STATES OF JERSEY

Health, Social Service and Housing Scrutiny Panel
Health White Paper Review - Family Nursing and Home Care

MONDAY, 30th JULY 2012

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

Witnesses:
Chief Executive, Family Nursing and Home Care
District Nurse Team Leader
Operational Lead Home Care Support Team

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

[15:01]

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

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

Deputy J.G. Reed of St. Ouen:

Deputy James Reed, a panel member.

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

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

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

Operational Lead, District Nursing Team:
Jane Le Ruez-Lane, Operational Lead, District Nursing Team.

Operational Lead, Home Care Support Team:
I am Jean Hinks, I am the Operational Lead for the Home Care Support Team.

Chief Executive, Family Nursing and Homecare:
Julie Gafoor, Chief Executive, Family Nursing and Homecare.

Deputy J.A. Hilton:
Thank you very much. I would like to give apologies of behalf of our chair, Kristina Moore who is off Island at the moment. I would like to start by asking, what services do you currently provide and how are they funded?

Chief Executive, Family Nursing and Homecare:
We provide district nursing services, child and family services, which is health visiting, school nursing and community children's nursing team, and homecare. At the present time approximately 70 per cent of our funding from a Health and Social Services grant and the rest is through membership at the present time and charitable donations.

Deputy J.A. Hilton:
You said 70 per cent of your funding comes through a grant provided by the Health Department, is that tied into any sort of service level agreement?

Chief Executive, Family Nursing and Homecare:

Yes, we have service level agreements for each division, for each of the 3 divisions.

Deputy J.A. Hilton:
What term of ...

Chief Executive, Family Nursing and Homecare:
It is an annual contract, yes.

Deputy J.A. Hilton:
Does that present you with any particular problems?

Chief Executive, Family Nursing and Homecare:
We have requested that it goes to a 3 year contract but at the present time, because there were so many different changes we realise it is probably quite difficult to do that but we are hoping like a block contract for all existing services and then to develop S.L.A.s (Service Level Agreements) over the next 3 to 5 years.

Deputy J.A. Hilton:
But currently it is only a year.

Chief Executive, Family Nursing and Homecare:
Currently it is only a year.

The Deputy of St. Ouen:
Is there any variation in funding over, say, the last 5 years?

Chief Executive, Family Nursing and Homecare:
There has been obviously are reduction with the Comprehensive Spending Review.

The Deputy of St. Ouen:
What affect has that reduction had on the services that you provide?

Chief Executive, Family Nursing and Homecare:
Hopefully we have managed to maintain the services because we always do have a cushion of money from the charitable donations and then obviously we have looked at becoming much more efficient.

Deputy J.A. Hilton:

For the record, could you just tell us what the reduction was?

Chief Executive, Family Nursing and Homecare:

I think it was 3 per cent the year before last and 5 per cent last year in line with all other Health and Social Services departments.

Deputy J.A. Hilton:

Okay, thank you. How would you describe your present working relationship with the Health Department, G.P.s (General Practitioners) and other third sector and private providers?

Chief Executive, Family Nursing and Homecare:

I think at the current time we have very good relationships, particularly with Health and Social Services, we have regular meetings and updates and we are involved in lots of different spheres within their organisation. I think there is a good understanding that the services we deliver in the community are reliant on some of theirs as well, and it is really joint working. So I think it has improved considerably.

Deputy J.A. Hilton:

Your relationship with other third sector providers?

Chief Executive, Family Nursing and Homecare:

I think we generally have very good relationships. We also work with the hospice, in particular, with an end of life project that we have at the present time and other places like Brighter Futures and Pathways, we work closely within children's services. So, yes, I think that generally I would describe them as very good.

Deputy J.A. Hilton:

Good working relationships, okay.

Chief Executive, Family Nursing and Homecare:

I think the G.P.s, we obviously work together with patients but it is much more fragmented than it probably should be.

Deputy J.A. Hilton:

Does the relationship between hospital primary and community services need to be further developed and, if so, in what way across the 3 services that you provide.

Operational Lead, District Nursing Team:
Yes, we are in process of developing the working relationships and trying to integrate some of the care and, at the moment, we are in discussions really of looking at increasing services and trying to fill some of the gaps that we have previously had with the 24-hour care and the extra services.

Operational Lead, Home Care Support Team:
I think a lot of the developments are going to be about how we develop community services, so there is going to be a big emphasis on how we do develop community services. So I think what we are trying to build is a more strategic partnership working so it is not fragmented and it is seen that we are working together for these big developments that are about to happen. I think the emphasis from our point of view is that we are trying to develop a strategic partnership rather than an uneven relationship where it might be a little bit more directed from the acute sector.

Deputy J.A. Hilton:
Are you talking about the unevenness in the relationship between you and the Health Department?

Chief Executive, Family Nursing and Homecare:
Yes, because when you have got an S.L.A. situation and a substantial fund, it can be that they are seen as a commissioner role when they are also providers. So there is a tension there but I think we are trying to break that down and I think what the White Paper has given us is much more of a common goal. So we all know what our contribution is and I think that is what we are working towards.

Deputy J.A. Hilton:
As a third sector provider, do you feel that you have been adequately consulted in the development of this White Paper and I assume that you have been involved in the outline business case that is relevant to your organisation.

Chief Executive, Family Nursing and Homecare:
Yes, we were all interviewed individually by KPMG workers who were very well informed and understood, I felt, what we were doing, so that was a very good

process. Then we were involved in the dementia care, the elderly care and long-term conditions, end of life care and the early intervention. So in the areas where we really have most services we were part of that, yes.

Deputy J.A. Hilton:

As far as the early interventions go with children, currently are you just providing the sort of health visitor type of role?

Chief Executive, Family Nursing and Homecare:

We provide health visiting, nursery nursing is attached to that, we provide school nurses and children's community nurses, which is like a district nurse for children.

Deputy J.A. Hilton:

Their model, the MECSH (Maternal Early Childhood Sustained Home-visiting) model, do you think, as far as you are concerned, that is the best way forward?

Chief Executive, Family Nursing and Homecare:

I think it is. We are really lucky to have the professor who developed that programme. She has been over twice and I have met her 3 times, and she is from Australia but she has looked at models throughout the world and there is Professor Olds in America, which does not have health visiting which is why they use that model, and in the U.K. (United Kingdom) they have used the family nurse partnership which is aimed at young pregnant women, which we also do not have here. So the MECSH model is much more about a vulnerability which we do have, substance misuse, domestic violence, mental health problems, people who have been in care who have particular vulnerabilities. It has got a very broad criteria to get on to it which I think fits really well with Jersey. It also fits with what we have already got in place. MECSH is about health primarily, so improving the family's health, helping them understand their health choices and accessing services and also child development helping them pre-empt their child's development, helping them pre-empt their child's development and their motivation to be inspiring for their family not to stay to where they are. So I am really clear that that is the right model for Jersey.

Deputy J.A. Hilton:

Yes, Brighter Futures do something very similar, do they not?

Chief Executive, Family Nursing and Homecare:

They do but they do not have the health element, you see. That is why I think ... so also you are talking about meeting people antenatally, explaining their pregnancy, what they expect. So even things like that you get many less complications in pregnancy, improvement in breast feeding, you do get improvements in attachment because of that input on a weekly basis in the home and then there is all the child development, speech and language and readiness for school. So it is a health visitor model and it is a completely different profession to Brighter Futures. Brighter Futures is about attachment and mental health. This is very broad.

Deputy J.A. Hilton:
One final question on that. Will be directing this sort of MECSH model at all pregnant mums or ...

Chief Executive, Family Nursing and Homecare:
Yes, what happens is that they are given ... all mothers on booking to hospital are given a psycho-social questionnaire and on that questionnaire it is a lot of information they already collect and should be collecting but it gives us an idea about their vulnerability and then they will be offered the programme.

Deputy J.A. Hilton:
So depending on what is filled in on the questionnaire you will then pick out the ones that you see as being vulnerable?

Chief Executive, Family Nursing and Homecare:
Yes, that is right.

Deputy J.A. Hilton:
Thank you for that.

Chief Executive, Family Nursing and Homecare:
It is going to be part of, we hope, the health visiting anyway. So you are not going to have special workers. So the workers will be seeing other mothers as well but they will have time to see those mothers more intensively for 2 years.

Deputy J.A. Hilton:
Because you will increase the number of health visitors you have?

Chief Executive, Family Nursing and Homecare:
Yes, that is right, yes.

Deputy J.A. Hilton:
Okay, thank you very much.

Chief Executive, Family Nursing and Homecare:
It is in line with what they are doing with the U.K. They have got an extra 4,500 health visitors in the U.K. to do these models and they are doing it in Essex and Lancashire at the moment, yes. I just do not want it to get confused with other models because it is reliant on the expertise of the health visitor, the skills of the health visitor. It sounds all very simple but it is not, it relies on a high skill base.

The Deputy of St. Ouen:
I suppose that fits quite neatly into the next question which is about obviously the White Paper identifies a number of different changes to the services provided over a 10 year period and the first part runs to 2015. What changes are required within your area of responsibility that are linked directly this White Paper and what new services have you been led to believe you could be asked to provide?

Chief Executive, Family Nursing and Homecare:
The biggest change I think is the district nursing service and homecare. It will affect homecare as well because they are really looking at providing 24-hour care, which is obviously a big change for us because at the moment we only provide care during the day time until 10.00 p.m. or 11.00 p.m. 7 days a week but then we want to be able to offer patients a sitting service or an on call nurse to be able to prevent them going back into hospital or going into hospital. That is the biggest change so it will be a big shift for the staff and a different cultural change.

Operational Lead, Home Care Support Team:
Because we have a much reduced service in the evenings and a much reduced service at the weekends. So it will be a whole change for us to develop a 24 service and that is what we are spending most of our energy working on at the moment, looking at how that would develop.

The Deputy of St. Ouen:
So we are looking at doing just more of the same?

Operational Lead, Home Care Support Team:
Sorry, Julie. The end of life project that we have got now, that relies heavily on having the availability of a nurse and the availability of care assistants to care for somebody who is dying at home. So you cannot end the service at 11.00 p.m. if the person needs help during the night.

[15:15]

So it is how we use the resources carefully that we already have but then develop the services to met a full 24-hour service, so if someone falls at home and they are taken to A. and E. (Accident and Emergency) they do not necessarily, once they have been seen by the medic, have to be admitted. In fact there can be a team of people to then bring them home and care for them at home, and maybe put some intensive care in over the first 3 to 4 days, get some reablement in so that then they are back to their previous abilities and then the services can pull back. So that is a complete change to the way we do services now. We do not have the rapid response. We do not have quick turnaround teams who can go in and help people. But I would think that that would really help the pressures on the hospital beds.

The Deputy of St. Ouen:
Not only does it sound as though that is quite a significant change from what you are doing now ...

Operational Lead, Home Care Support Team:
It will be significant for a lot of resources ...

Operational Lead, District Nursing Team:
Of the team working with Health and other services to get this up and running.

The Deputy of St. Ouen:
How many staff do you currently employ?

Chief Executive, Family Nursing and Homecare:
In the whole of Family Nursing, 240.

The Deputy of St. Ouen:

Two hundred and forty?

Chief Executive, Family Nursing and Homecare:
But the majority of those are healthcare assistants; 100 are healthcare assistants.

The Deputy of St. Ouen:
So to achieve this new improved service, where do you need to be?

Operational Lead, Home Care Support Team:
They are the models that we are working on now so we are trying to do those mathematical workings out to see just how many whole time equivalents, how many hours does this mean so that we can have this service up and running. I think that is one of the biggest ... one of the issues for us is that if these ideas are to go forward then you do need investment in the areas. So if it is about community care you need investment in community services so that we can get the services developed, therefore the patients can start coming through the services. I think one of our fears is that it will be a reactive rather than a proactive attempt to develop the services and will be on the back foot trying to do things because we have not had the resources to enable us to truly develop them. It is a bit like the role of the advance practitioner. The advanced nursing practitioner has to be running to get the people trained and skilled up so they can take it on.

Operational Lead, District Nursing Team:
That is where we need nurse prescribing, which obviously the community has not been trained for that and nurses who come from the U.K. with it have lost their skills. So we need this training in place but we also need to be using it. It is not good sending people off for training if they are not using it. That means, you know, working very closely with the G.P.s because they have to support and develop that skill base. So we do need the training.

Deputy J.A. Hilton:
You have been involved obviously in the outline business cases, are you confident that you can get the staff in place, the numbers ...

Chief Executive, Family Nursing and Homecare:
I think that is the biggest problem and in our response to the White Paper, we have sent that in, that is one of our biggest concerns is recruitment of staff both on Island

and off Island. We sort of really want it to be looked at as a whole Island approach to recruitment for nurses because if not us I am sure the hospice and lots of the homes will be having similar difficulties and at the present time I think the hospital runs at a 10 per cent vacancy rate. So I think we are going to have to crack that nut before this can go forward.

Deputy J.A. Hilton:
I think the hospital told us that they have probably got between 40 and 60 vacancies at the moment but were you thinking ... you employ 100 healthcare assistants, is that the area where there will be the greatest numbers?

Chief Executive, Family Nursing and Homecare:
Yes.

Deputy J.A. Hilton:
So do you think that need can be fulfilled on the Island?

Operational Lead, Home Care Support Team:
I think that is quite interesting because in fact we have not done that needs analysis really to find out about the amount of workers that are available within care and that I think that would be quite interesting because there may just be a cohort that we are all sharing between residential homes, nursing homes, hospital, community services and it is how do we develop that, how do we start to look at career development for the people who are leaving school and those sorts of things so that the world of caring is a good career for them to come into. So despite a lot of ... there is quite a lot of unanswered questions at the moment about whether we could recruit enough staff.

Deputy J.A. Hilton:
Do you think Highlands College do enough to provide training for healthcare assistants, because they do provide some training and I did not know ...

Operational Lead, Home Care Support Team:
They do. Our links are not great with Highlands because the difference between preparing a care assistant to work a care setting, a residential home or nursing home, means that they are supervised all the time, whereas we have lone workers. So the ability to prepare somebody to work alone in a home, and each home can be

completely different, asks for a whole different set of skills so we tend to take the more mature people into the community services. But it is probably avenues that they all have to be looking at and exploring.

The Deputy of St. Ouen:

Apart from the recruitment of staff, I can understand why you are concerned, and I think we share some of those concerns ourselves, what indication has been given to you today with regards additional financial resources to help deliver the goals that are identified in the White Paper?

Chief Executive, Family Nursing and Homecare:

We have been given some information about prime pumped money, particularly around the end of life and intermediate care. So we are in discussions about that.

The Deputy of St. Ouen:

Can you explain prime pumped?

Chief Executive, Family Nursing and Homecare:

Some money that will help us get ready for the 2013 services that are planned. But it is quite vague at the moment.

The Deputy of St. Ouen:

If you were seeking greater reassurance from the proposals that are contained in the White Paper and especially in the area that you are involved in, what would you expect to see happen next? Obviously, we have got the White Paper now, what would you be saying: "Right come on, these are the matters really need to be dealt with so that we have confidence in getting on with the job?"

Chief Executive, Family Nursing and Home Care:

One is the sort of recruitment strategy and training strategy because there it is also about assessment skills, and as Jean has already said, advanced nurse skills that we have not really developed on the Island, because we are very medicalised - as we say, medicalised - so even nurses from the U.K. have previously worked in a different way, and they have not been able to continue that level of service, so we have got to have a culture where we are allowed to do that, yes? Then there is the things about the infrastructure. I would like the whole computer systems to be able to talk to each other to best be able to do single assessments, for information to be shared in a

much more fluid fashion between G.P.s, ourselves, hospital, hospice. So I would really like support in doing that, because although the largest sector, we are still a small organisation to take on those big, big chunks of work. Then the technology also, we were talking about the telecare and the telehealth monitoring and that is again something that is going to be really necessary if we are going to have nurses working effectively in the community, you know, best use of resources, because these trained nurses are going to be really valuable, are they not, and we are going to have a couple on available at night, so they have got to be able to do it in a smart way. Again, we really need help with that to develop those packages.

The Deputy of St. Ouen:

So it is the funding that will help you explore matters in more detail. Is there no present commitment to ongoing annual funding that you will be able to rely on, given that you can deal with and provide the services as required?

Operational Lead, Home Care Support Team:

Other than the S.L.A. for normal services.

Chief Executive, Family Nursing and Home Care:

There is with the Service Level Agreement, because we are going to continue doing our normal services at the moment that we provide now.

The Deputy of St. Ouen:

You do not have to say about that. **[Laughter]** We will get to that in a minute.

Chief Executive, Family Nursing and Home Care:

These will be additional, because obviously we are still going to continue our care during the day and the weekend, but this is a whole different care, as an extension of that care to allow people to be at home, cared for at home at end of life, which will prevent them going into hospital or allow them to come out of the hospital earlier. So it is an enhancement of services that we already provide. It is not a whole different ballgame. It is just a different way of working.

The Deputy of St. Ouen:

I mean, as I say, we joked earlier what I know that you do not. The question is not a case of what I know, and what I would like to understand is that are you aware that

discussions have been taking place with private providers to help offer and deliver some of the services ...

Chief Executive, Family Nursing and Home Care:
Of course, yes.

The Deputy of St. Ouen:
... that perhaps certainly somebody like myself might automatically assume that Family Nursing might provide?

Operational Lead, Home Care Support Team:
I mean, I think there are a couple of questions there. We do know that there is, and quite rightly there will be a need for some choice on the Island, no one is disputing that, but I think for people who have not worked in Jersey, it is difficult to grasp the concept that our care services are integrated in our nursing services. So our nurses lead the carer systems. They do not do that on a daily basis, but they are there for the training and development, they go and see the patients together at the outset, so that the health needs, the care needs are directed by a nurse at the outset. Now, we skill mix all the time to make sure that they are most appropriate, because they are like a little gold dust at the moment, so of course we have a large number of senior healthcare assistants who then pick up the day-to-day running of the delivery of care and they monitor the standards of care that is going in. But primarily, it is integrated within the nursing team. Now, one could put forward the argument that that this works incredibly well and that is why we do not have the scare stories and the horrible stories that you get from the U.K. because we have that level of security and robustness that the care delivered is headed by nurses. I think that will cause some tensions as we go forward and there will be a lot of questions about whether that is the right and proper way to go forward, but we would always advocate for that. But the other problem is we do not have regulation and inspection of private domiciliary agencies either, so no one can put their hand on their heart and say what quality of services are being offered.

The Deputy of St. Ouen:
Whereas you are inspected?

Operational Lead, Home Care Support Team:
Well, we are not inspected ...

The Deputy of St. Ouen:

Oh, you are not.

Operational Lead, Home Care Support Team:

... but we work to all the things like the N.M.C. (Nursing and Midwifery Council) guidelines and we have our own auditors. We get external auditors to come in and review what we are do. We are quite happy, I mean, we had to go through several tenders to bring new services on board, because they are looking at this preferred provider system and the provider/commissioner separation, and we can, I think, be quite proud of what we put forward when we do the tenders, because we have such a robust system from taking someone who is new to the care world and developing them and making sure that they are competent to provide the care when they are alone with people, vulnerable people at home. We supervise that work annually, and we go in and make sure that all the care teams are working to a good standard, and we offer training. I do not think anybody else on the Island at the moment could offer the degree of training that we put in.

The Deputy of St. Ouen:

We know of course Family Nursing and Homecare are very highly regarded within the community, and it really is we just want to get a sense of how the services might be delivered, but not only just how, who, because obviously for a group like Family Nursing and Homecare, there is already that trust and confidence in that service, then it is far easier for the public to enable or encourage and support an extended service.

Chief Executive, Family Nursing and Home Care:

I think it can be very confusing for patients and clients too to know who to go to, so we do provide that safety, where other agencies can be ... as Jane said, they do not have to be inspected at all. Anyone can start a domiciliary care agency.

The Deputy of St. Ouen:

Do you see it that as the service has developed that you will maintain your independence or do you see perhaps that as an alternative the Health Department becoming more involved in some of the services that you provide?

Chief Executive, Family Nursing and Home Care:

I do not see that there is the tension there at the moment, and I think it is quite useful to have separate organisations. I think it keeps us all keen and sharp, on top of our game. I think it is a huge area, health and social services, so we provide our own organisation that has the ability though to change quite rapidly, which maybe other areas do not have certain ...

Operational Lead, Home Care Support Team:
Yes, we are not restricted in that way in some ways by being a different organisation, and I think there is always a benefit to having sort of this mix, because people do support us and they are very generous, and we do get help from the public because we are a charity. So I think that persona of being a charity and serving the public is quite a good one to have.

Chief Executive, Family Nursing and Home Care:
Yes, I do, and it is an interesting question though, because the hospice has, I am sure, never asked that, because people automatically think because in the U.K. a hospice is also a charity, but they find it quite difficult to understand that we are.

[15:30]

I do not think there is a tension there at all.

Deputy J.A. Hilton:
No, okay. Gerald?

Mr. G. Wistow:
Thanks, yes. I mean, I am not going to argue with somebody who comes from the U.K. that the relationship between district nursing and homecare is brilliant in every place. I mean, you have on paper the advantage of a single integrated organisation, so if you were to sort of just treat me as a visitor from the U.K., I mean, what can you do because you are an integrated organisation that you do not think you could? I mean, some of you have probably had experience with working in the U.K. anyway. What is the advantage of it?

Operational Lead, District Nursing Team:

Well, our induction programme, for homecare, you know, the district nurses participate and train the carers so they get the skills from us, which it is very indepth, The homecare staff and the district nurses work very closely together.

Chief Executive, Family Nursing and Home Care:
Yes, I think a lot of the homecare patients may vary in their needs, so they can be assessed quite quickly and responded to, where I think it may be more difficult in the U.K. if you have got different organisations going in for different things. So I would say that the homecare patient may at one stage only be having personal care or social care and then can become unwell and they can respond quite quickly, so the flow is much more seamless, I would say, and the quality is really good.

Mr. G. Wistow:
So there are good day-to-day communications within your teams?

Chief Executive, Family Nursing and Home Care:
Oh, yes.

Operational Lead, District Nursing Team:
Well, we are based in the same building.

Operational Lead, Home Care Support Team:
Yes, I mean, the team that are responsible largely for the social care are based right next door to the co-ordinators and virtually manage the service for the carer assistant teams, so they are right next door and we are right next door to those.

Mr. G. Wistow:
So tendering the services separately would ...

Operational Lead, Home Care Support Team:
Well, that is a new thing that has just ... sorry, Julie.

Chief Executive, Family Nursing and Home Care:
What do you mean tendering the services separately?

Mr. G. Wistow:

Well, service. If, for example, home nursing and homecare were to be tendered separately, that would have some impact on the extent to which integration takes place at an operational level.

Chief Executive, Family Nursing and Home Care:
Not provided by the same organisation.

Mr. G. Wistow:
Well, yes, exactly. **[Laughter]**

Chief Executive, Family Nursing and Home Care:
That is right, we do have that difficulty at the moment, where some of the social care packages have been purchased by private agencies.

Mr. G. Wistow:
Yes.

Chief Executive, Family Nursing and Home Care:
Then the district nurses have - do you want to explain this, Jane - had to go in and care for those patients.

Operational Lead, District Nursing Team:
Or we get called in and then ... you know, whereas when it is our patients, the nurses will do the assessments of these patients and then a care plan will be written up, so there will be the supervision of that patient throughout, so any concerns or problems immediately, you know that the G.P.s are called and the district nursing team go in to do the nursing tasks. When it is private agency, sometimes there can be a ... they may not get in contact with us, there might be a delay or the nursing care might be bypassed completely, you know, there could be episodes where there has been skin damage or pressure trauma where it has not been noted or picked up when the nurse had been able to go in straight away.

Operational Lead, Home Care Support Team:
I mean, I think one of the things that is coming through more and more is about who takes responsibility to train and develop the care assistants from a private agency, and there it is very varied. So some agencies will take a lot of responsibility in

developing their own staff, but other agencies will not, and one of the keys really is about safe handling and moving patients safely.

Operational Lead, District Nursing Team:
Equipment.

Operational Lead, Home Care Support Team:
We do not have any responsibility and we would not train care assistants from another agency, because it might be Jenny today and Samantha tomorrow and it is far too ...

Mr. G. Wistow:
Continuity of care is greatly enhanced by your organisational ...

Operational Lead, Home Care Support Team:
Yes, whereas if we have ...

Mr. G. Wistow:
... structure, I imagine.

Operational Lead, Home Care Support Team:
Yes, that is right, and we, the organisation, has paid - and it is quite an in-depth and long training - to have what is known as key trainers in safe handling within the organisation and they go off and troubleshoot with equipment and things all the time, but we cannot take responsibility for training care assistants from a private agency.

Mr. G. Wistow:
Indeed, because you would be tooling up your competitors, apart from anything else.

Operational Lead, Home Care Support Team:
Well, it is not only that, it is once you have trained them you are taking the responsibility of delegating that care, and we cannot do that, because we do not know the staff that are going to be going in day after day.

Operational Lead, District Nursing Team:
We do not know what their competencies are.

Mr. G. Wistow:
Sure, sure.

Operational Lead, District Nursing Team:
Whereas we know what our staff's competencies are.

Mr. G. Wistow:
Of course, of course. So have you also got the advantage of being able to develop a different kind of skill mix and do you see the skill mix continuing to change because you have got, you know, the opportunities for substitutability, have you not, at a fairly quick and responsive rate?

Operational Lead, Home Care Support Team:
We are doing that all the time, really.

Operational Lead, District Nursing Team:
Within the district nursing team now, we now have senior healthcare assistants who carry out many of the nursing tasks, you know, they are being trained by the nurses, they have had their competencies signed off and they are able to go out and care for some of the patients doing actual nursing tasks, but the ...

Mr. G. Wistow:
What about the boundary between or the nature of the homecare ... sorry, the healthcare assistant role and homecare? How is that changing?

Operational Lead, Home Care Support Team:
Well, it does sound complicated probably, but it is not really that complicated. Within the care assistant world, we have 2 basic kinds of care assistants, so we have what stemmed from the original home helps - because I do not know if people remember, but it was the Home Help Association that got brought into the bigger charity - so some of those original home helps are still with us. We have 23 at the moment, so their primary responsibility is about the domestic support, which can be cleaning, shopping, laundry, all those sorts of things, picking up prescriptions, everything that helps people on that day-to-day basis. Now, we know that this potentially could be a little bit vulnerable, this section, so we are trying to look at how we can best develop those workers so that they can meet more of the things that people will ask of us in the future, so that is an ongoing piece of work that we are doing now. Healthcare

assistants, the largest number of care assistants that we have, they are the ones who we automatically put through our long programme of training, which starts, as Jane was saying, with an induction programme. They have classroom sessions, they are supported by a named supporter for 6 months and they have their more extensive competencies assessed and signed off, and they are the ones who receive all the extra training, like the end of life training and we work with the Alzheimer's Society, and they have dementia care training and things like that. They automatically go through the N.V.Q. (National Vocational Qualifications) training, except it is now called the C.Q.F. training, I think it is called, Care Quality Framework training - this has all just changed - and they can then develop and become ... we have a group of those who have gone further and are doing their level 3 to become senior healthcare assistants and have a greater role in training and supervision of clinical audit and things like that.

Mr. G. Wistow:
Did you say senior healthcare assistants?

Operational Lead, Home Care Support Team:
Yes, and this is where we know that nursing is going to be a very valuable profession ...

Mr. G. Wistow:
Absolutely, yes.

Operational Lead, Home Care Support Team:
... so we are constantly looking at how we can best skill up the layer below. I mean, for the ones of us who are state-registered nurses will remember very fondly the state-enrolled nurse, and in fact I know the N.M.C. has been talking about bringing the state-enrolled nurse qualification back, but that is the group of staff that we are trying to build up so that they are doing more and more of the nursing tasks. So the last piece of work that we did was to make a paediatric care package that we had, and so there were a cohort of staff who were going in to siblings and being taught about feeding and suction, because that was the need there. We can do that in house, because we have got the paediatric nursing team who will take them through the training programme. So we develop our own workbooks, we do the classroom sessions, then they are observed and then they are signed off as soon as the nurse

feels that they are competent. So that is the sort of system that we work, which is a huge advantage, I think, for the Island in lots of ways.

Mr. G. Wistow:
Yes. No, I agree, compared with some of the ways of organising the services. Just one last thing, which is going back to the costs issue, I mean, you said you were doing the maths at the moment, as it were, doing the modelling and I was just wondering ...

Chief Executive, Family Nursing and Home Care:
It is quite difficult, because you do not quite know what is going to be asked of you.

Mr. G. Wistow:
Yes, but there are some costs in the White Paper.

Chief Executive, Family Nursing and Home Care:
Yes, there are quite a lot of those.

Mr. G. Wistow:
Did you contribute to that at all?

Chief Executive, Family Nursing and Home Care:
No, that was all done by care ... oh, we obviously talked to them about services and in the workshops about what services could be delivered and they have come up with the maths.

Mr. G. Wistow:
Right.

Chief Executive, Family Nursing and Home Care:
I think it is 8 district nurses or something and 5 health visitors, yes, and then I think about 40 care workers, healthcare assistants. Yes. We are not sure how they are going to be used or where they are going to be sited or ...

Mr. G. Wistow:
Yes. So it is your view that the White Paper has sufficiently costed the 24-hour 7 service sufficiently confidently, competently?

Operational Lead, Home Care Support Team:
I think it is the detail, you know, the devil is in the detail, really. I think the strategic vision, I think we are all pulling together for the same vision, but now operationally somebody has got to start pulling that work all together now so that we really know, because although I think there are 5 of the business ...

Chief Executive, Family Nursing and Home Care:
Workstreams.

Operational Lead, Home Care Support Team:
... worksteams, yes - thank you, Julie - a lot of them, as far as we are concerned, in the community they overlap, so it may be that you have a registered nurse on duty, say for nightshift, but you have got 2 people who are end of life, and they have got a care assistant with them because they are right at the very end of life, then there will be somebody in a step-up bed, because the G.P. has been doing some joint work, and it stops them all going into hospital. So you might have to visit them in the step-up bed, wherever that be, and then you have got called out because you have got somebody with a urinary tract infection who have gone off their feet and the team have got to go in. So I think we see it as a completely integrated service. Or it might be a carer with somebody caring for Alzheimer's and they have gone wandering, so I think although it is dementia, C.O.P.D. (Chronic Obstructive Pulmonary Disease), end of ... I think we see that it is just this integrated 24-hour caring service just for the Island.

Mr. G. Wistow:
So the funding case behind some of the bids are still be tested, in effect?

Chief Executive, Family Nursing and Home Care:
Yes, I would say so.

Operational Lead, Home Care Support Team:
But we have not ... I mean, the full business cases have not gone forward yet.

Mr. G. Wistow:
Of course, no, no, I understand that.

Chief Executive, Family Nursing and Home Care:

That is why we are in that situation like that.

Mr. G. Wistow:

Yes, thank you very much.

The Deputy of St. Ouen:

It is very natural that it does take time to develop, as I said, because we have just finished a consultation, so yes, it would be strange if numbers were already being discussed and agreed, although I have just heard that if you pick up the current medium term financial plan, you will see numbers in there that identified costs for the next 3 years and perhaps it is something that you as an organisation need to just review, because it would be awful, I think, and we are all well aware that to deliver the services that are described, it does need additional resources, and the worst thing that could happen is that we start off on a particular route and we do not have the sufficient resources to be able to deliver the plan. But just picking up on another matter which was raised this morning, a slightly different angle, when we had the Managing Director of Community Social Services speaking to us, and we were asking him and saying where did he see the improvements within our primary care and the third sector, and he basically said: "Greater co-ordination and integration." He then went on to talk about obviously the changing role of G.P.s and how sort of the care will be provided by all sorts of different people around an individual specific to their needs. We said to him: "Okay, well, who is going to co-ordinate this?" and it was not clear. Who do you see as taking responsibility for co-ordinating that sort of overall contribution and care that is going to be coming from different sources to provide and to meet the needs of a particular individual?

Operational Lead, District Nursing Team:

We see that as being like the case manager, and the case manager would be the person that has the most involvement in that client, so if the patient had particularly high social needs, then it would be a social worker; if it is someone that had a high nursing need, that would be the nurses, or we have some highly skilled nurses for long-term conditions which we hope to develop that will become advanced practitioners in the future when we have got nurse prescribing and we get funding for training, and we have that in place.

Operational Lead, Home Care Support Team:

I mean, it could be an occupational therapist.

Operational Lead, District Nursing Team:
Or a therapist.

Operational Lead, Home Care Support Team:
I think there are quite a few models about, looking at interdisciplinary work, where you have a hub, and it sounds a bit ethereal, I suppose, but if the hub is sharing ... because there will only be a group of patients ...

Chief Executive, Family Nursing and Home Care:
These same people doing all the work.

Operational Lead, Home Care Support Team:
... and I was going to say, so it is identifying, as Jane says, the key worker, and if it is mainly for a therapist or mainly for a social worker or mainly for a nurse, then they become the co-ordinator.

Chief Executive, Family Nursing and Home Care:
That is the only way it can work, with the person who has got the most input to co-ordinate that case.

[15:45]

Because we have had packages organised by social workers when there is a lot of nursing care and that has been an issue, so it just has to be the person who has got the most influence over that person's care.

The Deputy of St. Ouen:
I hear exactly what you are saying, but experience has shown us - perhaps not necessarily over here, but certainly in the U.K. - there have been significant cases where you have had a whole group of different people involved in supporting an individual and no one has taken responsibility in co-ordinating and making sure that that individual is safe and provided with the care. I suppose my question to you, and maybe it is an open question, is how do we ensure that whether it is the midwife, whether it is the home help that turned up, whether it is a number of other individuals who we are going to come across, people that may be at the early needs of care get

dealt with appropriately, because all of this is about ... well, for the most part, early intervention. It is getting to people, dealing with people's issues before they even get to the point of needing acute type of care, which perhaps your organisation has been more used to providing up until now.

Operational Lead, Home Care Support Team:
Yes. I mean, we certainly have, because firstly, you can self-refer into the organisation, and that early intervention, we are probably one of the few organisations that go in when the first needs arise, so that just might mean that somebody rings up and says: "Look, can you help me now, because I cannot do X, Y and Z myself." But when we talked before about communication and information technology and being able to communicate well with everybody, I think that is still going to be my emblem.

Chief Executive, Family Nursing and Home Care:
The single assessment too ...

Operational Lead, Home Care Support Team:
Yes, the single assessment.

Chief Executive, Family Nursing and Home Care:
... is the thing that might improve that, but that is constantly an issue within all health and social care, I would say, because there is always multi-agency working, so I mean, that is maybe about inspection and looking at patient pathways and all those sort of things, but I cannot give you any more reassurance than that.

The Deputy of St. Ouen:
I suppose - and maybe I am not asking the question quite as well as I should - but it is really to just get a sense from you as to whether if greater responsibility is placed on your staff, will they be able and are they able to deal with that?

Chief Executive, Family Nursing and Home Care:
I think that is what they are doing now.

The Deputy of St. Ouen:
Right, fine.

Chief Executive, Family Nursing and Home Care:

Yes, and the only thing is that I think it will really help them, because they have at the moment the tension that they are having to leave the patient at 11.00 p.m., which is dreadful, when you have got to make that decision about whether they are going to go into hospital, whether you can get a family member to sit with them. You know, they have to make that call, which is really a horrible thing to do, so I would think it is going to enhance it and make it in some respects easier, because they will have the reassurance of another qualified nurse on.

Deputy J.A. Hilton:

Can I just ask you, why do you have to leave the patient at 11.00 p.m., if that is not a too simplistic question?

Operational Lead, District Nursing Team:

We do not have a night service.

Chief Executive, Family Nursing and Home Care:

We have not got the resource.

Deputy J.A. Hilton:

Because you have not got ... right, so it just really down to money?

Chief Executive, Family Nursing and Home Care:

Yes, it is down to money, but also it is about the technology to support that. Now there are so many technological advances that patients can be much more remotely monitored, so now it seems much more of a realistic thing to be able to offer people, because you can remotely monitor them and have less people, otherwise you would be thinking you were having little virtual wards everywhere, yes.

Deputy J.A. Hilton:

Well, it is going to make a big difference once those resources are in place that you can provide a 24/7 service. Could I just ask you a question about the Wellbeing Centres and what you see your role as in those Wellbeing Centres?

Operational Lead, District Nursing Team:

That is the ones based in the parishes.

Deputy J.A. Hilton:

In the parishes, yes. Do you see yourself having a role in that context?

Chief Executive, Family Nursing and Home Care:

Well, not explicitly, no.

Deputy J.A. Hilton:

No, okay.

Chief Executive, Family Nursing and Home Care:

No, to be honest, we have not. We are trying to concentrate on our core business and enhancing that, yes, so I do not think we are going to be highly involved in that. Do you? Does anybody ...

Deputy J.A. Hilton:

No.

Chief Executive, Family Nursing and Home Care:

We are not sure. We have not really been involved in those ...

The Deputy of St. Ouen:

What do you understand the Wellbeing Centre to be, because I think that is something that we maybe ... I mean, I must admit, one conclusion we came to is it is a British type of a ...

Chief Executive, Family Nursing and Home Care:

It is a portal, presumably, is it not, so that people can signpost and get themselves to their own care and ...

Deputy J.A. Hilton:

Self-refer.

Chief Executive, Family Nursing and Home Care:

Self-care, yes.

The Deputy of St. Ouen:

Does that not happen in a doctor's waiting room?

Chief Executive, Family Nursing and Home Care:
I doubt that.

The Deputy of St. Ouen:
No. Well, not a waiting room. Sorry, surgery, should I say. Once again, you have to get in there first.

Deputy J.A. Hilton:
Can I just ask you a question around hospital services? Do you see that there are services currently being delivered by the hospital that your organisation could deliver, and if so, what the barriers might be to that, to the delivery of those services? Can you think of any at all?

Operational Lead, District Nursing Team:
There is only the ... some of the outpatients' dressing clinics, but then in the U.K., the patients would be seen by practice nurses, at a G.P.s surgery, because we currently do not have premises/resources really to take that one up.

Chief Executive, Family Nursing and Home Care:
I mean, obviously KPMG do. That is one of the things they identified, that a lot of people were going to hospital for services they should have in the community, so of course there are quite a lot, but the development of practice nurses, like Jane was saying, should see some of those, but also services for children and oncology care, things like having chemo at home, those sort of things need developing. So I think there are things that we could offer some patients in their own home, yes.

Deputy J.A. Hilton:
Okay, thank you.

Operational Lead, District Nursing Team:
We have been doing more and more, really. We have been taking on extra work for the development of our clinics and ...

Operational Lead, Home Care Support Team:
The other thing will be the early discharge, because I think probably they stay longer in hospital, so if you had that integrated team of nursing therapy care staff, you could

do some of the therapeutic work at home, whereas if they are staying in a hospital bed that would not be carried out.

The Deputy of St. Ouen:

Does the White Paper, in your view, give sufficient recognition to issues affecting carers themselves and, if not, what more needs to be done?

Operational Lead, Home Care Support Team:

That is quite a big question. I am not sure that the entitlement to the carer's assessment … I do not think most of the public take that offer up and I think that it is quite difficult to get a carer's assessment. I know that the social workers themselves have been under great strain to be able to provide carer's assessments and so there is quite a lot of hidden work going on, there is quite a lot of strain held by carers and I think we probably do not do enough work to help carers manage their loved ones at home at the moment.

Operational Lead, District Nursing Team:

There are quite a lot of elderly carers who I think the expectation that somebody in their 80s can manage their spouse in their 80s or 90s and care for them and deliver all their medication is …

The Deputy of St. Ouen:

But if you were going to seek to support people in their own homes for longer, surely one would expect that the home carer, the relative, is one of the key elements?

Operational Lead Home Care Support Team:

Yes, I think there has been huge numbers of studies showing that the health and wellbeing of the carer deteriorates rapidly when they become carers. In fact, we were talking only today about the *Sunday Times* article. I do not know if any of you have read it.

Operational Lead Home Care Support Team:

It was about a daughter who looks after her 90-year-old father and just what breaking point she is at. So the respite services, home-based respite, is an area where their loved one can go in for more respite. Children's respite, I mean, I think at all ages …

Chief Executive, Family Nursing and Home Care:

The overnight sitting helps because obviously it is getting up in the night and the day and those sorts of things that wear people down.

Operational Lead Home Care Support Team:
Yes, and those services are not there at the moment.

The Deputy of St. Ouen:
So are there any services specifically that Family Nursing and Home Care provide that would be focused on the carer at the moment?

Chief Executive, Family Nursing and Home Care:
Well, the respite service is, is it not?

Operational Lead, Home Care Support Team:
That is outside the S.L.A. A tender became available so we did tender for an outreach service. I do not know if you can remember but it was originally the amendment that Senator Shenton put forward and so there was some money put on one side and it was used to provide some respite beds and they had 4 beds which eventually went to Highlands and that was for the care of younger people, young adults, and then we were successful in tendering for the home-based respite service so that is 4 hours of care which is primarily for the carer to be able to go out and we care for them at home. So we were successful. That stands outside the normal …

The Deputy of St. Ouen:
So that is for children?

Chief Executive, Family Nursing and Home Care:
No, that is for young adults.

The Deputy of St. Ouen:
Sorry, young adults.

Chief Executive, Family Nursing and Home Care:
We also have a respite worker for children. That provides respite in the home for children with special needs under 3 who are not yet in Mont à l'Abbé, a very small amount.

The Deputy of St. Ouen:

Yes, but what we have not got at the moment is that the support for the close relative that is supporting their elderly wife or husband?

Operational Lead, Home Care Support Team:

We do not have it for the older services at all, this particular …

The Deputy of St. Ouen:

No, so that is the …

Operational Lead, Home Care Support Team:

… bit of money was just for young adults.

The Deputy of St. Ouen:

That is where we are saying, that the greatest pressure is going to be moving forward because we are all getting older.

Operational Lead, Home Care Support Team:

Yes.

The Deputy of St. Ouen:

Right, okay. So bearing in mind that there is a gap, what can be done or could be done to address that issue and is there anything that your organisation could offer to provide some additional respite or help for those individuals?

Operational Lead, Home Care Support Team:

Well, we could extend the respite service as it stands today which would be to give, you know, sessions for people to be able to book their hair appointment and go off and do their shopping and things like that so we could extend that to the elder people.

The Deputy of St. Ouen:

Okay, so you could use the existing models and just …

Operational Lead Home Care Support Team:

Yes.

The Deputy of St. Ouen:

Okay, so that is relatively easy but again we come back to more people and more money.

Deputy J.A. Hilton:

We will wrap up very shortly. There is just one thing I wanted to ask you. As far as the Health White Paper goes, the services it intends to provide over the next 10 years, is there any one thing that you believe is missing from that, any one service that you feel should have been included or are you satisfied?

Chief Executive, Family Nursing and Home Care:

I think from our perspective a lot of what is being planned is things we would have liked to have done if we had had the money and resources. So for us we can see that it is a very good way of enhancing the services we provide and just being much more productive and effective in caring for people in the community. So for me there is nothing from our point of view that is missing. Is there anything …

Operational Lead, Home Care Support Team:

No, I would agree.

Mr. G. Wistow:

Well, just on the issue of practice nurses, what are your thoughts about the development of practice nurses in Jersey?

Chief Executive, Family Nursing and Home Care:

Well, I think it is really necessary. I think it will change the model of primary care in the perspective of G.P.s, but my experience of practice nurses is it takes many years to become a competent practice nurse. There are a huge lot of changes, it is a very broad role, and we do not have the skills on the Island at the moment. There are some practice nurses but they have a very limited role. They do not do the chronic disease management, they do not do family planning.

Operational Lead, District Nursing Team:

There is a cost implication. In the U.K. it would be free to go to a practice nurse whereas you have to pay here so that is a disincentive to keep them.

Mr. G. Wistow:

Is it a threat to your workforce, to the retention of your staff?

Operational Lead, Home Care Support Team:
For the staff, yes; not another threat in delivery of care, I do not think.

Chief Executive, Family Nursing and Home Care:
We are all competing for the same people. One nurse goes back to the hospital and another comes out. That is how it is. We are all competing for the same workforce but it should be in primary care, all these people should be going back to their doctor and having their dressings done and being seen in primary care, yes. We need to concentrate on the care in the home, I think.

Mr. G. Wistow:
Could you not provide practice nurses under contract?

Chief Executive, Family Nursing and Home Care:
We could do that and we have thought about that because we could have the training enhancements and specialist nurses for that but it is just how thin you want to spread yourself. We want to be good at what we doing and we are quite clear our primary role is about providing care to people in their own homes and we could do that but I do not think we would be able to keep that level of service.

Deputy J.A. Hilton:
Okay.

Mr. G. Wistow:
Okay, thank you very much.

The Deputy of St. Ouen:
You spoke earlier about your submission relative to the White Paper. I just wondered would it be possible for you to be able to share that submission with ourselves because it would certainly be useful to draw out and remind us of what the issues are.

Chief Executive, Family Nursing and Home Care:
Yes, that is fine. Do you want a copy now or electronically?

[16:00]

The Deputy of St. Ouen:
Also if you do have any thoughts after the meeting on any of the matters, please feel free to contact Kellie and she will …

Chief Executive, Family Nursing and Home Care:
Do you want me to send it electronically?

Deputy J.A. Hilton:
To Kellie, please, that would be lovely, thank you. Thank you very much indeed for coming.

Operational Lead, District Nursing Team:
Can I bring up something because there is not anything mentioned about the cost of dressings to patients and I thought that Soc Sec was going to help with this but I have not heard anything about … whereas in the U.K., all dressings for patients and stores and stock are on prescription. Here the patients have to pay and the bills are phenomenal and, for instance, if we are going to provide patients out in the community with more tube feedings and intravenous injections, all the consumables, as they are called, are highly expensive. I am just wondering who is going to pick up the cost of that because there is not …

Deputy J.A. Hilton:
I think it is the same with oxygen, is it not? People have to pay for their oxygen as well.

Operational Lead, District Nursing Team:
Yes, I think the oxygen is free but it is the consumables that are extremely expensive.

The Deputy of St. Ouen:
But currently that is coming from …

Operational Lead, District Nursing Team:
The patients have to pay. They pay or they get funding from some source.

Deputy J.A. Hilton:

Low income support or something.

Chief Executive, Family Nursing and Home Care:
It makes it difficult with the choice of dressing, does it not, because some dressings will be expensive and they will just say: "No, I cannot afford that." Imagine making that, it is not a clinical decision.

The Deputy of St. Ouen:
This is dressings?

Chief Executive, Family Nursing and Home Care:
Yes, so …

Operational Lead, District Nursing Team:
It can be hundreds of pounds a week.

Mr. G. Wistow:
And early discharge will increase the cost burden on the individual, yes. So things that were paid for by the hospital will transfer across.

Chief Executive, Family Nursing and Home Care:
They can choose then not to have it because of that so that needs to be on prescription basically, yes.

Deputy J.A. Hilton:
Thank you very much for coming this afternoon. It has been very interesting talking to you, thank you.

[16:02]