States of Jersey
States Assembly

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Health, Social Security & Housing Scrutiny Panel

Long Term Care of the Elderly

Presented to the States on ….

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Chairman's Foreword

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1. Terms of reference

Health, Social Security and Housing Scrutiny Panel Terms of Reference

Long Term Care of the Elderly Review

To consider possibilities for developing a new model for care of the elderly in response to perceived inequities in the current system and the demographic shift towards an increasing proportion of older people in the Island's population.

In undertaking this review the Panel will have regard to:

- Public and private provision of services for the elderly, including proposals for new services to maximise the potential for independent living for older people
- Possible funding models, with reference to relevant experience in other jurisdictions and particularly to the financial implications of a move towards a social insurance scheme
- The need for a 'fee and dependency' agreement between the public and private sectors and governance issues arising
- Proposals contained in the Health and Social Services Department's draft New Directions initiative, with due regard to confidentiality issues pending its approval or otherwise by the Council of Ministers and Departmental decisions concerning the timing of public consultation
- Proposals for unified assessment of care needs
- Any other pertinent matters that may arise during the course of the review.

The Panel will report its findings and recommendations to the States.

NB These terms of reference were revised in July 2008 to reflect continued uncertainty regarding the progress of 'New Directions'.

2. Executive Summary

There is an increasingly urgent need for a new policy in respect of long term care in Jersey. Existing services are stretched, costs are high, there is little flexibility within the system to respond to the growing demand for care in the community and the population is ageing. These factors will present significant challenges in terms of achieving the right balance of services and support for older people; deciding how the long-term care system is structured and managed to deliver these services; and putting in place a set of funding arrangements with which to pay for services and support.

The Panel's main observations are as follows.

Services and support

- There is an over-use of residential care
- Numbers of people receiving some form of home care are relatively high, but intensive home care services which could effectively reduce the need for residential care are lacking

One recommendation is therefore that the provision of intensive home care services should be increased.

The Panel also found that there was a lack of very-sheltered or 'extra-care' housing facilities. Although some Parishes have their own sheltered housing schemes these tend to lack on-site support facilities. States support for extra-care schemes should be considered because they can provide a viable alternative for people who can no longer safely or economically be supported in their own homes, but who do not need or want to move into a residential care institutional setting. It is noted that extra-care is not a cheap option; mixed tenure models could be one way forward, allowing people to retain a capital stake in the property through 'downsizing'.

To encourage more people to remain in their own homes while giving them the reassurance of support in case of accident or emergency there will be a greater need for supporting technology. At a basic level there will be a need for investment

in equipment such as grab rails and accessible baths or showers; moving to 'Lifetime Homes' standards should gradually improve the situation in this respect, but there may be a need for grant funding, particularly to help people living in older properties where modification is needed. More advanced technology will also play a part; services such as the existing community alarm scheme may need to be expanded, which could require extra funding and possibly additional support staff. The latest smart home technologies can employ a range of sensors and help to reduce avoidable hospitalisation, improve home security, and even allow 'virtual visiting'. Social alarm systems can also help older people retain their confidence and independence. Advanced monitoring technologies could be very suitable for Jersey, given that the likely scale of new developments is relatively small.

In the future continuing nursing home provision is likely to be in greater demand. Jersey needs to retain a significant capacity in public sector control; currently provision at the Limes and Sandybrook is supplemented by contracted-out beds in the private sector. This is expensive care, catering for people with the most intense long-term care needs and it is considered that planning to update and replace the public provision before it becomes out-dated is essential. Further contracting out may have a place, but it is felt that it would be prudent to maintain or even increase levels of public provision to avoid encouraging market dominance by large private providers in a small market place.

It is also considered that dementia care services on the Island need additional investment to cope with existing demand and provide for expected future increases in need. This would imply a need for more specialised residential facilities, rather than home care.

Organisation

While integration between the hospital and long-term care in the Jersey system appears to be effective, the separation of responsibility and accountability between home care, residential care and nursing home care creates numerous inconsistencies and is inefficient. Use of the placement tool helps to ensure consistent assessment, but as resources do not automatically follow service users

and people face different charging regimes for different services there remain serious inequities.

It is therefore recommended that a single commissioning body should be established to bring together the funding and procurement of all States funded nursing homes, residential and home care. The commissioning function should operate at arms-length from providers and use unified assessment and placement frameworks, including the existing placement tool. The commissioning body would need to build strategic partnerships with the acute health sector to ensure good co-ordination and continuity of care.

Service level agreements should become an integral feature of the procurement process. An SLA is currently under discussion to formalise arrangements for the provision of home care by Family Nursing and Home Care; this policy should be extended to cover other services.

It has been suggested that each individual, following assessment, should be given an indicative budget for care and support, based on their needs. The possibility of allowing the person to take the indicative budget (or some proportion of it) as a cash payment should be explored as a way of increasing choice and reducing demand on public provision.

The proposed extension of regulation to all providers is welcomed. It is recommended that 'lighter touch' forms of regulation could eventually be supported, such as giving inspection holidays for consistently high performing providers. The focus of inspection should be aimed at service user outcomes.

Funding

There is a growing consensus that 'means-testing' for the funding of long-term care is no longer sustainable or desirable. With an ageing population, access to good quality care that does not threaten to impoverish people should have a much higher priority.

The Health and Social Services Department (in New Directions) has shown a willingness to consider a long-term insurance system. The Guernsey system offers an interesting model, but would need to be extended to cover non-residential care. However, under such a system new contributions would be high.

As an alternative it is therefore recommended that consideration be given to the possibility of a social insurance partnership scheme. This would reduce the sum needed to be raised through the contributions system. Instead of aiming to cover the full costs of care in advance, a partnership system could be designed to cover part of the service or support cost, with the remainder paid (out-of-pocket or by way of private insurance) at the time of use. For example, the insurance scheme could cover a minimum of the first two-thirds of the cost, allowing people to top-up for the remainder if they wished.

The coverage rate could be means-tested so that people on lower incomes would have a higher proportion of care costs covered. This would give people some assurance that they could secure a minimum level of care from the scheme without having to pay anything further.

It is further recommended that the States investigate a framework for people to secure standardised private insurance to cover the top-up charges. The French system is an example where these secondary private insurance policies are used and has seen a very significant increase in people taking them out.

In conclusion it cannot be avoided that any significant improvements to the care provided for older people in Jersey will have cost implications. It is believed that better co-ordination of services, together with new funding options proposed in this report could help to mitigate the effect on individuals and reduce or hopefully eliminate many of the inequities which currently plague the system. However, the general population will need to be persuaded of the need to pay somewhat more now, to obtain an assurance of better care later. In the present financial climate that is likely to present a challenge. It is felt that significantly better information about the

current system and its shortcomings would help the public to understand the need for change, which will hopefully be assisted by the publication of ‘New Directions’ as a consultation document early in 2009.

5. The Way Ahead?

In carrying out its review the Panel discovered a number of weaknesses within the current arrangements for long term care of the elderly in Jersey; it is reassuring that many of these are also identified in the New Directions consultation document, which is expected to be made public in the New Year. It seems that professionals within the system may have been aware of its shortcomings for some time, but until now have not perhaps found a way of channelling their concerns into a positive agenda for change. New Directions may eventually prove to be an appropriate vehicle for this – however the ambitious scope of the policy takes it beyond the range of this investigation.

Focusing as far as possible on issues primarily relating to long term care the Panel has produced its findings and made a range of recommendations in Sections 3 and 4 of this report. Key requirements that have emerged during the review are:

- the need for a single commissioning entity to overcome current inequities in costs and access to care
- the need to allow people flexibility and choice in the kind of care they want
- the need for investment in support mechanisms to allow care to be delivered in people's own homes, to encourage independent living
- changes to regulation to ensure consistently high standards of care from all providers, wherever delivered
- the need for a new approach to funding to support both institutional care (where necessary and appropriate) and care in the community on an equal footing
- the funding system to provide security against the risk that people may be forced to sell their homes to pay for care

Some of this is seen to be happening already, some is implicit in New Directions. The Panel took the view that its role was not to pre-judge matters of detail which would be for future Ministers, their officers and eventually the States to decide. However, it was felt that one area in which it had expert assistance available in the form of its adviser was that of funding systems. Professor Forder was therefore

asked to use his knowledge and experience of funding models in the UK and elsewhere to investigate a small range of options that he felt would be most appropriate to meet Jersey's needs in the future.

6. Funding

6.1 Options for Jersey

Consideration of the available options throws up a number of possible approaches. If one accepts that the current system of means-testing is no longer suitable, one possibility would be a universal public model, like the Scottish 'free personal care' scheme. However, this raises questions about just how much support is appropriate for those on middle incomes, who tend to be hit hardest under means-tested models.

Also, if means-testing is dispensed with altogether, there is a risk that demand for support will escalate, possibly to a point where it exceeds supply, but in any event raising costs substantially, as has been seen in Scotland.

Free personal care requires a great deal more public tax financing than the current system. In England it has been calculated that a move to free personal care for people over 65 would require an increase in public funding of more than 40%, adding approximately 2.5% to the basic rate of National Insurance. At a time of global economic uncertainty this is not seen as a realistic option politically.

The obvious alternative to a fully-funded solution is some form of social insurance/partnership model, as employed in Guernsey. Assuming that some of the shortcomings of that system could be addressed a model could be put forward for a **Jersey long-term care insurance scheme**. Another alternative which perhaps offers a more cost-effective solution could be termed a **partnership social insurance scheme**. The difference between these approaches is outlined below.

6.1.2 A Jersey long term care insurance scheme

Social Security obtained some initial indication of the cost of such a scheme some time ago, based solely on covering the costs of residential care. The UK

Government Actuaries Department estimate indicated that the gross costs of covering residential and nursing home care in Jersey would add just under 2 percentage points to the social security contribution, on a pay-as-you-go arrangement.

On a positive note, perhaps half of these costs are already covered by the public sector. Also, if it were decided to make a figure for 'hotel costs' chargeable to the resident (subject to a means-test) as in Guernsey, where the resident pays the first £154 per week, the additional contribution required could be reduced.

However, the latest thinking is clearly that any long-term care insurance scheme for Jersey would need to cover the option of non-residential care as well, which would suggest greater costs and therefore higher contributions. Some part of the greater use of home care would come as a result of a lower use of residential care, but overall to cover both residential and home care for over 65s inevitably would cost more than institutional care alone. An additional contribution to cover this figure would therefore be expected to increase social security contributions by more than 2 percentage points.

These estimates are on a pay-as-you-go (PAYG) arrangement, which means that contributions for each year cover the costs of care in that year. With care costs expected to double over the next 20 years, contributions would need to increase significantly over time; while predictions are that the revenue base for social security contributions could fall (Oxera 2007).

If the decision was made to fully fund the scheme, those already in the scheme would have their contributions pegged (in real terms) at an agreed rate based on predictions about future costs, but new members joining would face significantly higher rates of contribution. Contributions for a fully funded system would be at least a third higher than PAYG contributions.

The increases to contributions are high because the costs of care are high (and increasing). One of the Panel's first findings was that these costs are far greater than most people expect. In order to make any new funding system acceptable, both politically and to the public at large, there may be a need for awareness-raising on this point. It is felt that long term care needs reflect pension provision in that both issues tend to be ignored by younger people, unless or until they have direct contact with them through shared family experience; by which time unfortunately it may be too late to make adequate arrangements.

As a further consideration, the Panel believes that contributions to any future scheme for long term care should be ring-fenced, both to secure and protect the investment and to reassure those making contributions that their money would only be used for the intended purpose. It is thought that this could go some way towards overcoming resistance, although this may still be significant.

It is noted that both the German and Japanese long-term care insurance schemes have come under considerable cost pressure since their inception. The value of benefits in the German system and in the Scottish system of free personal care have been held constant, and so have fallen in real terms as a result of inflation. The German system has also seen a substantial increase in the contribution rate since it started. By contrast the Guernsey system has only been in operation since 2003, but has built up financial surplus; this could be because it only covers residential care. Moves to expand the system to include home care would require a reappraisal of its financial footing.

6.1.3 A partnership social insurance scheme for Jersey

As the name implies, a 'partnership' social insurance scheme would reduce the amount needed from direct contributions by sharing responsibilities between the individual and Social Security. Such a system would be designed to cover a specific proportion of the anticipated overall cost of care, with the remainder to be paid at time of use. For example, the insurance could cover two-thirds of the cost, giving people the assurance that they would receive a basic minimum level of care

through the scheme, without having to pay anything further if they so wished. People would have the option to pay the balance remaining either through taking out additional personal insurance, or paying from savings or retirement income. If the coverage rate was means-tested, people on lower incomes could have a higher proportion of their care costs covered in a 'progressive universal' arrangement, under which everyone would get some level of public insurance, but the better-off would pay higher point-of-need charges; if desired, contribution levels could also be adjusted so as to be non-regressive. A similar system with people taking out additional private insurance to cover point-of-need charges appears to be successful in France.

As an illustration, an 85 year-old person might be assessed to need care costing £750 per week. The social insurance scheme could be designed to pay roughly two-thirds, or £500 per week in most cases, leaving the person to pay the co-payment of £250 per week out of income or savings. If the person was on a low income or pension with no other savings, part of the co-payment could also be covered by the social insurance: in this case the social insurance might pay £640, leaving the person only £110 per week to find. People would be able to take out private insurance to cover the risk of needing care and having to fund the co-payment; such a policy could be entered into at retirement age or earlier, so that individuals would be completely covered against the costs of care, through a combination of social and private insurance.

The social insurance component would be mandatory and taken as a hypothecated social security contribution, specifically ring-fenced to cover the cost of long term care. The private top-up insurance could be voluntary, but people would be encouraged to take it up. People could be invited to join an insurance plan at age 65, or even be auto-enrolled and have to actively opt-out if they wished. The private insurance would need to be regulated in some way to ensure that it was appropriate; a small number of standard plans could be approved or perhaps even supported by the States. To avoid people simply opting-out, the plans might need to be 'risk adjusted' so that contributions were broadly in line with expected risk. This could well have some political issues – for example as a result of greater life

expectancy, women might be expected to pay significantly higher premiums than men. Such design issues would need to be addressed at an early stage to ensure that the overall costs of care were adequately covered while keeping the options straightforward for the individual.

Varying the model could introduce more choices, or lower costs. For example, the 'standard' social insurance coverage rate could be set at 50%, 75% or some other percentage of costs, rather than 67% as above. People could be invited to choose their own coverage rate from a set range of options, with appropriate adjustments to their contribution rate. Although it might appear to complicate how contributions would work, an actuarial adjustment could be calculated which would enable those who wanted (and could afford) to ensure that their care needs would be entirely covered from within the system, with no need for a private top-up. It is believed that some people might prefer this degree of certainty if the costs were not extravagant. Alternatively, there might be an opt-out position for those who could demonstrate that they had private insurance sufficient to cover the costs of care, as under the German system. Ultimately the determining factor in terms of flexibility would be the additional complication and cost of administering more than one contribution and benefit rate; realistically there would seem to be no practical objection to the scheme offering two or three standard packages to suit the needs of people on varied incomes.

Depending on the level at which the partnership social insurance coverage rate was set the cost could be significantly lower than that of a full long-term care insurance model.

7. Introduction

This review by the Health, Social Security and Housing Panel into Long Term Care of the Elderly may be considered slightly unusual for coming at a time when no specific policy for long term care has been put forward by States Departments. In fact the initial intention of the newly-formed Panel in early 2007 was to carry out a review of the Health and Social Services Department's draft 'New Directions' strategic policy; and then to drill down into specific parts of it in more detail. Long Term Care of the Elderly was seen as a topic of great potential interest to the public and so this was chosen as the area for detailed study.

As it turned out the Panel's plans were overtaken by events at the Health and Social Services Department. Delivery of 'New Directions' was held up; members were told that it needed more work. Eventually a new Health Minister was elected; the Panel was assured that the launch would soon be back on track, but further delays ensued. Somewhat to the frustration of the Panel it gradually became clear that the launch of 'New Directions' as a consultation document was not going to happen until Spring 2009 at the earliest, some two years later than the Scrutiny Panel envisaged.

Faced with this disappointment Panel had to consider carefully its possible impact on the complimentary study of long term care. It had become clear from preliminary research that existing arrangements for long term care of the elderly in Jersey left much to be desired, despite widespread recognition that something needed to be done. The Chief Minister identified ***'the need to care for the growing number of elderly people in our population'*** as one of the key features of the States Strategic Plan 2006-2011[1]. Under Commitment 3, item 3.6.1 read:

'Determine the priorities for future development of the Social Insurance system as reported in "Policy Review of the Social Insurance System in

[1] Strategic Plan 2006-2011 foreword p.4

Jersey – Interim Report" by undertaking public consultation and developing future strategies for the States to consider by 2007 (SOC SEC)'.

This was reflected in Social Security's Business Plans for both 2007 and 2008. The former noted that:

'Once Income Support has been introduced attention will turn to addressing strategies for the future of the Social Insurance scheme in Jersey, further to the interim report published in 2004.

The Department participated in the Jersey Annual Social Survey 2006 by formulating questions with a view to developing policy and the Department will continue to gather evidence in 2007 to determine the priorities for future development of the Social Insurance system. Major areas to be considered will be pension provision and the funding of long-term care.' (Emphasis added.)

In the Department's 2008 Business Plan the reference to long term care became more specific:

'As a result of social and economic trends, including the ageing population and changing fiscal environment, a review of the benefits provided by the Social Security Insurance System will be commenced on completion of the Income Support System. This project will include further research and consultation and views will be sought on a range of policy initiatives, including a long term funding scheme to provide people with the means to pay for long term care and opportunities of increasing flexibility in the provision of pensions.' (Emphasis added.)

Unfortunately, the implementation of Income Support has taken much longer than anticipated. The transition period has now been extended into 2009; as a result Panel members have serious concerns about exactly when long term care will become a Departmental priority. Section 7.7 of the report referred to in the Strategic Plan - 'Policy Review of the Social Insurance System in Jersey – Interim

Report' (**R.C. 49/2004**) from the Employment and Social Security Committee concluded with the following statement:

'It is planned to take a full review of the Social Insurance system forward next year once the framework for the Income Support system has been agreed by the States and development of the Fiscal system is more advanced.'

Nearly four years later substantive work on a new system for long term care has still not commenced. The Minister informed the Panel[2] that the next round of the Jersey Annual Social Survey was due to report its findings in January 2009 and contained ***'lots of questions'*** on the subject which would help his Department to formulate a strategy to bring forward next year. The Panel was thus very conscious that as part of the overall 'New Directions' agenda for Health and Social Services, initial proposals for a new system for elderly care would not be expected to come forward for debate until late 2009; a meeting with officers from that Department[3] indicated that they would not envisage implementation before 2012. That seemed to members to be an unacceptably long time for elderly people and their families to have to wait for the assistance which many feel very strongly should be available now.

Appointment of Panel Adviser

In the meantime the Panel had obtained the services of Professor Julien Forder as adviser to its review. Professor Forder is a widely respected academic with much experience of social care issues in the UK and abroad, having been project leader for the 2006 Wanless Report, which considered the same issues for England. Given clear evidence that the Island's long term care arrangements were in need of change; a sense of frustration at the apparent lack of progress on such an important issue; and reluctant to lose the opportunity of working with such a well-qualified adviser in the field, the Panel therefore decided to press ahead with this interim review into Long Term Care of the Elderly.

[2] Public Hearing with the Minister for Social Security, 30th July 2008
[3] Public Hearing with Health and Social Services, 27th June 2008

8. Background

8.1 Demographic issues

National and international attention has become much more focused on long term care issues in the last twenty years. The growing proportions of elderly people in global populations have brought a sense of increasing urgency to demands for new approaches to caring for older citizens in society. There is also clear evidence that with better education, nutrition and medical care more generally available, life expectancy for successive generations is steadily increasing. Taken together these developments suggest that the number of people eventually needing some sort of care and support in old age is likely to increase dramatically over the next twenty to thirty years. The 'Imagine Jersey 2035' consultation highlighted the prediction that by 2035 the retired population in Jersey will grow by 70%. While many countries have yet to formulate a response to the challenges posed by the ageing population, some have already developed new systems changing the way society deals with long term care. This review includes references to developments in places as far apart as Germany, Japan and Guernsey in the hope that Jersey can benefit from their experience to improve its current arrangements, fill gaps in existing provision and take a longer term view.

8.2 Other factors

8.2.1 Independent living

Alongside the demographic pressures there are other factors at work in the care environment which also support the call for change. It is becoming more widely accepted that it is better for people to live independently for as long as possible in their own homes, rather than entering institutional care either unnecessarily, or earlier than required. To achieve this will require long term initiatives and this approach is emphasised in the Health and Social Services Department's draft 'New Directions' strategy, which also aims to encourage people to embrace behavioural change and healthier lifestyles. It not only has positive implications for the

individual's quality of life, but also offers at least a partial solution to the problem which may otherwise be posed by an unmanageable increase in the number of elderly people seeking places in residential and nursing homes in years to come. However, it also highlights the need to develop new mechanisms to support and maintain independent living for the growing numbers of elderly people within the community, in contrast to the heavy reliance on 'traditional' institutional care which has characterised local provision for many years. It thus brings with it a lot of questions about the nature of the support that will be needed and how affordable it will be; the Health and Social Services Department has made it clear that delivering more care in the community should not be seen as a low-cost option. Other factors will also have a part to play; for example the adoption of "Lifetime Homes" standards will help to ensure that in future homes can easily be adapted to accommodate changing needs, such as wheelchair access – although adequate support will still be needed.

8.2.2 The cost of care and selling the family home

The care market has become a multi-million pound business in recent times, with larger chains of care homes developing as a result of substantial international investment. Several of the biggest players in the UK market have already established a presence in Jersey. Naturally, with increasing standards and regulation come increased costs. Evidence presented to the Panel during its review suggests that the cost of a place in long term care in the Island currently ranges between about £650 and £1400 per week.

Such costs easily exceed the average earnings of most Islanders in employment; yet every year more and more retired elderly people are faced with this burden. There is also evidence to suggest that many of Jersey's elderly enter residential care earlier than might strictly be considered necessary, sometimes because of lack of family or home care support, which would perhaps be available and expected elsewhere. The average length of stay in residential care in Jersey certainly appears to be quite long; one local home reported that a resident had been staying with them for fourteen years, although this is exceptional. While these long stays may be a tribute to the quality of care available locally, they also imply

that the accrued cost to the individual, their family or (if they are in receipt of States support) the public is going to be far higher than might be anticipated.

The price range quoted above suggests that a one-year stay in a local care home could cost between £33,800 and £72,800. Typically many elderly people will be living in an 'asset rich, cash poor' scenario – owning their own homes, but with relatively low incomes from pensions or savings. With costs at these levels and lengths of stay commonly extending to three or four years it is hardly surprising that often the only way they can manage financially is by selling the family home. A decision such as this would always be potentially traumatic; however, with first time buyers and young families facing acute difficulties in finding somewhere to live owing to elevated house prices in Jersey, retaining the family home has also become a matter of vital importance to the next generation. Parents see the home as an asset that has been worked and paid for, while children see it as their rightful inheritance; the pressure to sell thus seems doubly unfair. The Panel established early on that one of its priorities should be to try and find a solution to this intractable problem.

8.2.3 Issues of equity

What makes a difficult situation potentially even more contentious is the fact that others who have perhaps not had the opportunity to buy their own homes or the ability to put aside savings will often be eligible for State support. This can give rise to feelings of grave injustice amongst those families finding themselves substantially disinherited, whilst at the same time creating perverse incentives for others to 'beat the system' by divesting themselves of assets in advance of their old age to minimise liabilities; discussions with Parish officials revealed that this was not unknown, albeit not a regular occurrence. More financially sophisticated and far-sighted individuals may thus be able to protect their property and assets by means of trusts and other mechanisms; but the 'average' elderly home-owner still faces a high risk of initial impoverishment and subsequent dispossession if the need for long term care arises. It is an unfortunate fact of life that few people can be certain whether they are likely to need long term care in advance; the ability to

mitigate this uncertainty by designing a more appropriate 'safety net' for older people will be a key issue in facing up to the challenges of the ageing population.

8.2.4 Categories of Care

The system is further complicated by a range of distinctions between levels of care, some of which qualify for state support while others do not. The field of elderly care abounds with definitions which are open to different interpretations; residential care, nursing care, continuing care and personal care are all terms in common use but whose meanings can be less than clear to the lay person, and can sometimes even cause confusion amongst experts as to exactly what is covered and what is not. One apparently unforeseen consequence of Scotland's bold decision to offer 'free personal care' to the elderly (from 2002) was the dissatisfaction expressed by many people on discovering that they were still expected to pay towards their keep[4]. Similar confusion also applies to the situation whereby purely residential care (not involving medical intervention) attracts no support - unless recipients are unable to pay for themselves, in which case benefits such as Income Support may come into play; whereas nursing care costs tend to be borne by the state (locally out of the Health and Social Services Department's budget). In the UK, seemingly arbitrary and often quite minor distinctions then turn the process of determining what level of care attracts what level of funding into something of a minefield; the 'postcode lottery' can also have a marked effect on the quality and level of care that people can expect to receive. While this effect is less noticeable in Jersey given its geographical size, prior to the introduction of Income Support there were some differences in the treatment that might be afforded to residents of different Parishes, and funding anomalies still exist that can only be addressed on a somewhat ad hoc basis at present.

Evidence of the complexity of the local long term care funding arrangements comes from the Health and Social Services Department's own draft 'New Directions' policy document. This includes the following rather stark warning:

[4] Joseph Rowntree Foundation July 2007 - Ref 2101: Free personal care in Scotland: recent developments

'It is generally the case that islanders who are the children of older people will not come to understand the anomalies and the inequities which exist in this field of funding until a health or social care-related crisis occurs whereby a parent requires institutional care. The family will then discover the fact that the public funding of institutional care is means-tested; this includes the parent's fixed assets as well as income. The two SoJ Departments (HSSD and SSD – the latter having taken over the Parish means-testing regime) operate different means-testing arrangements. As a result it is possible for two older people to receive the very same service and yet pay differing amounts from their own estate for those services.'

As a general principle one would think that clarity and above all, equity, should be central to any system for delivering care to those in need; people should have a right to know what they are entitled to, and everyone with the same needs ought to be entitled to the same treatment. Sadly neither appears to be the case under existing arrangements. While the advent of Income Support may have brought about more centralisation in funding arrangements, there is no clear evidence that this has improved people's ability either to understand or to access the benefits available for those in need of long term care. The comment quoted above surely points to a need for urgent action to put an end to unfair discrimination within the system.

8.2.5 New Directions

As demonstrated above, the draft Health and Social Services 'New Directions' policy document identifies numerous shortcomings and concerns about provision for elderly care in the Island. The Panel is broadly in favour of many of the arguments put forward in 'New Directions'; however, it has serious concerns that the scope of the policy document is so ambitious that it could easily take years to reach agreement on the inter-Departmental responsibilities and funding arrangements that will be needed before a global solution can be agreed. The

Panel's experience of delays over the last eighteen months seems to bear this out only too well.

Unfortunately, in the field of elderly care time is the resource in scarcest supply; promises to look at the situation next year, or the year after that offer no comfort at all to those whose elderly relatives need help now. In the initial stages of this review the Panel was contacted by a number of people willing to contribute evidence from their experiences; unfortunately even in the space of a few months some of these people suffered the loss of the elderly family member concerned. The Panel is strongly of the opinion that some of the more pressing problems relating to care of the elderly can and should be addressed as discrete and manageable issues in the short term, rather than being subsumed as part of the wider Health agenda with the attendant risk of being put on the back burner for a further period. In particular the Panel feels that a more appropriate and robust funding mechanism is needed to protect older members of our society, their children and relatives from unnecessary suffering and financial hardship.

9. Key Issues in Detail

9.1.1 Existing Provision in Jersey

The range of facilities associated with Long Term Care in the Island is fairly extensive, although as noted above there is a noticeable bias towards residential provision. In a broadly descending order of need or dependency facilities can be identified as follows:

- **Continuing care:** for patients with a long-term requirement for care in respect of physical or mental health needs arising from disability, accident or illness, this covers very high levels of dependency, including clients with severe dementia and challenging behaviour. Currently provided by the Health and Social Services Department, with a total of 77 beds split between Sandybrook and the Limes; the last remaining provision in this category at Overdale (McKinstry Ward) was recently closed

- **Nursing home care:** for clients needing a high level of social and/or nursing care, sometimes due to progressive or chronic illness. There are currently just over 200 nursing beds available for the elderly in the Island, most in private nursing homes although there is also some Parish provision in St Helier. Currently some 70 beds in private nursing homes are occupied by public sector patients under contractual arrangements established by the Health and Social Services Department, or 'spot-purchased' by the Department, examples being at Silver Springs, Palm Springs, Lakeside nursing homes

- **Residential Care 'topped–up' by the Health and Social Services Department:** examples of this would be residential care homes also catering for a number of residents with high-level needs such as severe cognitive impairment or dementia. Currently La Haule and Ronceray homes fall into this category

- **Residential Care funded by Social Security (or the Parishes):** this includes residential beds partly or wholly funded by Social Security for those on low incomes with high social care (but not medical) needs. Since the advent of Income Support, Parish involvement in the actual funding and administration has largely ceased, although some have residential homes which can offer places to people who have strong connections with the Parish (e.g. Maison St. Brelade)

- **Private self-paying residential care:** where individuals fund the full cost of their own residential care in a private care home

- **Sheltered housing:** usually refers to housing built specifically for the use of elderly people, which generally benefits from the support of a warden living on-site although this is not always the case; there are no set 'benchmark' standards or guidelines locally. There is a limited amount of sheltered housing in small developments in several Parishes with differing levels of support. The Island currently has no '**extra care'** developments, which would include facilities for a care team to be based on site

- **Home Care and Nursing:** this covers social care and community nursing services delivered in peoples' own homes. The majority of this work is carried out by Family Nursing and Home Care, who receive a grant of approximately £5.5m p.a. from Health and Social Services which covers some 75% of their costs, the remainder being raised from fees, charitable donations and fund-raiding activities[5]. A number of other private agencies also provide personal and domestic support to self-funding clients

[5] See Section 9.1.5 and appendices for details of FNHC services

- **Respite Care:** refers to temporary short-term stays in a residential home to allow family or other carers to take a break. There are currently only 7 respite beds available in Jersey

- **Day Care:** there are three day care centres run by the Health and Social Services Department, who also have links to other private day care facilities

In addition to these facilities dedicated to the elderly there is also a range of additional support available via Health and Social Services, for example consultants and support services in the areas of geriatrics, physiotherapy, and occupational therapy. There is also an intermediate care service based at Overdale which specialises in short-term rehabilitation for those recently discharged from acute hospital care, to prepare them for return home or a move into long tem care as appropriate.

Finally it is perhaps worth noting moves initiated by the Ministers for Planning and Environment and Housing to introduce a new category of housing for the Over 55s. This will involve new homes being constructed to 'Lifetime Homes' standards, which include access and other features suitable for those who may develop moderate care needs in later life, also allowing for the installation of further aids should they become necessary.

9.1.2 Supply and Demand

Levels of 'traditional' residential care in Jersey remain unusually high by comparison with the UK. In 1997 the Strettle report into Residential Care Provision for Older People in Jersey showed that the ratio of residential care places to the elderly population in Jersey was greater than anywhere in the UK. Calculations showed that the Island then had some 154 residential care beds per 1,000 members of the population over 75 years of age, compared with an average of 75 beds per 1000 for the whole of England. One suggested explanation for these high

levels was an early cultural acceptance of residential care in an Island community where the distances for relatives and friends to visit were short, while there was a prevalence of small hotels and guest houses suitable for conversion as a result of the decline in the tourist industry.

Although this high level of provision might appear on the face of it to be a good thing, best practice had already begun to reflect the importance of home care and supporting older people in the community, as opposed to the residential care model. This was recognised in the policies of the Health Department of the time, but despite this care home provision remains unusually high today. In 2007 there were around 850 people in local care homes (residential and nursing), which equated to approximately 140 people per 1000 population over the age of 75. This was considerably higher than the equivalent figure for the UK, of 85 residents per 1000 over 75. Possible reasons suggested by witnesses to the review for these continuing high numbers in residential care in Jersey were a declining emphasis on family ties, with higher numbers of people living alone, and a growing tendency for Jersey families to separate as younger members migrate to live and work in other countries. Greater wealth may also enable more people to self-fund than perhaps would be the case elsewhere.

9.1.3 Delivering the Required Care

(Extracts from the paper prepared for the Panel by its adviser, Professor Julien Forder; see Appendices:16.2)

There are a number of key processes undertaken by the long-term care system in delivering services and support to people with care needs. They determine how:

- people are referred;
- their needs are assessed;
- their care plans are determined;
- the required services and support are commissioned;
- services are provided;

- and how quality and standards are regulated.

The following (highly summarised) account describes the relevant processes in Jersey. Referrals to the long-term care system in Jersey come from the hospital, GPs and also self-referral to Social Services or directly to FNHC and private provider agencies. Where people present to the public system an assessment is undertaken. This can occur at a number of different points in the system, but a placement tool is available which acts as a template to standardise assessment outcomes. The placement tool rates the severity of people's needs in a range of categories including, nutrition, incontinence, medication, personal care, mobility, memory, depression/anxiety, challenging behaviour, pain, sensory impairment and a number of health conditions. A scoring algorithm and in some cases a case conference then determines a service need as one of the following:

- Supported home care;
- Residential care;
- High dependency residential care;
- High dependency mental health residential care;
- Nursing care;
- High dependency EMI (Elderly Mentally Infirm) nursing care;
- High dependency continuing nursing care.

Case managers are assigned to undertake this placement assessment and then manage the referral to final placement process. Departmental responsibility depends on which of the above service options is required. Most home care is managed by FNHC. As outlined above, FNHC is primarily funded through a grant from the States.

People needing residential care can apply to the Social Security Department (SSD) for means-tested public funding support, or refer themselves privately. In the former case, provisional eligibility for SSD support in residential care is predicated on the result of the placement tool analysis. If the tool indicates a residential care need, then the amount of financial help from Social Security is determined by the financial

means-test (details of this means-test are given in Section 4 of Professor Forder's paper). People can choose from the range of private, Parish and voluntary sector homes on Jersey outlined above. Fee rates differ between homes and are met by service users, drawing on SSD support where relevant.

As with residential care, people can either privately refer to nursing home care in an independent nursing home or approach the Health and Social Services Department (HSSD), where they are assessed as above. People qualifying for standard, EMI or continuing nursing care are then placed by HSSD in a public home (e.g. the Limes), a contracted out bed or a spot-purchased bed in a private nursing home. Placements in any of these settings are funded by HSSD although a means-tested accommodation charge is made to the resident. Some people will pay the full charge (just over £420 per week) and some will receive public funding to help pay this charge. At present there are 47 contracted beds i.e. where HSSD purchases the place for a period of time, and 30 spot purchased beds where the bed is purchased only while the named person remains a resident of the home.

Through choice or to avoid waiting lists, some people directly approach nursing homes rather than HSSD. In this case, they are liable for the whole fee, rather than just paying an accommodation charge.

HSSD manage (acute) hospital services as well as long-term nursing care placements. This contrasts with other systems (e.g. in England) where long-term care is primarily a social services responsibility and hospital care is a health (NHS) responsibility.

At present private and voluntary care homes are regulated by the Health Protection Department. Reforms are in train to extend inspection to cover non-residential care providers, including FNHC. The legislative basis for inspection is currently the 1984 Act. Providers receive two unannounced inspection visits per year. Inspection reports are shared with providers but are not publicly available.

9.1.4 Care in the Community

There are various reasons why institutional care is more widely considered as a less desirable option or as a last resort today. Not least amongst these is personal preference; it is generally accepted that older people would usually want to stay in their own homes for as long as they can and are able to manage. There are clear benefits to both the physical and mental well-being of individuals who are capable of being supported to stay in their own homes for longer, whereas institutional care can have a negative influence. The draft 'New Directions' policy document states:

'By its very definition, institutional care for older people can be profoundly disempowering, ambition-limiting and intrusive. For these reasons the option of high-cost institutional care must be the last option.'

'The underlying assumption must be that older people will live in their own homes, albeit with support if required.'

There are also clear-cut financial arguments in favour of this arrangement – at least to the state. The high costs of institutional care are a key driver behind policies to improve the availability of home and community care options; and the willingness of informal, unpaid carers to look after family members and friends undoubtedly saves government huge sums of money that can be used to provide other services. In 2007, Carers UK found that Britain's 6 million unpaid carers provided support worth £87 billion a year, outstripping the entire National Health Service budget of £82 billion for 2006-7. However, it was also found that UK carers lost an average of over £11,000 earnings per annum through giving up or reducing work commitments to look after relatives and friends. Considering their vital contribution it is open to question whether support available for local carers is sufficient; currently there is an Invalid Care Allowance available from Social Security to those who cannot work because they stay at home to care for someone who has a severe disability and requires a very high level of personal care, and the Income Support scheme also provides for a 'Carers' Component' for carers on low incomes, although both schemes are subject to conditions.

While informal care has a much reduced cost when compared with residential care, it is clear that increasing the amount of care available in the community will not be a low cost option when all necessary infrastructure is taken into account. A whole range of new or extended services will be needed to support larger numbers of elderly people remaining in the community, whether living in their own homes or moving into accommodation dedicated to the elderly. The Panel found that many of the services currently provided by voluntary or charitable organisations were already under considerable pressure, partly as a result of smaller numbers coming forward to offer their time; younger people often had too many commitments to work and family to be able to volunteer many hours, and so frequently those helping the elderly would be past retirement age themselves. Increased living and fuel costs were also having an impact on the ability of people to offer free help, for example with delivering frozen meals, or assisting with transport to day centres or other activities.

9.1.5 Family Nursing and Home Care

In terms of home care funded by the States, it is interesting to note that the vast majority of this is provided not directly by the Health and Social Services Department, as might be expected, but by Family Nursing and Home Care (Jersey) Inc. (FNHC), a charitable organisation which receives around 75% of its funding in the form of a £5.8m grant from the States, with another £2m coming from the membership fees of some 7,000 members, charges for home care and medical supplies, donations and fund-raising. FNHC works in the areas of district nursing, professional therapy and child and family services, employs 260 staff and delivers health and social care services from birth to end of life. In 2007 they provided home care services to some 2,200 older people, with a total number of around 110,000 home visits, or approximately one visit per client per week on average. Care offered can be divided into three types:

- Level 1 - Practical and Domestic Care (951 recipients in 2007)
- Level 2 - Personal Care (1063)
- Twilight Care (224)

Most of FNHC's home care work for the elderly focuses on caring for people with moderate personal care needs; Twilight Care (personal care and nursing including helping people to bed) and Level 2 Personal Care address those with somewhat higher needs. Referrals can come from GPs, hospital and direct from users. However, there is currently no service available for those needing intensive home care, requiring three or more visits per day, despite the fact that there is an increasing number of patients with more complex needs. There are smaller private agencies also offering home care and nursing services, but FNHC has the lion's share of the market.

A Public Hearing with FNHC representatives indicated that they see increasing flexibility and choice for users of the service as a priority for the future, but are constrained by current funding levels and thus unable to expand on what they can offer at present; for example they are limited in their ability to carry out home visits at times to suit the individual, something raised by other witnesses to the review in their comments. Several mentioned that it was not really acceptable that some of those receiving care at home would have to eat an evening meal and be put to bed much earlier than they would like, simply to fit in with the visitors' need to complete their 'rounds'; it was reported that some people found themselves obliged to 'top up' FNHC services with additional help to ensure a degree of flexibility. Panel members also heard some criticism of the level of charges applied to services, although these are in fact very heavily subsidised, as outlined in an explanatory e-mail received from FNHC:

'There are 2 types of Home Care services currently offered:

Domestic Support service - daytime - Monday - Friday (no BH's or W/E's)

Personal Care service - morning and evenings everyday but with a much reduced service at W/E's and BH's

Charges to clients are worked out on a banding system and are per week as follows:

Band A - 0-3hrs per week - £13.20

Band B - 3-8hrs per week - £23.75

Band C - 8-21hrs per week - £29.05

One of the main benefits for the clients accessing FN&HC services is that the charges are heavily subsidised by the charity. Most care agencies would charge in excess of £13 per hour, often with a 2hr minimum call out fee. For a client receiving the maximum 21hrs of care from FN&HC they are currently paying the equivalent of £1.39per hour.

All clients receiving the Domestic Support service fall into the Band A category as we are currently unable to provide more than 3 hours service per person for this part of the service and often have to hold a waiting list.

All clients accessing Home Care services receive an assessment by a registered nurse. Following the assessment, care assistants are allocated to address the need of the person (if we have the capacity to do so). For people with more complex care needs, FN&HC often work in partnership with family members, other carers or care agencies. For people requiring more care than FN&HC can provide, it falls to the District Nurses / Social Workers to negotiate how any unaddressed needs are to be met.

Membership of FN&HC is required for both parts of the service. The current rates per person are £45 if no immediate care is required and £65 if care is required within the first 3 months of joining the organisation.

We currently have a caseload of 575 clients; just under half are receiving the Domestic Support service, 96 clients are receiving both parts of the service and the remainder the Personal Care service.

The majority of clients fall into the Band A category, i.e. receive up to 3 hrs of either personal care or domestic support each week.'

In their submission to the Panel FNHC highlighted several areas of potential concern for the future in respect of care for the elderly, including:

- increasing numbers of dependent clients, particularly those with some form of dementia[6]
- difficulties in obtaining mental health assessments
- the difficulties of managing clients with acute confusion in their own homes
- limited availability of respite care – a need for step-up beds for short term respite and intermediate care beds
- the need for a handyman service to assist with home adaptations

Significantly they also identified a requirement for patient choice to be incorporated in funding arrangements for long term care. Increasingly in the UK and elsewhere there are opportunities for funding to 'follow the client' and allow choice in where the care is delivered after assessment – either in a care or nursing home setting, at home, or even by way of cash payments to the individual which can then be used as desired. Under the long term care insurance scheme in Guernsey, if a person is assessed to have care needs the funding is attached to a placement in a residential or nursing home; there is presently no flexibility to support care at home. This is felt to be a priority in considering any new scheme in Jersey.

There is currently no service level agreement (SLA) with the Health and Social Services Department, although this is under discussion for the future. Family Nursing and Home Care believe that they are presently under-funded to the tune of some £600,000 per annum for the core services they deliver, and an SLA would help to clarify the services to be delivered by the Island and those which would be paid for by clients or FNHC's charitable status. A key issue for the organisation of the whole system was seen to be the commissioning of services, which FNHC indicated needs to change in the interests of both fairness and efficiency:

'Jersey needs to address commissioning of services, especially in the Health and Social Care arena. The Health and Social Services Committee is a

[6] See Section 9.1.7

commissioner, regulator and provider, which blurs boundaries re governance issues and also affects any lobbying by Third Sector Providers.

Involvement of Third Sector organisations in Strategic Planning requires improvement to prevent duplication between public and private organisations. A commissionary body requires development that has transparency and also addresses issues of tendering processes.'[7]

This was felt to be a prerequisite for any positive change in the system. Moves towards extending regulation to home care services were felt to offer benefits to the client, but this would require the commissioning and provision of services to be separated from the regulatory body.

Dr Mike Richardson (Consultant Physician for Health and Social Services with responsibility for the elderly) commented on the practical difficulty of providing adequate care in the community[8]:

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

[7] See Family Nursing and Home Care Response 28th July 2008 (Appendices: 16.1)
[8] Public Hearing with Health Officers and Consultants, 29th July 2008

nursing home environment which is far more cost effective but not easily available for people and we are certainly capped in terms of finances, in terms of what we can offer patients."

It seems clear that with existing resources there are relatively tight constraints on what can be achieved by FNHC in caring for the elderly at home; if more extensive provision of care in the community is agreed as the way forward this will only be achieved through significant increases in public funding, whether applied to FNHC, other agencies, or to create additional services within the public sector. Effective service level agreements and a new approach to commissioning and regulation would appear to be essential as part of any package to extend home care.

9.1.6 Respite Care

One area causing particular concern to the Panel is that of respite care. This is care provided on a temporary basis to enable regular informal carers the opportunity to take a break from their caring responsibilities. The physical and mental stress of looking after others can put enormous pressure on the carer, whose own health and well-being can easily be affected. Respite can provide the opportunity for regular carers to 'recharge their batteries', look after personal business, recover from illness, or take a much-needed holiday. Given the number of people caring for others either full- or part-time within the Island it came as a shock to Panel members to discover that there were only seven dedicated respite beds available in the Island, all in private care homes. This was felt to be inadequate to meet community needs. It is considered that the provision of additional respite beds could in some cases prevent demands for permanent long term care arising where carers find themselves unable to cope without a break; and would provide much-needed opportunities for others to rest and recover from the strain of extended caring responsibilities. Alternative short-term respite services were also felt to be lacking, although it is expected that the forthcoming 'Carers' Strategy' will address this matter in more detail.

Work began on a Carers Strategy for Jersey following the recommendation of the 'Review of Respite for Carers' commissioned in 2007; the draft strategy is expected to be complete by the end of 2008, although details were not available at the time of writing of this report. The initial review of respite highlighted that there were huge variations in the recognition of carers' needs and the support they receive across the States which needed to be addressed. Estimates suggested that there were about 10,000 carers in Jersey, with approximately one in seven members of the population having some caring responsibilities, although it is recognised that many of these will not necessarily involve caring for the elderly. However, improving services to meet carers' needs could significantly improve the efficiency and cost effectiveness of public provision; whereas there was evidence that without adequate support, carers frequently suffered higher rates of illness, stress and depression than members of the general population. The review gave reasons for this:

'Evidence shows that the causes of ill-health among carers are based on the following factors:

- ***Lack of information - timely information is very valuable to carers but many are unaware of the respite and financial support available to them. Access to information is even more problematic for those living in rural areas and for those from minority ethnic groups.***
- ***Inadequate support - carers can be on call 24 hours a day, constantly worried about the person they care for and tasked with physically demanding work such as moving and lifting to bathe and dress. If carers do not get an adequate break, their mental well-being is greatly affected. Current support arrangements are not considered fit for purpose by most carers***
- ***Isolation - the time devoted to caring means less time for socialising and many carers have to give up work. They can find themselves increasingly isolated under their new duties***
- ***Financial burden - one in five carers have to give up work to take on their caring role and often find it increasingly difficult to manage financially. Money worries account for some of the stress experienced by carers***

For the Health and Social Services Department the cost of carers' ill-health is potentially substantial both in terms of treating the carer and, should the carer reach the need for inpatient care, having to pick up the care of the person they look after.'

The review of respite concluded that there was a lack of provision and that a wider range of respite services was needed, including alternative provision such as domiciliary, day and emergency respite in addition to residential respite beds. Various forms of respite care were defined as follows:

'

1. ***Domiciliary respite:***

Someone comes into the cared-for person's home and takes over care for a while (a few hours or, sometimes, overnight) so the carer can go out or have some time to themselves. This is sometimes referred to as a sitting service.

2. ***Day respite:***

Carers can sometimes get a break when the cared-for person is involved in other activities – for instance at school, at a Day Centre.

3. ***Residential respite:***

The cared-for person goes away to be looked after by someone else for a short period in residential or nursing respite care.

4. ***Emergency respite:***

Required when the carer is taken ill suddenly or when they may be called away at short notice.'

From evidence received during its review the Panel believes that significant improvements to respite care provision are overdue, and will be essential if care in the community is expected to have a greatly increased role in the future.

9.1.7 Dementia Care

One problem closely associated with greater life expectancy is the growing incidence of severe cognitive impairment. This is generally linked with increasing age, rather than ill-health or physical impairment. There is a growing understanding of the characteristics of specific conditions such as Alzheimer's disease and vascular dementia, although as yet no cure has been found for these often distressing and debilitating conditions. Looking after people suffering from advanced dementia or cognitive impairment almost invariably implies a very high level of care, as sufferers will usually have complex needs. A hearing with Mr Mike Tomkinson of the local branch of the Alzheimers' Society[9] referred to the need for early diagnosis of the disease and for extra training to be available to help General Practitioners and nurses correctly identify the symptoms. It was also felt that a lack of funding and resources for specialist services meant that Health and Social Services were failing to provide the support needed to help people in the community with dementia:

"I think there is real evidence of failure to provide service. I think what happens is, and I think the same happens with family nursing and home care, is if you do not get an increase in staff, but are having more to deal with, the people who would need the service get less. It is the only way you can cope, and I think that is what has happened. To some extent they are getting very little if they have got dementia and they are more or less going straight in to private care. They are bypassing the Health and Social Services system and going straight into private care, and that seems awfully wrong. You know, this is an illness. We are supposed to provide support for it."

Mr Tomkinson believed that over 1,000 people in the Island suffer from some form of dementia problem, but many of these cases were not known to the Alzheimer's Society or to their own GPs. The scale of the problem in the Island was thought to be growing in line with the ageing population. In another hearing[10] Dr Lesley

[9] Mr Mike Tomkinson: Public Hearing 30th July 2008
[10] Public Hearing with Health Officers and Consultants, 29th July 2008

Wilson, (Consultant Old Age Psychiatrist for Health and Social Services) warned that the Island is not keeping up with existing demand for assessment:

"Which brings me to people with dementia, which is the big scary one because as the total number … as the proportion of the population who are senior citizens, and some of them are very elderly, goes up the number of people with dementia that we are going to be looking after is going to go up…"

"This is not something that is going to happen in 10 years' time. This is something that is happening now. Our patients are stacked up in the community and in the general hospital who need to come to one of my assessment beds and they cannot."

She also drew attention to the problem of finding private places for patients with dementia and more challenging or socially unacceptable behaviour. While prepared to look at all possibilities for residential care if a patient reached the stage where they could not safely have their needs met in the community, in more difficult cases such placements do not always work. Often such patients would eventually need a place in a specialist unit such as Rosewood House, St Saviour. The cost of private care was also a factor:

"… most of my patients who need a long-term nursing bed cannot fund it themselves and very few people can fund long-term nursing beds themselves. The independent sector is very, very expensive and they will end up in one of my 52 long-stay beds."

Some of the key requirements of successful dementia care have been described by the Panel's adviser as follows:

1) continuity in care staff, so that the person with dementia is not unsettled by regular changes in domiciliary care staff
2) staff with specific training in dementia care

3) an emphasis on maintaining physical health, despite the mental deterioration
4) high-quality day care centres for leisure and social contact
5) 'memory clinics' – effectively a 'one-stop-shop' offering assessment, diagnosis, support and counselling, information, monitoring of treatment, and education and training
6) regular respite care as part of a package of measures to relieve the burden on informal carers

The Panel found during the course of its review that amongst these basic requirements, continuity and training of staff did not always meet the ideal looked for by relatives, while increased provision of respite care has been identified as a priority in its recommendations. It was also concerned to learn that of the 52 long-stay beds at Rosewood House only 12 were in single rooms, with 8 in 2-bed rooms 32 in 4-bed rooms. Members were reminded of earlier criticism of the lack of privacy and personal dignity at the old McKinstry ward at Overdale (since closed), and question whether multiple occupancy of rooms can be considered an acceptable standard for long-stay patients today, whatever their needs.

10. Regulation and Governance

10.1.1 Legal Framework

Historically the situation regarding regulation and governance of long term care provision in Jersey has been somewhat undermined by the fact that the existing laws applying to health and social care in Jersey specifically exempt Health and Social Services and other States-operated facilities and services. In addition, agencies providing staff to give personal (as opposed to nursing) care to older people in their own homes are not covered by legislation at all.

This situation is clearly far from ideal, particularly where the regulator – Health and Social Services - has also been acting as a commissioning body and provider. A consultation paper[11] issued by Health Protection in November 2007 acknowledged that the legislation underpinning care home and domiciliary care regulation in Jersey was no longer fit for purpose. The Panel was therefore pleased to learn that it was proposed to extend regulation and inspection to all public and private providers of both care homes and home care.

The proposed extension of regulation to all providers is welcomed as a means of ensuring that standards of care will be adequate, wherever the care may be delivered. It is understood that an additional benefit of new legislation could be the opportunity to make the results of inspections available to the public, so that people could see for themselves what standards were achieved in different establishments and use the results to inform choices, as is already the case in the UK; this is not possible under existing legislation. The consultation document stated that the primary purpose of a new Regulation of Care Law would be:

'to present legislation that facilitates best practice and is fit for purpose by producing an equitable, comprehensive and consistent regulatory framework for a range of health and social care provision. This will ensure that those working with vulnerable people have appropriate skills and expertise to be

[11] Regulation of Care (Jersey) Law 200- Stakeholder Consultation November 2007

safe practitioners. It will ensure that there are clear, where necessary enforceable standards based on the needs of those using the services, and in so doing it will be consistent with the States of Jersey's role in ensuring the health, safety and the protection of well being of the population.'

It has been suggested that a practical approach to monitoring standards could eventually involve a 'lighter touch' for providers who demonstrate a consistently high level of performance, perhaps even enabling inspection 'holidays' for those demonstrating best practice. This would seem to be worthy of consideration, to ensure that the inspection team could concentrate resources where they were most needed; although Christine Blackwood, (Registration Manager for Health and Social Services) pointed out that it would first require some time – perhaps up to five years of operation - to establish a 'baseline' of performance against the new standards before such decisions could be made[12]. The Panel is of the opinion that inspection should increasingly be focused on service user outcomes; it is hoped that if some older care homes initially had difficulty in meeting new guidelines owing to space or access constraints, for example, that some flexibility might be possible in the short term to allow time for them to adapt their premises, provided that safety was not compromised and the care delivered was considered to be of a sufficiently high standard. However, it is acknowledged that for regulatory purposes there must be recognisable standards that are applicable to all.

Another aspect of regulation touched upon the issue of contracts for care. As Christine Blackwood explained:

'There is no requirement within the law to have a contract, which I think is again something we would probably want to put in any new legislation. Certainly for a long time, I have been suggesting it is good practice for care homes to have a contract that specifies what the fee is and what people can expect for the fee, and most places have it but not all and we cannot enforce that. In terms of what homes charge, that is entirely up to them. If they want to charge £2,000 a week, then there is nothing that the regulator can do about

[12] Public Hearing with H&SS Department (Regulation and Governance) 30th July 2008

that and their charges do vary, they vary quite considerably. I think it gets difficult if we, as a regulator, would be setting how much people should pay. I am not sure how that would work.'

The Panel agrees that contracts setting out exactly what the client can expect to receive from a care home are very important, particularly in circumstances where the person receiving the care may be confused or vulnerable and family members or friends may not have any independent means of verifying exactly what level of care has been paid for. It is also common for an individual's care needs to increase over time, and proper contracts would provide a transparent means of identifying any increased costs incurred for additional support required.

With regard to the cost issue, members believe that there is a need for some form of price monitoring to ensure that prices do not spiral out of control, particularly in a market that is now dominated by private providers. Whether this should be a role for the regulator is open to question. However, it was noted during the Panel's visit to Guernsey that their Social Security Department has access to the financial accounts of care providers in the Island, which it uses to help ensure that levels of support under its Long Term Care Insurance Scheme are set appropriately. It was felt that this could be a useful tool for Jersey's Social Security Department in setting its own benefit levels in future, especially as the effect of taking a range of pre-existing Parish agreements into Income Support gradually diminishes and the Department is able to establish a more consistent pricing policy with providers for new applicants.

10.1.2 Staff Issues

One matter of particular concern to Panel was discovered at this Public Hearing with Health and Social Services: the fact that currently, staff working in independent residential and nursing homes cannot be police-checked.[13] This was recognised as being an unacceptable situation and will need to be addressed as a priority under

[13] Public Hearing with H&SS Department (Regulation and Governance) 30th July 2008

new legislation. However, there remain other practical problems in respect of checks on prospective staff members; it was noted that at present health care workers, care assistants and support workers are not regulated in the U.K., although there is an intention that this will be addressed in due course. It also seems unlikely that reliable checks on workers from abroad will be possible in the foreseeable future; however it seems inevitable that Jersey will continue to rely heavily on other countries for recruitment of new care staff. This also raised some concerns about possible language issues for support workers whose first language was not English; it was noted that this could sometimes cause difficulties for those undergoing training, where reading and writing skills in English might be more relevant, but generally the level of spoken English was not considered to be a problem.

Given the potential vulnerability of frail elderly people in need of care there seems to be a worrying lack of control at present over exactly who is working with them, potentially placing a great responsibility on employers who have no better access to information. For this reason it is considered that rather than waiting for new regulation to come into force in the UK it may be appropriate to consider whether extending local requirements for registration to include all those who work in the area of social care would be of benefit. Although this may seem a large and potentially intrusive undertaking it is understood that the only check on unregistered staff moving from one care home employer to another at present is by way of an unofficial network of contacts between managers, which would not seem likely to stand up well to outside scrutiny in the event of serious problems occurring at some point in the future.

During the same Hearing the Minister for Health raised the question of the cost of regulation, and whether this could be more fairly applied across the care sector:

'At the moment, I believe we just charge a flat fee so you pay a flat fee whether you are a 4-bed nursing home or whether you are a multi-national. I think, certainly politically, we have to look at the whole funding aspect of

regulation to see whether the industry should, in fact, pay to be regulated because, at the moment, it is coming out of the taxpayers' budget.'

The Panel agrees that such an approach would fit the 'user pays' principle and could go some way towards offsetting the cost of the implementation and monitoring of new legislation and standards in due course.

Another concern voiced to the Panel by several care home managers during the course of the review reflected difficulties encountered in keeping care staff once they have begun employment in the Island. There was a somewhat uneven playing field in terms of wages, benefits and training available across the range of public, Parish and private care establishments and agencies which made it hard for some of the smaller homes in particular to retain staff, who were often tempted to move on to obtain better opportunities elsewhere; public sector pay tended to be better than smaller private homes could afford to offer. Asked about recruitment and training of staff in the Island, Carol Keenan, Manager of Ronceray Retirement Home[14] replied:

'… training is a big issue, but as I have said, both Mary [Mary Byrne, Deputy Manager] and I are N.V.Q. assessors. I am in the process of doing an internal verifiers award so that we can assess and verify a small group of homes, like ourselves, Pinewood, Little Sisters have formed a little group so we can do it for nothing, basically. But that means that the likes of Mary, I, other assessors and verifiers are putting in 80 and 100 hours a week in order to train staff at virtually zero cost. Because if you use the hospital system you are talking nearly £3,000 per candidate and you get them trained and then they are poached. So this way we have to put the time in but then we get the candidate at the end of it, so training is a big, big cost.'

While this concern to some extent reflects mobility in the wider employment market it was noted that continuity of care was a particular issue for the elderly; an

[14] Public Hearing with Ronceray Retirement Home, 27th June 2008

affordable regular programme of training with opportunities for staff from both private and public sectors to participate and obtain recognition for their skills was seen as very important, particularly in a field where the complexity of the client's needs tends to increase with age. It was noted that the States had supported grants for training in some areas in the past, repayable if the beneficiary left employment within a certain period; the Panel felt that this idea was worth revisiting, particularly given the anticipated increase in the ageing population. The emphasis on training highlighted the level of skills required in dealing with patients having some degree of dementia:

'…over the years it has become more dementia care, to the point where I have undertaken a degree in order to register it [Ronceray Retirement Home] at the end of this year as an E.M.I. (Elderly Mentally Infirm) unit because I would say that 95 per cent of our residents have some degree of cognitive impairment, and therefore we need to ensure that we provide dementia care to a high standard, so we have taken up the staff training and everything to gear ourselves up to re-register under a different umbrella, as it were.'

While many other homes have not elected to take up the challenging role of specialist dementia care it seems likely that in future there will be significant increases in the need for this sort of provision, which would imply a wider need to raise the skill levels of care assistants to meet the demand; it was also felt that better training opportunities generally increased the quality of care on offer, although this was balanced with a need for experience. One home manager indicated that she would not feel able to take on a newly-qualified staff nurse without experience, pointing to a demand for new entrants coming in from elsewhere with the requisite skills. Wider opportunities for on-the-job training and mentoring arrangements coupled with a States-supported programme to enable people already working in the industry to up-rate their skills could help to reduce the reliance on imported labour in future.

The Panel was pleased to hear from a number of witnesses who complimented the Health Protection inspection team on offering good advice, being proactive and

keeping them informed in respect of new developments and training opportunities. There appeared to be a positive relationship based on a deliberate policy of education for improvement:

Deputy R.G. Le Hérissier:

'… did you come to a point where, having inspected all these homes, you have clearly come to some conclusions about the level of care and the general mix of care available in Jersey and do you feed all this information into the system at some point?

Ms. C. Blackwood:

We feed it back to the managers and the owners and we do try to work with providers rather than being heavy-handed in enforcement. I would see enforcement as the last resort and we would look to try and encourage people and assist them. One of the things our department does is training for staff. We have an annual training programme that is a partnership with the sector and Health and Social Services so we have social workers, we have care home managers and our department organises a monthly training update for staff.

Mr. S. Smith:

Health Protection Services as a whole has a policy with regard to how we deal with the regulatory aspects of the service and it is called Inspecting for Improvement and we have this scenario of discussion, education and improvement. Enforcement of any aspect really is a last resort. We are looking to engage very strongly with businesses to ensure that they understand what it is that they have to do, that we assist them in trying to get where they need to be and to make sure that that happens.'

The Panel hopes that the proposed new regulatory framework embracing all public and private provision will also support enhanced training opportunities backed by States funding, as it believes that appropriate training is vital to maintaining the

highest standards across the range of private, Parish and public sector organisations offering care for the elderly. While the overall impression obtained by members and the Panel's adviser from visits and meetings during the course of the review was that Jersey can be proud of the standards maintained by many of its care homes and the obvious dedication of their staff, members did become aware of a number of instances where individual patients in both public and private care homes had reported unsatisfactory experiences regarding their own or relatives' care. Some of these were already the subject of specific complaints, and it is not the role of Scrutiny to deal with individual cases. However, the Panel was sufficiently concerned at information received in two instances that contact was made with the Health and Social Services Department to enable it to investigate further. Clearly there can be no room for complacency where the care of potentially vulnerable members of society is at stake, and members took some reassurance from the fact that the response from the Department was immediate and at the highest level. Extending regulation to all providers is seen as a necessary step towards ensuring that potential difficulties can be identified and corrected in future before any serious problems ensue.

11. Alternative models

Essentially a distinction can be made between delivery systems and funding models for long term care, although the two are of course related. Internationally a number of different funding models have been implemented in recent years to attempt to improve or modify the delivery of care. Notably both Germany and Japan have introduced new long term care insurance-based systems in the last twenty years; the extent to which they differ reflects different starting points, as well as differing cultural and social attitudes.

Germany

Germany brought in a mandatory insurance scheme for long term care in early 1995, prior to which long term care was not considered a public responsibility. Part of the reason for this was that under German law, children were responsible for supporting their parents in old age, insofar as they were financially capable. Support for institutional care was introduced under the scheme in 1996.

The main objectives of the new insurance were:

- To support and encourage care provided at home by relatives or neighbours, so clients could stay in their own homes for as long as possible. Institutional care was only to be provided when care at home was regarded as impracticable
- To reduce the risk of developing dependence on income support for long term care needs. (Income support needs had increased considerably amongst patients of nursing homes, partly as a result of the German pension system not making allowance for incomplete contribution records)
- To develop an effective standardised care infrastructure able to provide care in the community as well as in an institutional setting, with a view to reducing the need for hospital beds for elderly patients

Some characteristics of the system are of particular interest. For example, employers and employees pay the same percentage of salary. The level was

originally set at 1% of gross income, but subsequently nearly doubled; retired people also contribute. Employees with an income above a certain level are allowed to opt out provided they take out a private insurance instead. The LTC insurance also covers family members, who are included without the need for extra contributions to be paid. For people dependent on income support, the local authority concerned can choose between paying contributions for the individuals concerned, or take the risk of having to pay for their care.

One of the most striking features of the scheme is that families are encouraged to take benefits in the form of cash, as an incentive to reduce the costs of formal care provision; the cash benefit is paid at a much reduced rate, but it is understood that over 70% of clients choose this option rather than opting for formal care.

Japan

Japan adopted a ten-year strategy for long-term care in 1989. The aim was for expansion of nursing homes as well as home and day-care services. Following its introduction the country experienced rapid growth in the formal care sector, but also in costs. A mandatory long-term care insurance system was devised and introduced in April 2000 that moved the responsibility for long-term care from families to the state.

The insurance is funded 50% from taxes and 50% from insurance premiums. Premiums are collected from people aged 40 years and over, and all family members are automatically covered. For those in the working population, the premium originally amounted to 0.6 % of income, shared between the worker and the employer.

For the elderly, income-related premiums are deducted from pensions at different levels. A co-payment is required from individuals, and amounts to 10% of care costs. Eligibility for benefits is solely based on need; the financial position and family structure of the insured are not taken into account. The insurance covers institutional as well as home-based care, and all clients except the least needy may

choose between them. Short-term stays in institutions as well as grants for home rebuilding may also be available. However, unlike the German system there are no cash benefits available as an alternative.

The Japanese LTC insurance is mainly designed for the elderly, so people aged between 40 and 65 are only entitled if they suffer from age-related diseases (e. g. Alzheimer's). A key feature of the system as first introduced was that the insurance contributions were only collected from those aged 40 and over in the working population, and retired people. The rest of the population were only affected by the taxes raised to finance the remaining 50% of the cost.

England

Inevitably the complexity of large national systems can only be hinted at here, but it can be seen that there have been big changes particularly in the home care sector in recent years. Over the last decade there has been a significant increase in the total hours of home care provided in England. Between 1998 and 2007 the number of hours of council-funded home care increased by nearly 50%; however, the overall number of households supported fell as the hours were increasingly targeted at people with higher levels of dependency. This contrasts somewhat with the current Jersey situation, where information received from Family Nursing and Home Care suggests that there is a slightly higher level of visits than in England for those with low dependency levels, but significantly less support is available for those needing intensive home care. FNHC indicated that they were aware of a demand for more intensive support services but were constrained by lack of resources.

Another area in which Jersey appears to be lagging somewhat behind England is in the provision of sheltered housing, particularly developments with 'extra-care' features which may include leisure facilities, communal lounges, cafés, laundries and support functions including wardens, maintenance and on-site medical suites. While this sort of development is not cheap to build or to run, in England housing benefit is available to meet the basic rent, and social services funding is used to meet the care costs. The costs of support and communal facilities can be met by

the user, from a central funding initiative called 'Supporting People', or from various housing related benefits. 'Supporting People' has been instrumental in a number of publicly-funded extra-care schemes, including one visited by the Panel during the course of this review[15], and provides funding additional to the housing and care components.

'Extra-care' housing schemes in England come in many shapes and sizes, from small apartment blocks to full-scale 'care villages'. Some of the latter developments enable residents initially to move into a flat or bungalow designed for independent living, but with the reassurance that there are medical and other facilities on site if needed. Should their care needs increase over time there are opportunities to move into more supported accommodation or obtain nursing care within the same development, thus minimising the stress of moving into a completely new environment. Tenure models can include market or social rent, full purchase and shared ownership units and in many cases, a mixture of these arrangements. Research has suggested a need to consider the 'social mix' of such developments carefully at the planning stage. It is believed that shared ownership options could be an important feature for Jersey, as they would allow people to 'downsize' and release some equity but also maintain a capital stake in the property.

[15] See Section 15: Fact-Finding Visits and Appendices re: Darwin Court

12. New Directions

As noted above, the current review was originally intended to provide a detailed focus on one area of the over-arching Health and Social Services draft New Directions policy proposals, which would themselves have been the subject of a broader study. Given the postponed launch of the New Directions consultation it was not felt appropriate to pursue detailed discussion of the full range of proposals in this report, although it could be argued that many of the issues arising from the current study are linked to the broad principles underpinning New Directions. For this reason a number of illustrative quotations from the draft policy document have been included in this report and a brief explanation of the most relevant issues follows.

New Directions essentially proposes a radical restructuring of the Island's health and social care system. This is seen as vital by the Department to ensure that States of Jersey health spending is put on a sustainable footing for the future. Put in the simplest terms it focuses on three major issues:

1. lifestyle changes to ensure that more people enjoy better and more prolonged good health throughout their lives
2. better education and support services targeted on the reduction of chronic disease in society, enabling people to manage their own health more successfully
3. enabling people to live a healthier and more independent life into old age, followed by a short period of illness and decline into a 'good death'

Clearly the parts seen as most relevant to the current report are those proposals specifically aimed at achieving improvements for care of the elderly. Chapter 4 of the policy is entitled ***'Adding years to life, adding life to years'*** and is summarised as:

'An analysis of the challenges that lie ahead, as structural shifts in the demographic profile of the population in Jersey occur. It proposes a programme of measures which is informed by full engagement and by the need to take risk-based decisions as to where older people are best supported and cared for, the default position being support and care in the older person's own home.' (Emphasis added.)

As many of the reasons why this 'default position' is considered to be the right one have already been considered in detail above it is not felt necessary to rehearse these again. However, New Directions does offer extra insights into care of the elderly. Referring to the high level of institutionalisation of older people in Jersey (outlined in section 6.1.2 above), New Directions puts the blame for this largely on the absence of desirable low-cost alternatives, indicating that the range of primary and community care services is presently insufficient to provide viable and safe options. The increasing costs of supporting older people in institutional care are putting pressure on the resources remaining to pay for services for other age groups, while FNHC has to prioritise from within a growing list of dependent clients needing care at home. The conclusion reached is that further incremental and piecemeal development of the present system is not a solution:

'The need for a profound paradigm shift in how care for older people should best be provided and funded in the 21st century is the key challenge. When the current care and funding regime is examined from this standpoint the deficiencies, anomalies and contradictions are all too apparent. Because of these flaws the current system represents, at best, rough justice for some - at worst, it is inequitable and unjust.'

It is recognised that because of the demographic situation there will still be an increasing need for high-quality institutional care for those with high dependency (owing to debilitating physical and mental conditions) in the future. However, the aim would be to balance this with a significant increase in the number of people able to stay in their own homes for longer, encouraged by healthier lifestyles and supported where necessary by new initiatives (such as the 'Lifetime Homes'

mentioned above to facilitate home adaptations) and targeted support. It is noted that the benefits of living independently at home for longer will need to be weighed against the potential risks to more frail elderly people, who will often be living alone. One point of particular interest is the effect of gender differences on long term care planning. At the time of the 2001 Census, 52% of women aged 80-84 were living alone, compared with only 23% of men. Because women are expected to live on average five years longer than men (and frequently marry slightly younger) the probability is that increasing numbers of older women will be living alone in years to come, which needs to be taken into account when designing services to suit their needs. New Directions cites as an example the increasing popularity of 'handyman' schemes in the UK, where assistance with simple home maintenance tasks is supported by some local councils, often provided by newly retired residents on a voluntary or part-time paid basis. Although some might justifiably consider the concept to be based on rather old-fashioned stereotypes, such relatively inexpensive schemes could have additional benefits to the elderly of either sex, as better maintained homes may reduce the number of minor accidents that can lead to an older person losing their independence, while having someone to call on could also provide a measure of social contact and reassurance for those living alone.

New Directions highlights the need for changes to the current system of funding long term care for the elderly. 'Anomalies and inequities' identified under the current system of means-testing have been mentioned above (Section 8.2.4). The system penalises those who have been prudent, but protects those who have either been unable or have chosen not to save against the full cost of exactly the same care. This in itself may or may not be considered sufficient reason for change; however in the context of New Directions the need for a more equitable and transparent system where funding is flexible enough to respond to the client's individual needs becomes very apparent. Current arrangements to pay for residential and nursing care not only show a lack of cohesion, but also are primarily geared to cope with the cost of traditional institutional placements. The Health and Social Services Department acknowledges in New Directions that supporting elderly people to stay in their own homes for longer will require fundamental

changes to both services and funding arrangements, and makes the following proposals (paraphrased for brevity):

- **new primary and community care services to be created to support older people, and those with long-term conditions requiring care and support, to live independent lives in their own homes**

(It is noted that this may involve the expansion of existing services such as the Community Alarm Scheme and FNHC home care services.)

- **services to promote active living and greater engagement with society**

(These could include self-help groups, fitness programmes and voluntary service.)

- **a single assessment process (SAP) for the assessment of health, social and material needs**

(This would build on existing partnership-working between the Parishes, Health and Social Services and Social Security, based on a robust assessment, monitoring and review process.)

- **the transfer of all Health and Social Services budgets funding accommodation charges for institutional care placements to Social Security**

- **a new funding mechanism to manage the growing health and welfare needs of an ageing population which must fund not only the residential care sector, but also community-based care so that older people can remain in their own homes for as long as is appropriate**

- **the funding mechanism to be based on a social insurance model, which would move the risk of high cost payments from the individual to the general population**

- **a 'fee and dependency' structure to be agreed with the private institutional health care sector, updated on an annual basis**

- **a 'capacity model' identifying how much sheltered housing and institutional care accommodation will be required over the next twenty years to be developed**

- **All future policy proposals put forward by the States of Jersey to be subject to 'an impact on the agenda of ageing' test to ensure that policy takes account of demographic change**

Potential risks identified by the Department include the danger that demand for new services created could outstrip supply, and that placements in nursing and residential care could in fact increase if professional advice and assessment became too 'risk averse' – the opposite result to that intended.

Accepting that there will be a need to guard against these possible negative outcomes the Panel fully endorses the Department's proposals for the future of long term care of the elderly.

13. Changes to date: Income Support

'Until very recently, the public funding of older people's institutional care was drawn from three sources – the Parishes, HSSD and the SSD. The funding of a placement in the institutional sector was not based on rational criteria – simply on what 'felt right' or what appeared opportunistically to be a good deal at any one time. It has been quite possible to pay a higher fee to a private sector home for a low dependency older person – because there was pressure to free up an acute hospital bed; and it has been quite possible to pay a low fee to a private sector home for a high dependency older person – because the home wanted to fill the vacant bed.'

(New Directions 4.7 - Current provision and funding for older people's institutional care)

The advent of Income Support and the takeover of Parish responsibilities for the funding of residential care benefits by Social Security have gone some way towards reducing any previous confusion or different treatment of entitlement and eligibility issues, such as the 'native' and 'non-native' question. However, apart from this and a change to savings limits the system remained essentially the same as before, as explained at the Public Hearing with the Minister for Social Security on 30th July 2008:

'Ms. S. Duhamel:

... the savings limits are used from income support so it is just under £19,000 for a couple and £11,000, I think, for a single person[16]. So those are basically based on 50 per cent above the old Parish rates, so we put the rates by 50 per cent straightaway and that is it. That is all that happens. Then your income is taken -- your whole pension is taken. It is still the Parish system whereby you put all your income in, that goes towards your fees, you get pocket money allowance on a weekly basis.

[16] Now £19,669 and £11,886 respectively

Mr. J. Forder:

Then any difference is taken from your estate?

Ms. S. Duhamel:

If you own a house, that is right. So if you had £150 pension, your fees were £500 and you owned a house, so we are paying £350 a week towards your care, so that £350, yes, it is added up and that is the cost --

Mr. J. Forder:

You would reclaim that from the estate?

Ms. S. Duhamel:

Yes.'

However, discussions with a range of witnesses from all sides of the long term care arena revealed that the situation is still very much in transition, both literally and figuratively. Given the importance of the changes to the system the Panel was surprised that there seemed to be a considerable degree of uncertainty around who was responsible for paying what and when, with some care homes still sending accounts direct to their residents' Parishes and unsure of where the funding actually comes from. Concerns were also voiced by a number of homes and Parish officials about people having to make numerous phone calls and visits to get applications processed by Social Security; although there was a sense that things were gradually improving as Income Support 'bedded-in', the level of confidence in new arrangements did not appear to be very high as yet.

Despite the obvious intention to rationalise the system and improve consistency by removing long term care funding responsibilities from the Parishes, it is still too early to assess how successful the move has been. During the course of the review Scrutiny officers visited all the Parishes to discuss their experiences of long term care provision, and came away with a distinct feeling that in a number of cases

officials regretted the change in their role and were not convinced that the issues could be handled as well centrally. Some clearly believed that this would result in higher costs in the long run, although there was more general acceptance that a uniform approach to entitlement was a positive change.

The position of homeowners was also raised at the Public hearing on 30th July:

'Deputy A. Breckon:

What I was going to say was, and it has been raised a number of times is the thing about selling your home, and especially, I mean, evidence has been given to us of cases where you get a couple, one who would remain in the home and one who needs a level of care and the family home is set against the care they get; and this has happened. It causes stress and tension and whatever else, and with the Parish system we had different interpretations of that. Could you tell me where we are with that now? How does that fit in with people who might leave, they might be asset rich and cash poor, how does the family home fit in now with, say, income support?

Ms. S. Duhamel:

Income support does take the value of the home into account in the shape of a bond, which means that nobody is required to sell their house or give us their house, but that the cost of the care is retrieved after the death of the person and their partner, or the person in the care, if that is the situation, because it is a means tested system and you do have to be fair to the taxpayer as well as to the people who claim the system. That is one of the great advantages being put forward by the insurance system, which is that you would know -- you would not worry about other assets people had. The 2 things are quite separate and we are not going to ... to ignore the value of houses under income support you get into all sorts of trouble about what do you do if you have got money in the bank and, you know, it gets very complicated. So we take a charge against the house but it is done in a way such that it is of no ... people are not required to sell their houses, if they

want to pass their houses on then all that is required is the son or the daughter would pay the money back at the end of the day.

Deputy A. Breckon:

There is a legal document that does that? You have got a standard document?

Ms. S. Duhamel:

Yes.

Deputy P.N. Troy:

Many people who go into care, it is often for a limited amount of time so you would not necessarily see the whole value of the home disappear on the care issue now because I think the average time that someone is in care is 2 or 3 years. So, you will not see the whole value of a Jersey home disappear in that time.

Deputy A. Breckon:

They would have to fully fund the cost of their care from the home? They would only get a loan, in effect?

Ms. S. Duhamel:

Yes. They are basically getting an interest free loan from the States for the value of their care fees because if we counted the value of their house they would not qualify for income support and they would be required to pay it all themselves up front which would require them to sell their house. So we give them a mechanism by way that they do not have to sell their house, they get an interest free loan on the value of it but at the end of day they have a substantial asset in many cases and from the taxpayer's point of view it is not fair that we should disallow that asset but somebody who has got £100,000 in the bank who is unfortunate not to own their house we say you

must use your £100,000 up before we pay for you. So we need to be fair across the board to homeowners and non-homeowners.'

It became evident during the course of visits and hearings with various care providers that some new pressures have been created in the system by the move to Income Support. Social Security took on board all pre-existing Parish agreements with providers when the Department became responsible for funding long term care; as a result they found themselves faced with paying a variety of fees to individual homes for people with a range of different needs. In an attempt to resolve this, discussions with the Care Federation (representing providers) resulted in the agreement to a simple banding system for all new residential care placements with just two levels; those assessed as needing basic residential care being supported at a standard rate of £560 per week, those having higher dependency (but not nursing) needs attracting a higher level of support of £720 per week, intended to cover additional staffing costs and any sundry medical items that may be required, together with membership fees for Family Nursing and Home Care.

It was pointed out to the Panel by several providers that elderly people have very diverse needs. While the 'standard' rate for residential care presupposes a basic level of care which could be assumed not to vary all that much, higher level needs may manifest in many different forms. It is understood that the higher rate was agreed on the basis that it would allow homes to absorb the 'swings and roundabouts' of providing care to individuals with differing needs to a certain extent, perhaps gaining a little on actual costs for some, while losing a little on others. This seems to represent a sensible compromise in a situation where precise accounting for every minute of time spent or every item consumed would be impractical.

For the most part this system appears currently to be acceptable to providers, although some witnesses felt that the move from the Parishes to Social Security had led to a more inflexible system. It was noted that economies of scale would tend to benefit the larger operators over smaller, family-run homes and allow bigger homes to run more economically, especially where higher care needs were

involved. This effect may be exacerbated as the costs of compliance with new regulation could be expected to impact more heavily on smaller and older homes. As many care homes have a mix of private and publicly funded clients it is expected that some degree of cross-subsidy may be used to even out accounting differences between the two sources, as private patients could be expected to be prepared pay more for additional comforts, for example larger rooms. This raises the likelihood that if group operators with larger homes are able to afford to take larger numbers of publicly funded clients, they could eventually come to dominate the market and squeeze out smaller providers who cannot sustain their level of services where fees are tightly controlled.

The Panel considers that this matter deserves serious consideration, as not only do many people prefer the more 'personal' feel of smaller homes, but there are also concerns that market dominance by perhaps two or three large operators could put the States in a very difficult position when negotiating contracts for larger numbers of beds in the future. In addition, it is known that even before the latest developments in global economic markets at least one of the market-leading groups supported by substantial international investment (a chain owning several homes in Jersey) faced an uncertain financial future involving major restructuring of its debt; while it is to be hoped that this will be resolved satisfactorily, in extremis it is not known how the local care market could respond to the loss of an operator responsible for large numbers of residential or nursing beds. It seems likely that this could put the Health and Social Services Department under extreme pressure, as it depends heavily on the private sector for nursing beds since the closure of its own long term care wards at Overdale. Members agreed that the growing dependency of States provision on private providers needed further investigation, and that the option of developing new residential and nursing care facilities either wholly under public ownership, or in partnership with another provider should be considered under the New Directions proposals to guard against an uncertain economic future.

Parish Homes

The Panel also became aware of other tensions in respect of the split in provision between private/public and Parish provision from discussion with representatives of

the Parish of St Helier and Maison St Brelade[17]. It was noted that (unlike the States homes at present) the Parish homes are fully registered, and in the case of St Helier they also pay the highest rates, including pensions to their workers. This naturally has a significant effect on their costs. Historically the two Parishes with their own residential homes (St Helier and St Brelade) had a greater degree of control over the clients using their long term care beds. With the advent of Income Support this has to a large extent been taken away, as Social Security is now responsible for funding public clients, and the Parishes are thus put in the position of competing with other providers. St Helier have never run their homes at a profit, and set their fees to 'break even' at a very high level of occupancy of 98%. To cover their costs they were under increasing pressure to take a larger proportion of higher dependency patients in one of their homes (St Ewold's) which they felt would have a negative effect on the existing balance of residents at the home, as well as driving up running costs still further. With 80% of their beds going to public sector patients, they were also concerned that private homes were thought to be achieving better deals with Social Security while they were being held strictly to the two published bands, although this was denied by the Department. A further problem raised concerned a lack of choice; people were being restricted as to which home they could go to based on the strict financial guidelines, rather than on needs or family circumstances.

Given the limited size of the market at present and the service that the Parish homes provide to people from all over the Island it seems unfortunate that there should apparently be a lack of understanding between them and Social Security. Mrs Pearl Thebault, manager of Maison St Brelade noted a need for more transparency in current arrangements:

'…we have never had any service level agreement or a contract. We have never been given anything. I certainly have never received a letter from Social Security saying that this is what they will pay for a bed. There has been no evidence. I have not found … like what you are saying there is no transparency. I understood that on the fee banding it would be Island-wide

[17] Public Hearing 7th October 2008

and we would all know what would be happening. Maybe that is something that they are working on.'

Pocket money

There was also concern that the only money some residents receive under Income Support is a £29 per week 'pocket money' allowance after pensions have been deducted to pay towards their care. This allowance was generally felt to be inadequate and indeed humiliating by everyone who spoke about it to the Panel.

It is very likely that some of these worries stem from the transitional nature of Income Support at present, as suggested in New Directions:

'… it is important to note that even within the context of the new income support regime there is, as yet, no agreed framework by which funding will be rationally allocated for the needs of the older person. This task, which is still very much 'work in progress', includes a wide range of important policy considerations, including determining where responsibility for the funding and formulation of future policy should lie.'

The important differences between the way public funding is applied for residential care (under Social Security) and nursing care, under the Health and Social Services Department also give rise to some concern. The majority of nursing care beds are currently contracted from private providers on a long term basis by the Department, although others are 'spot-purchased' at need. Access can therefore be difficult and there is frequently a waiting list, with emergency access often involving a preliminary stay in a hospital bed. This compares unfavourably with the situation for residential care, where availability is generally not a problem. The financial terms of Health's contracts with providers for nursing beds are not known, as this information was considered to be commercially sensitive; this would seem to add to complications in a system where transparency and a level playing field would surely be preferable for Departments, providers and clients. New Directions acknowledges there is a problem:

'There is a need to devise an appropriate 'fee and dependency' structure as the private institutional care sector cannot currently operate to the optimum level in the absence of a clear 'currency' which directly links the differential cost of provision to the different levels of dependency of the older people. The absence of an agreed structure is bad for both the commissioner of service (the SoJ) and the providers of service (the private institutional sector). Worse still, it is bad for the older person because there is no comprehensive 'joined-up' assessment of his/her needs. Placement of an older person in the institutional sector is largely a product of where he/she resides and his/her status prior to the placement itself (i.e. in an acute hospital bed, presenting at the Parish for help, or following a domiciliary visit by a health or social care professional).

The lack of transparency, the absence of an agreed fee and dependency structure or any certainty about how much all this costs conspire to focus the efforts of all of the stakeholders heroically on how to get the best out of the current system rather than focus upon rational alternatives. A key rational alternative would be comprehensive, cost-effective primary and community care services which would enable older people to continue to live independent lives.'

14. Public Consultation

As noted above, at the outset of this review it was expected that it would follow the Health and Social Services Department's launch of public consultation for their 'New Directions' policy. When this did not take place, the Panel decided to start its review into Long Term Care of the Elderly independently. A call for evidence was arranged towards the end of June 2008, timed to coincide with a media release drawing attention to the review. This generated a number of contacts from families and individuals with experience of care homes and funding issues. Subsequently a public meeting was held at Haute Vallée School on 29th July, which gave the opportunity for a lively discussion between members of the public and representatives of Health and Social Services, Social Security and Panel Members and the Panel's adviser. Speakers included:

- Senator B E Shenton (Minister for Health and Social Services)
- Mr M Pollard (Chief Executive, Health and Social Services Department)
- Mr J Le Feuvre, Health and Social Services Department
- Deputy P N Troy of St. Brelade (Assistant Minister for Social Security)
- Ms S Duhamel (Policy and Strategy Director, Social Security Department)
- Professor J Forder (University of Kent, Panel Adviser)

Mike Pollard gave a presentation outlining the fundamental challenges facing his Department and the Island in terms of a steadily increasing proportion of elderly people in the population over the next 25 years, bringing an associated increase in long term ill-health and physical problems linked with old age, coupled with rapidly rising costs of treatment. Specific concerns were identified as follows:

- The current tax yield will not fund the impact of ageing
- Growing cost of institutional care
- Inequality in long term care costs

- New and additional funding needed to manage the growing health and welfare needs of an ageing population

Solutions proposed centred around improving primary and community health care, including the following steps:

- GPs to provide overall coordination of primary and community health care service
- Invest in Chronic Disease Management in Primary care
- Expand prevention services in general practice
- Redraft the Health Insurance Law (1967)

Mr Pollard emphasised the importance of keeping people in their own homes for as long as possible, but drew attention to the inevitable costs of looking after an ageing population:

'… something that is well known within health and social care is that a person aged 75 and over requires 4 times more health and social care than people in the younger age group… So in our plans and in our thinking in Jersey we have to respect those figures and to make sure that we invest and recognise that there is significant cost if we are to resolve and meet the challenge of an ageing society.'

He also outlined his view of the some of the steps the Island will have to take to meet the challenges ahead:

'The solution is in many dimensions. There is, for example, the need for big investment into institutional care because despite what I said many older people will require intensive environments of nursing and residential care. We need to invest in home care, which I think is the desired area of investment, and we need to make sure that we keep fit in older age, which is why the concept of full engagement is very important, full engagement, that

is, with the community, with people like you, with older people currently and people who look after older people and support them to meet their aspirations.'

Deputy Troy indicated that Social Security was already working to prepare a framework for elderly care provision:

'Within income support, from February of 2008 new placements into residential care have all been coordinated through Social Security. This replaced a complicated system involving the Parishes and Health and Social Services. An over-65 placement tool has also been created which provides a consistent record of the assessments needed to ensure that someone requesting assistance gets the right level of care and that, of course, could be either care at home, as has been said perhaps by Family Nursing and Home Care, or residential care or nursing care.'

He also pointed out that preliminary calculations (believed to have been prepared several years ago) had suggested that the cost of implementing a 'Guernsey-style' long term care insurance in Jersey might involve contributions at a level around 2% of income, rather than 1.4% as in Guernsey; although there could be other options to consider:

'…we would have to raise the individual social security rates by creating a long term care rate and that would be charged to individuals throughout their working life and perhaps, as I said, even on into retirement as in Guernsey. There is a question there: do the public, in taking on a scheme such as this, want to grapple with the fact that they have got to pay for it and contribute into it out into the future? The other possibility, of course, in funding such a scheme is that you might want to consider funds from other tax revenues and if those could be identified, if you had surplus funds either coming in from G.S.T. (goods and services tax) or we raised additional taxes, then you could consider funding a scheme that way. That is very much the whole process that we have to go through over the coming months to look at that as to how we grapple with the financing side which is really quite a big issue.

It is inevitable that we as individuals are going to have to pay for the system, whether we pay for it either directly or through increased taxes.'

In addition to the public meeting, the Panel received a number of individual submissions from members of the public in response to its call for evidence. In following these up it became clear that in a number of cases publication would not be appropriate, owing to the personal nature of the evidence. Other contacts led to public or private meetings with individuals and where appropriate the transcripts of these will be found on the Scrutiny website, together with transcripts of all the Public Hearings which were carried out in the course of the review. A list of meetings and hearings conducted appears in the appendices to this report.

15. Fact-Finding Visits

Meeting in Guernsey – 11th July 2008

Background

A meeting was arranged in July 2008 in Guernsey at the request of the HSSH Panel to discuss that Island's Long Term Care Insurance arrangements. Members of the Panel met with the Chief Officers of Guernsey's Social Security and Health and Social Services Departments and the Director for Older Peoples' Housing.

It was explained that in the 1980's Guernsey had four separate charging systems for Long Term Care, depending on where the individual went. Some meant that the family home would need to be sold, others had conditions applying a very high rate of notional interest to savings; the best deal for the client at that time was to find a place in a home run by the Health Department, which enabled the family home to be retained.

These systems persisted until around 1997, by which time it was clear that changes were needed. At that point an officer group was tasked to find a solution. At the time a specialist care health insurance scheme had recently been devised to help with the cost of hospital care, which historically had to be paid for in Guernsey; a new 1% tax-funded insurance system had therefore proved very popular.

The Guernsey States and public were thus well-disposed towards another insurance-based solution. The officer group was aware of developments in Germany, Austria, Luxembourg and Japan, and used this knowledge to propose a simple system that could help to solve the long term care problems in Guernsey. The decision was taken only to insure care in private sector care homes, leaving public sector care to be paid for out of general taxation. (There was no intention that the public sector would become involved in making the new provision known to be required.)

Benefits

The scheme that was developed was essentially one of co-payment. At today's rates the client pays £154 p.w. This equates to the charge made by public sector homes. Benefit top-ups are then available for private sector care homes - £341 for residential care, and £637 for nursing care, on top of the co-payment charge. For those who do not have a full pension or sufficient assets to afford the co-payment charge there is an Income Support scheme which can offer assistance. Under this scheme the family home is protected, but capital is means-tested.

An important feature of the insurance scheme is that it only indemnifies against private care home charges; there is no provision for any payments to be made towards the cost of home care. Thus as presently constituted the Guernsey system cannot respond to the increasing demand for individual choice in provision of care, in particular for those who wish to stay in their own homes for as long as possible. Although it was acknowledged that this may need to be looked at in future, it was felt that it was unlikely to happen in the next five years. Health and Social Services do provide some home care services, but make a charge for them. They directly employ home carers and senior home carers for those with more needs; they also have a support network for informal carers. Health and Social Services do not make any co-payment charge for respite care, as it is considered better to support respite (up to 4 weeks per year) rather than to have to provide full time care. They also pay for 'meals-on-wheels' and for a day-centre run by the WRVS. It was considered that there may be a need to review Attendance and Carers Allowances, which could be a way of providing for some of the costs of home care.

The long term care scheme is not restricted to older people; as an example it was noted that a fifteen year-old in need of care could access the same benefits at need, although it was more often older people who have Long Term Care needs. However, at least one local home was beginning to specialise in care for younger clients, in a converted hotel setting. This was proving to be quite expensive, so at present Health and Social Services and Social Security were 'topping-up' the benefit to keep the arrangement going.

Funding

The social security contribution towards long term care insurance is currently set at 1.4% of earnings. This applies to all those over school-leaving age, depending on income. There are three categories of contributor:

- employed
- self-employed
- non-employed

Those over 65 pay at the non-employed rate but continue to contribute. The upper earnings limit for contributions has risen sharply over the last two years, and is now £64,000 p.a., or £108,000 for those employing others; however there is no employer contribution as such to the scheme. The contributions for long term care insurance are loaded fully onto the individual. An individual can elect to pay at the maximum level if desired to avoid a detailed declaration of earnings; in this case they would pay 1.4% of £64,000, i.e. £896 p.a. The separate compulsory health care contribution is now 1.2% of earnings.

When the scheme started there was a three month initial period when contributions were levied but no benefits paid; this lasted from January until April 2003, when benefits became payable. It was noted that the pool of 30,000 economically active residents paying in contributions easily enabled the scheme to cover the costs of care for a few hundred patients in the first instance. Initially there was also a States grant to the fund, which was capped at 12% of contribution income; however this was later stopped as the contribution rate was increased. Currently the fund income is approximately £14m p.a., expenditure £11m p.a., and there is an accumulated reserve of £18m. Although it was originally intended to be a fifteen year plan, there are some doubts that it will last that long without further increases to the current contribution rate of 1.4%, despite the savings arising from not having to pay for public provision or home care.

Provision

The scheme has encouraged a growth in private provision of long term care which has resulted in increased uptake; on the other hand numbers in public sector continuing care are dropping. A Needs Assessment Panel is responsible for assessing suitability of applicants, but there is some concern about numbers in residential care, partly arising as a result of a very low level of provision of sheltered housing; those with a relatively low level of dependency have no option but to enter expensive residential care. There is practically no sheltered housing provision at present, although some investment has been made in 'extra-care' housing in partnership with the private sector in the last 18 months, which is providing 1 bed self-contained social-rented accommodation and two bed homes for the private sector. Health and Social Security has commissioned but is not providing these homes; need is assessed using the Needs Assessment Panel process as the gatekeeper. For these properties the minimum qualification is a requirement for at least four hours of personal care. The Department is also beginning to look at options for community care, for those with needs at the lower end of the spectrum.

Health and Social Security are both provider and regulator; there is a single inspector of care homes. Public provision is exempt from inspection at present, but as it contributes the most expensive, 'last resort' services for those with most acute needs, this helps to keep the overall costs of the scheme down. The Health Department still provides long-stay geriatric and psychiatric wards.

There has been some discussion of possibilities for private provision of supported housing. Departments have a very clear sense of what is needed, so developer-led initiatives are less common than may be the case elsewhere; the States would prefer to retain overall control of the extent of Long Term Care provision, although a fine balance needs to be struck. Guernsey has 8 sites in 'land banks' which are intended for social rented housing for the elderly. Dementia care in the Island is assisted by Methodist Care Homes, but these do not follow the same model as in the UK. The Director for Older Peoples' Housing has been contracted to produce a joined-up strategy for Long Term Care, bridging any gaps between Departments;

the aim is to improve financial and operational efficiencies. There is a belief that on a small island support services should be capable of being delivered on a peripatetic basis, as there is not the space for any new integrated development. The Health Department has access to excellent information on the population profile, including ages, although it does not include full details of household make-up.

Within the States sector there is no longer an issue with 'bed-blocking'; since the insurance scheme started there have always been beds available for continuing care. However, as the public sector fills the gaps in the market it is hard to compare costs. Generally, homes that were in operation at the beginning of the insurance scheme feel 'morally obliged' to keep providing care beds at the States rate, but newcomers to the market do not necessarily feel the same way.

Concerns for the future

Benefit rates for Long Term Care are reviewed each year and compared with care home accounts, which the Chief Officer of Social Security receives annually, to set a suitable level. Concerns were expressed about the difficulty of keeping care home fees at reasonable levels in the future. The way the system works is that individuals make their own contract with the homes, then claim the benefit back from the insurance; any shortfall has to be made up by the client. Anyone seeking to set up a new home would need to convince the Department of the demand, as well as obtaining for example change of use permission from Planning if it was intended to convert a hotel; so controls remain fairly tight. The existing structure of the insurance scheme does encourage a high level of demand for care home places, although this is to some extent balanced by the Needs Assessment procedures.

There is a desire to strengthen the social care area to match the excellent health care already provided. In particular it was felt important to respond to evidence of need, rather than focus on supply; a strong corporate approach would be beneficial in this area.

Great difficulties were experienced with staffing in the island, as the public sector was not competitive in some areas. Guernsey still operates 5 year housing licences for in-migrant staff, and there was a particular problem with retaining specialist staff who could find relatively little employment fort their particular skills in a restricted local market. At a lower skill level (e.g. hospital cleaning) many migrant staff were still employed on 9 month licenses, meaning they had to leave the island after this period before they could be employed again. However, Health and Social Security were able to train nurses locally, and had also developed a link with the University of East Anglia.

Other Issues

One difference in approach commented upon by the officers was that Guernsey has integrated its Health and Social Services, splitting them vertically into Adult and Children's Services rather than keeping the two areas distinct as in Jersey; this was felt to have positive benefits.

It was also noted that the Long Term Care Insurance Scheme was introduced in Guernsey when there was a strongly perceived need for better Long Term Care provision and protection for home owners, as well as a recent positive experience with the States specialist health insurance scheme. It was felt that these factors combined to make an insurance solution attractive to the public at the time, especially as the cost was deliberately kept at a low level by excluding public provision and home care from the calculations. It was suggested that the imposition of new taxes in today's economic climate might be more problematic.

Visit to London – 15th / 16th October 2008

A visit was also made to two examples of long term care provision in London considered of possible relevance to Jersey's situation. The first of these was Mendip House, a converted tower block in Edmonton Green, administered by the Metropolitan Housing Trust. This was transformed into sheltered housing for the over 55s and fully refurbished in 2004. It contains 184 one and two bedroom

apartments, spread over 25 floors, with safety and security offered by a 24 hour concierge service, CCTV coverage in all public areas (including lifts), and a pull-cord alarm system in every room. The scheme has proved highly popular owing to comfortable and spacious accommodation, regular social activities in community rooms and good communication with on-site managers, who contact all residents on a daily basis to ensure they are well, assist them with filling in forms and making sure they get all the benefits to which they are entitled, and maintain a friendly atmosphere while ensuring the building is kept immaculately clean. The scheme provided an excellent example of what can be achieved with an older high-rise building (at one time considered for demolition) and now has a waiting list for residents.

The other facility visited was Darwin Court, a housing scheme for the over 50s in Southwark developed by the Peabody Trust, opened in 2003. The six-storey development contains 37 one bedroom and 39 two bedroom flats designed to 'Lifetime Homes' standards. The scheme provides a wide range of facilities for residents as well as community resources including a restaurant / café, health care suite with large swimming pool, multi-purpose training and education suite, fitness and activity classes, and an IT suite with 16 computers. There are full-time support workers and tenants have access to 24-hour help. Care packages are tailored to meet the individual's needs to enable residents to sustain their tenancy and independence.

Unfortunately plans for a further visit to a 'care village' developed by the Joseph Rowntree Foundation in York had to be abandoned owing to extensive refurbishment works being undertaken at the time.

The Panel's adviser, members and officers also visited a number of local care homes during the course of the review.

16. Appendices

16.1 Family Nursing and Home Care (Jersey) Inc

Response presented at Public Hearing 28th July 2008

16.2 Long-term care for older people in Jersey

Paper prepared for the Health, Social Security and Housing Scrutiny Panel by Professor Julien Forder, PSSRU, University of Kent

16.3 Meetings and Hearings

The following list shows public hearings and other formal meetings undertaken by the Panel during the course of the review. Officer meetings and meetings with private individuals are not listed. Transcripts of public hearings are available on the Scrutiny website, www.scrutiny.gov.je

26th June 2008	Age Concern and Senior Citizen' Association
27th June 2008	Minister for Health and Social Services
	Ronceray Retirement Home
	Minister for Housing
11th July 2008	Meeting in Guernsey with the Chief Officers of Social Security and Health and Social Services and Director, Older People's Housing
29th July 2008	Family Nursing and Home Care
	Minister for Treasury and Resources
	H&SS Department Clinical Specialists in care of the elderly
	H&SS Department Long Term Care Management
	Evening Public Meeting – Haute Vallée School
30th July 2008	Alzheimer's Society

	H&SS Department Regulation and Governance
	La Haule Residential Home (Dementia Care)
	Palm Springs Nursing Home
	Care Federation
	Minister for Social Security
2nd September 2008	Minister for Planning and Environment
	GP Co-Op
7th October 2008	Parish of St Helier, Maison St Brelade