, as I say, be undertaken by the department itself although we would be a major stakeholder - will take place in 2007.

Deputy S.C. Ferguson:
Yes, because obviously, if you were thinking of moving back to providing State provision, it is a pity to let land go presumably.

Senator S. Syvret:
I do not think we have planned to let them go. Being team players, we have had to co-operate with what it is the Treasury and rest of the States organisation want to do, and they wanted to undertake a root and branch review lock, stock and barrel of all of the assets and property owned by the public sector. We happen to have a couple that they want to look at, which is what they are doing. If you are asking us do I ever envisage those sites being sold or having something else done with them outside of the bounds of Health and Social Care provision, I would have to say no. There are a lot of other facilities up at the Overdale site, lots of other very new high significant levels of investment in the rehabilitation centre; there are all kinds of facilities up there and it is just next door to the crematorium and the gardens of rest. It is virtually impossible to imagine that site being sold. Certainly, I would absolutely not favour selling it, as it is off strategic importance for Health and Social Care to retain that kind of property for potential uses in the future.

Mr. M. Pollard:
I think what will probably happen, going back to what Deputy Le Hérissier said, is that looking forward to our strategy there is a kind of a line of rating institutionalisation on the Island and that is in the major headline within this continuing care report, which is we are consigning older people to institutions on basically administrative, not clinical, grounds on the basis that we do not have community services that

will maintain people in their own homes. What we believe is that this line of institutionalised care, if nothing else happened, would drop with community care. But the demographics of the Island and the ageing society will pull that flag back up. So, it is a dynamic line and that would suggest to me that it is a bit of a no-brainer that you need Overdale - notwithstanding the political stance taken by the Minister - that we do need that kind of facility. So we have to think of these moving lines and the volatility currently brought about by changes in the structure of the population.

Deputy D.W. Mezbourian:
You referred to St. Saviour's Hospital and, in some of the correspondence that we have received; members of the public have asked why patients have not been able to be transferred from Overdale to St. Saviour's Hospital. Would you like to explain?

Senator S. Syvret:
Because most of the St. Saviour's Hospital building at present is antiquated, obsolescent and just in bad need of dramatic amounts of money putting into it and it would be effectively moving people from one poor situation into another; and there are some parts of that complex that have been refurbished and developed - and, indeed, built new in the case of some of the facilities there - to serve the needs of clients. But the fact is, while there may be a lot of space in the older buildings certainly, it is a wholly unsatisfactory situation and it would simply be moving people from one inadequate set of buildings into another.

Deputy D.W. Mezbourian:
If I may, one final question in connection with correspondence that we have received, the term "calculated neglect" was used by one correspondent for the condition of the wards at Overdale. Would you like to respond to that?

Senator S. Syvret:
I think that is completely incorrect. The fact is these buildings were partially built in the 1930s and partially then built in the early 1960s. They have been maintained but there comes a point where - with those kinds of buildings which were never substantial buildings at the best of times, were not really built to last - you are simply throwing good money after bad. Moreover, it simply is not a case of the wards not looking nice and being pristinely refurbished. The fact is even if you were to invest very substantial amounts of money in having done that to those wards, you would still be left with what are basically hospital ward kind of environments for people's long-term homes. Fundamentally, root and branch the design of those buildings is not satisfactory for people to be living in as their long-term homes.

Deputy. S. Power:
Just one very quick final question on account: it seems to me that with what you have said, like about the dynamic demographic, it seems to me that your message is clear, Senator, that retaining for future

use this site at Overdale and perhaps even the other site you have got at St. Saviour is probably necessary. I know you will have to go through this review process with Property Services but because you are who are you have to allow property holdings to do their thing.

Senator S. Syvret:
Yes, I think that is fair enough. I think, in this new era of joined up corporate government, it would not really be satisfactory and good government for us, or any other departments, to start going off on their own agenda and refusing to co-operate with broader strategic proposals that the public sector generally has to undergo. So, we are co-operating with these things and I am pretty confident that the outcome of the reviews in any event would be that strategically important sites like Overdale remain in the Health and Social Services portfolio. I would be profoundly surprised if the review did not conclude that.

Mr. M. Pollard:
I mean quite a number of the partners are looking to relocate back to Overdale to get the synergy with working with some of the other departments. So we welcome the review, not a reluctant endeavour but as a positive opportunity to see what we can refashion in the medium and get maximum use out of the facility. We are all into gaining maximum utility out of public buildings and public facilities.

The Deputy of Trinity:
Just a very quick question I wanted a brief answer before we move to in camera: the wards, when the patients after Christmas finish transferring to the private sector, what is going to happen? Is it just going to be left empty?

Senator S. Syvret:
They will be used for whatever kind of general purposes we need: storage, administration, possibly training, uses of that nature. We are not just going to lock them up and let them decay. We will be able to find some use for them of one kind or another.

The Deputy of Trinity:
Okay. So, due to the potential commercial sensitivity of the contract, we would like to ask the media and Senator Routier, thank you. **[Laughter]**

Senator P.F. Routier:
Very interesting. Sorry, I am not supposed to say anything. **[Laughter]** But I would have loved to. **[Laughter]** Bye, bye.