BILLET D'ÉTAT

VIII
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WEDNESDAY, 25th MAY 2011

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B I L L E T D'É T A T

TO THE MEMBERS OF THE STATES OF

THE ISLAND OF GUERNSEY

I have the honour to inform you that a Meeting of the States of Deliberation will be held at **THE ROYAL COURT HOUSE,** on **WEDNESDAY,** the **25th May, 2011** at 9.30am, to consider the items contained in this Billet d'État which have been submitted for debate.

G. R. ROWLAND
Bailiff and Presiding Officer

The Royal Court House
Guernsey
15 April 2011

PROJET DE LOI

entitled

THE LA MARE ROAD (CLOSURE) (GUERNSEY) LAW, 2011

The States are asked to decide:-

I.- Whether they are of the opinion to approve the Projet de Loi entitled "The La Mare Road (Closure) (Guernsey) Law, 2011" and to authorise the Bailiff to present a most humble petition to Her Majesty in Council praying for Her Royal Sanction thereto.

LADIES' COLLEGE BOARD OF GOVERNORS

NEW MEMBERS

The States are asked:-

II.- To elect

1. a member of the Ladies' College Board of Governors to fill the vacancy which will arise on 1st June, 2011, by reason of the expiration of the term of office of Advocate P J G Atkinson, who is eligible for re-election;

2. as a member of that Board of Governors with effect from 1st June, 2011, Mrs K M N Richards who has been nominated in that behalf by the States appointed Governors and the Education Department nominated Governors for election by the States.

(NB Advocate Atkinson does not seek re-election.)

(NB The Governors have provided the following profile of Mrs Richards

Mrs Kathryn M N Richards is a former pupil of the Ladies' College. She was President of the Ladies' College Guild before joining the Board of Governors of which she is currently Vice Chairman and Chairman of the Finance Committee. Mrs Richards also chairs the Guernsey Education and Business Partnership on behalf of the Education Department.

Mrs Richards graduated from Bristol University in Psychology and Sociology. She worked for the Imperial Group in the UK and was responsible for establishing a department to research and advise on management education and training. Following her return to the Island and a family career break, Mrs Richards spent a period of time as Senior Lecturer in Management in Further Education. In 1989, Mrs Richards became co-founder of ODL, a Guernsey based consultancy company which provides strategic organization development consultancy, tailored training and qualification design. She is still Proprietor and

Joint Managing Director of this business. Mrs Richards's commercial experience in this role has included responsibility for regulated training centres in the UK. The Company also has a UK national profile in workforce development and Mrs Richards is actively involved in the development of vocational qualifications.**)**

ADMINISTRATIVE DECISIONS (REVIEW) (GUERNSEY) LAW, 1986

NEW CHAIRMAN AND DEPUTY CHAIRMAN OF PANEL OF MEMBERS

III.- To elect, in accordance with the provisions of section 4 (2) of the Administrative Decisions (Review) (Guernsey) Law, 1986:-

1. a Chairman of the Panel of Members, who shall be a sitting member of the States of Deliberation and who has held a seat in the States for a period of three years or more, to fill the vacancy which will arise on 1st June, 2011, by reason of the expiry of the term of office of Deputy R R Matthews, who is eligible for re-election;

2. a Deputy Chairman of that Panel, who shall be one of the Deans of the Douzaines but who shall not have a seat in the States, to fill the vacancy which will arise on 1st June, 2011, by reason of the expiry of the term of office of Douzenier R A R Evans, who is eligible for re-election.

(NB The Deans of the Douzaines are Douzeniers R A R Evans, R L Heaume, MBE, J E Foster, M A Ozanne, Mrs B J Hervé, N N Duquemin, P I Le Tocq, N M Dorey, S J Bichard and G C Le Mesurier.)

HEALTH AND SOCIAL SERVICES DEPARTMENT

FUTURE 2020 VISION OF THE HEALTH AND SOCIAL SERVICES SYSTEM

The Chief Minister
Policy Council
Sir Charles Frossard House
La Charroterie
St Peter Port

9th March 2011

Dear Sir

EXECUTIVE SUMMARY

1. The purpose of this report is to set out a framework for future development of the health and social care system in Guernsey and Alderney. The States is requested to support the approach set out in this report. It will require all States Departments to work together. The purpose of the framework is to:

   i. describe the current health and social care system in Guernsey and Alderney and the estimated costs;

   ii. establish the key principles within which States Departments can plan, develop and deliver health and social care services and other related activities in Guernsey and Alderney;

   iii. seek States of Guernsey approval to further develop this framework and the constituent plans to review the services, funding, infrastructure and organisational structure of the health and social care system; and

   iv. set out the main benefits of this approach and the high level plans which will need to be developed to deliver this vision.

2. Health and social care related issues can be currently assessed as costing the economy over £300m per annum including private and third sector provision. States funding meets approximately 60% (£180m) of this assessed cost.

3. The current configuration of the health and social care system in Guernsey and Alderney is a complex mixture of organisations and organisational inter-relationships. This makes quality difficult to assess and creates some inconsistencies in the way services are delivered and funded. In addition the HSSD has a significant estate infrastructure – which is not always suitable for

providing modern services. These factors combined, can lead to inefficiencies in the way services are delivered.

4. The ability to understand what drives poor health and poor social circumstances is increasingly complex. Guernsey has a unique health and social care system and understanding where we are compared to other jurisdictions is very difficult to quantify. Historically, information about the health and social care system as a whole in Guernsey and Alderney is limited. One of the key elements of work for developing the future vision will be to ensure that more information is available for all parts of the system, both in terms of cost and quality and that these measures are monitored on an ongoing basis.

5. More research is needed on the impact of preventative measures that could be taken to improve health and social wellbeing. This will enable the States of Guernsey to make more informed and prioritised decisions about funding allocation which will enable investment in evidenced based prevention to realise longer-term benefits.

6. The health element of HSSD's services has traditionally been very focused on ill health and providing treatment and interventions. Healthcare services have been designed to treat symptoms rather than the cause.

7. In order to meet the future needs of the population and move to a more preventative model of health and social care, services will need to be organized in a different way. However, there will always be a need for interventions to be made to treat and care for people who are ill and disabled, to protect the vulnerable and help people in crises.

8. Changes will be required to ensure the most effective use of resources. Resources may need to move from secondary and tertiary services to, or there needs to be additional investment in, primary and preventative services. This cannot be done in the short term and it will not be easy to achieve. It may be necessary for other States' departments and other organisations to help facilitate this in the longer term by doing things differently, and acknowledge their role in supporting a healthy society.

9. This report identifies a number of essential key points. These need to be addressed to support the States in its future prioritisation of resources to meet future needs of the health and social care system. These include:

Key Point 1 - Further work is required to fully understand the costs of the current health and social care system and alternative projected models.

Key Point 2 - Further development is required to ensure there is a smooth transition for people moving from services specifically aimed at children and young people, to adult services and that the required services are appropriately provided and funded.

Key Point 3 - Further work is required to advise the States on the balance of investment between preventative, primary, secondary and tertiary services and the effects on different parts of the health and social care system including the HSSD estate.

Key Point 4 - There is a real need to ensure that clinicians from both primary and secondary care are able to contribute to the future shape of services.

Key Point 5 - Future decisions regarding the continuation of contracts with Medical Specialist Group (MSG), Guernsey Physiotherapy Group (GPG) and for Accident and Emergency (A and E) Department need to be made as part of the consideration of options for the future.

Key point 6 – States partnership and joint working with and between the third sector (charities and not for profit non government organisations) needs to be developed and strengthened.

Key Point 7 - The system of regulation for all parts of the health and social care system needs to be reviewed.

Key Point 8 - More research and financial modeling needs to be undertaken on the impact of preventative measures.

Key Point 9 - Disability and Mental Health issues are areas which require specific strategies to be developed to improve service provision and enable people to live as productive and independent lives as possible.

Key Point 10 - Any future strategy for health and social care must align with the States objectives.

Key Point 11 - The States of Guernsey will need to prioritise its resources and decide how much should be invested in supporting the determinants of good health and social wellbeing (education, employment, housing etc). This should be considered against the costs of maintaining the status quo.

Key Point 12 - The health and social care system needs to promote self care and independence and this should be with the support of a social care and prevention model rather than a health care model.

Key Point 13 - A complete review of the direction taken in health and social care is needed to ensure that the impending demographic demand can be met without financially over burdening the working population.

Key Point 14 - In order to provide a more sustainable framework for the provision of health and social care, services must move towards models of care more suited to responding to chronic, long term conditions and disability.

Key Point 15 - We need to know more, and make careful decisions about, what works and what interventions are most effective. We need to know what level of quality of service is being provided and what outcomes we are getting for the investment being made by the public.

Key Point 16 - The solution to the problem is as much about prevention and careful decision making regarding areas of investment as it is about delivering high quality services when needed. The current funding and organisational structure is unlikely to be able to meet future demands in the most efficient and effective way.

Key point 17 - There is considerable potential for increasing the commercial aspects of health care provision which shall be further explored.

Key Point 18 - A process for reviewing and establishing appropriate funding options to support the development and implementation of HSSD's 2020 Vision will be established and led by HSSD in close liaison with Policy Council, Treasury & Resources, Social Security Department and other stakeholder agencies and Departments.

10. Whilst HSSD is striving to cut costs, increase efficiency, improve quality, drive up performance and expand monitoring, it is highly unlikely that these evolutionary initiatives alone will meet the future demands for health and social care. The States will therefore have to make a more radical change in direction to do different things as well as providing the current services in a different way. Maintaining the status quo is therefore not an option.

11. It is essential that there is open debate with all stakeholders on the future model of health and social care in Guernsey and Alderney. This framework sets out the areas of work which are needed to be able to deliver future services against a set of agreed principles, objectives and benefits, which can then be monitored to ensure the targets are hit.

12. In summary the States of Guernsey is asked to support the proposed direction set out in this report. In essence this direction can be described as follows:

Our vision for the future of the health and social care system is to:

- Enable people to live healthy, independent lives.

To deliver this vision our job is to:

- Promote, improve and protect the health and social wellbeing of all.

To achieve this we have to:

- Promote healthy lifestyle choices and social wellbeing.

- Improve services, continuously striving for safety, quality, efficiency and effectiveness.

- Protect and support the community.

13. In conclusion this report does not commit the States to any increase or changes in public expenditure. There will be full consultation and opportunity for debate at each phase of the framework's development, including the overall direction contained in this report. The Department will bring back to the States a series of more detailed reports following a period of consultation on the issues contained in this framework. The HSSD, therefore, requests that this report be considered by the States in accordance with Rule 12 (4) of the Rules of Procedure of the States of Deliberation.

PURPOSE

14. At the 30th June 2010 States meeting the HSSD set out its five point plan as follows:

i. The need to ensure that spending for 2010 continues to be held to as low a figure as possible while still providing safe and effective services.

ii. The need to take further action to ensure that this financial position is sustainable into 2011.

iii. HSSD needs to ensure that it has the appropriate management information to constantly monitor its position.

iv. HSSD needs to set out what services it currently provides, provide evidence that these services are both necessary and cost effective and forecast what services might be required for the Bailiwick over the next 10 years. There is no doubt that the demand on health and social care expenditure will continue to rise, as it has in every country across the world. A continually improving and more productive way of delivering services can only ever mitigate against these rising costs - it can never reduce them. This problem will only be exacerbated by the demographic time bomb and the reducing ratio of taxpayers to support those in retirement.

v. Guernsey and Alderney need a full and open debate about the future portfolio of services that HSSD provides over this 10 year period, how these services might be configured and how they might be paid for. This is not just an HSSD issue. The States needs to decide from its fiscal policy how much money is available to provide public services and then it needs to decide "what are our priorities and how do we allocate those resources to Departments on a fair and equitable basis which reflects those priorities."

15. The HSSD is set to achieve the first two points and is making substantial progress on the third point. The purpose of this report is to set out a framework for future development of the health and social care system in Guernsey and Alderney, of which HSSD is only one element. The States is requested to support the approach set out in this report. It will require all States Departments to work together. The purpose of the framework is to:

    i. describe the current health and social care system in Guernsey and Alderney and the estimated costs;

    ii. establish the key principles within which States Departments can plan, develop and deliver health and social care services and other related activities in Guernsey and Alderney;

    iii. seek the States of Guernsey approval to further develop this framework and the constituents plans to review the services, funding, infrastructure and organisational structure of the health and social care system; and

    iv. set out the main benefits of this approach and the high level plans which will need to be developed to deliver this vision.

16. This report is intended as the start of a full consultation process and does not commit the States to any specific increase or changes in public expenditure. There will be opportunity for debate at each phase of the framework's development and the Department will bring back to the States more detailed reports. The HSSD therefore requests that this report be considered by the States in accordance with Rule 12(4) of the Rules of Procedure of the States of Deliberation.

THE CURRENT SYSTEM AND ESTIMATED COSTS

Guernsey and Alderney's current provision of health and social care

17. There are a number of elements of Guernsey's provision of health and social care services. Many, but not all, of these also apply to Alderney. A separate piece of work will be undertaken to examine Alderney's health and social services.

18. For ease of reading elements of provision have been divided into four groups. The inter-relationship between the categories is complex. In Guernsey and Alderney, many health and social care related goods and services are paid for by the individual directly and others are funded through taxation and contributions to the Social Security Department's Funds. This means that the assessment of the cost of the whole health and social care system is estimated and the costs relating to each group are not easy to determine.

19. The four groups (see appendix 1) are:

i. **Preventative services**, which largely focus on improving the determinants of health and social wellbeing. About £6m can be identified as directly relating to this area, while the total amount that Islanders spend will be significantly more (for example, gym membership, sports clubs, relevant school curriculum and extra curricula activities, pharmaceutical "over the counter" products and so on).

ii. **Primary services**, are usually the first point of contact for an individual when they require support or help. Guernsey residents generally pay directly for these services (with the notable exception of social services), although a considerable amount of subsidy is currently provided by States funding (for example diagnostic testing, the health benefit grant and the grant towards the cost of the Ambulance and Rescue service). The identified cost of primary services is approximately £64m, but again the real costs are probably significantly higher than this.

iii. **Secondary services**, which includes anything that is dealt with after being through the primary system and needing further intervention. These will largely involve accommodation based services such as hospital, residential or nursing home care. The approximate identified cost of these services is £110m, but this will not include everything that people pay for privately. These costs also include elements which could be considered as relating to one of the other three groupings (for example primary diagnostic services delivered by services based at the PEH).

iv. **Tertiary services**, which tend to be more specialised and complex. Many of these services are not delivered on Guernsey and an off-Island referral is required. This is mainly complex hospital based services, but also includes complex children, mental health and learning disability clients. The cost of these services has been identified as approximately £21m.

20. The total cost of the system as identified here is over £201m. However, there are also significant additional sums where individuals pay for services directly, the figures for which we do not have access to. It would be impossible to accurately quantify those costs at this stage. There is also an economic cost to poor health and low levels of social wellbeing, which has been estimated at £100m for Guernsey and Alderney. (Ref Dame Carol Black's review of the health of Britain's working age population in March 2008).

21. A more detailed analysis of these figures is available in appendix 1.

Key point 1: Further work is required to fully understand the costs of the health and social care system

Organisations that provide health and social care services

22. There are a number of key organisations involved in providing or funding current health and social care services for Guernsey and Alderney. These are:

Organisation	Funded by
Health and Social Services (HSSD)	Taxation, SSD and private income
Social Security (SSD)	Taxation and contributions
Housing Department	Taxation, SSD and rents
Home Department	Taxation
The Medical Specialist Group	SSD and private income
Physiotherapists	SSD and private income
St John Ambulance and Rescue Service	HSSD grant, charitable donations and private income
General Practice Partnerships	Private income and SSD
Off-Island hospitals	HSSD and SSD
Off-Island complex need providers	HSSD
Dentists	Private income, SSD and HSSD
Opticians	Private income and SSD
Pharmacies	Private income and SSD
Residential and Nursing Homes	Private Income, taxation and SSD
Charitable organisations	Charitable donations and some State grants (HSSD and SSD)
Other private health services	Mainly private income

Key functions of the organisations

23. The Health and Social Services Department was constituted with effect from 1 May 2004 by Resolution of the States of 31 October 2003 and 12 March 2008 in main replacing the functions of the old Board of Health and Children Board, and taking on St Julian's Hostel from the Public Assistance Authority. The HSSD's current constitution, mandate and membership are contained in appendix 2.

24. The HSSD, with net costs of £107,197,000 in 2009 (Billet d'Etat XII, May 2010), is the States second largest spending department after Social Security.

25. In examining the future care needs of the Islands it is important to understand the current services that HSSD deliver. A broad range of these are listed below.

i. Hospital based services

ii. Community based services

iii. Mental health

iv. Disability (including learning disabilities)

v. Public Health

vi. Health protection

vii. Health improvement including promotion

viii. Social care (including respite services)

ix. Environmental health

x. Youth justice

xi. Child protection

xii. Fostering and adoption

xiii. Prison health care

xiv. A range of supporting functions.

26. It is important to highlight that a considerable amount of HSSD's work concerns the provision of social care rather than just health care. This fact is often overlooked, but must be a key consideration for future services.

HSSD key activity and performance data

27. In 2010 there were 14,556 total admissions to the PEH hospital and admissions have been increasing by 2.8% on average for the last six years. The Castel Hospital had 313 admissions in 2010, and this is lower than in previous years which have averaged 370 per annum. Admissions to the KEVII have remained fairly stable at 220 per annum on average.

28. The admissions are different between the longer stay units where the residents are a relatively stable population, to the acute units where there is a high turnover of shorter stay patients. There has been a move for more work to be carried out as day patient work and the Day Patient Unit numbers reflects the increasing trend.

29. With the joining of the Children Board and the Board of Health to make HSSD in 2004 the responsibility to provide social care for children and adults came under one body. This now enables a cradle to grave service user focus on social care to be developed. However, vulnerable children and adults still have boundaries between some services which can lead to service continuity issues.

Key point 2: Further development of services is required to ensure that the transition years from young person to adult are appropriately provided and funded.

30. HSSD also provides social care and community based nursing care. During 2010 community nursing provided on average per month 411 service users with care during the day time, which was the same average as in 2009. It also provided on average per month services for 36 people at twilight (50 in 2009) and 27 people at night time (22 in 2009). In addition on average 320 (317 in 2009) service users were provided with personal care packages and 206 (210 in 2009) with domestic care support. The Social Work Service provided on average 250 (240 in 2009) service users support and occupational therapy 102 (90 in 2009). Rapid Response on average prevented 33 (32 in 2009) hospital admissions per month.

The following certificates were awarded by the Needs Assessment Panel for Long Term Care		
Type of Certificate	**Number 2010**	**Number 2009**
Hospital Nursing Care	29	46
Nursing Home Care	107	138
Residential Home Care	184	149
Extra Care Housing	18	12
Hospital Respite Care	22	37
Nursing Respite Care	37	59
Residential Respite Care	124	111
Regular Respite Placements	93	106

31. Within the Services for Children and Young People Directorate the average number of looked after children under 18 years of age for 2009 was 67 and for 2010 was 72. In terms of child protection, there was an average of 32 cases on the register for 2009 and 44 for 2010.

32. In addition to the running costs of the health and social care system, assets are tied up in property and estate. The HSSD has a significant property portfolio – which for insurance purposes has a rebuild value of £254m at March 2010 prices. In addition, the HSSD leases a considerable number of additional properties. Some of these assets are no longer suitable for the delivery of modern health and social care services or are expensive to maintain. A review of the entire infrastructure of the HSSD is required. This will include the relocation of the Castel Hospital to the PEH site by 2015. Over time it may also include the relocation or upgrading of Perruque House and King Edward VII Hospital - and other major sites within HSSD's current portfolio of properties.

33. In summary, the current health element of HSSD services has more focus on ill health and providing treatment and interventions.

34. In order to meet the future needs of the population and move to a more preventative model of health and social care, services will need to change to ensure effective use of resources. Resources may need to move from secondary and tertiary services to primary and preventative services or more investment will be needed. This cannot be done easily or in the short term and it may be necessary for other States departments, businesses and other organisations to help to facilitate this in the longer term by doing things differently.

Key point 3: Further work is required to advise the States on the balance of investment between different parts of the health and social care system.

Other organisations involved in the health and social care system

35. The provision and shape of medical services is strongly influenced by the States' external contractual partners, the Medical Specialist Group (MSG) - who provide the majority of the consultants working the hospitals in the acute secondary care sector. Primary care doctors, who serve the Islands' primary care needs in a private capacity, also have a major role and influence on services provided by the system.

Key point 4: There is a real need to ensure that clinicians from both primary and secondary care are able to contribute to the future shape of services.

36. In 1995 legislation was introduced to insure people needing specialist treatment, through the universal schemes introduced by the States. Prior to this being introduced, only the care provided by the hospital was free at the point of delivery - with patients being liable for the cost of the treatment provided by the doctor, consultant or physiotherapist. The benefits currently cover all treatment provided by the MSG, other than a small number of exclusions, treatment as an inpatient at the Mignot Memorial Hospital in Alderney and physiotherapy in conjunction with specialist treatment.

37. These benefits are provided through contracts with the MSG, Guernsey Physiotherapy Group (GPG) and Alderney doctors where both the Social Security and the Health and Social Services Departments represent the States jointly. HSSD also has a contract with primary care to provide 24 hour cover for Accident and Emergency in the PEH. The MSG and GPG contracts expire in 2017 and the A&E contract in 2018.

Key point 5: Future decisions regarding the continuation of contracts with MSG, GPG and for A&E need to be made as part of the consideration of options for the future.

38. HSSD is not the only States Department to contribute to Guernsey and Alderney's health and social care system, with significant proportions of the £179,130,000 (Billet d'Etat XII, May 2010) spent by the Social Security

Department (SSD) being for health and social care. These funds are raised through a combination of tax and Social Security contributions. Whilst SSD is not itself a provider of health and social care it provides this by:

i. Directly supporting people in need, through cash payments to the individuals or carers - such as sickness benefit, invalidity benefit, supplementary benefit, attendance allowance, invalid care allowance, etc.

ii. Financing the specialist health insurance scheme through paying the Medical Specialist Group and the Guernsey Physiotherapy Group contract fees.

iii. Subsidising the cost to service users of GP and nurse consultations, through £12 and £6 grants and paying for prescription drugs (apart from a prescription charge).

39. Since the introduction of the long-term care insurance scheme funded by the Social Security Department (Billet d'Etat III, 2001), there has been a recognition that some changes to continuing care support are necessary. All of this will be further explored jointly with Social Security Department. Whilst this scheme specifically relates to people living in residential or nursing homes it does not provide help to people who wish to continue to live in their own homes - even if they have the same needs. There is, therefore, a perverse incentive financially to move out of one's own home, even though one might be able to manage to live there longer with additional help and intervention. Many people want to stay in their own homes for as long as possible, but may find it difficult to afford the extra care required.

40. In 2010 there were 232 nursing homes beds and 425 residential care beds provided in the private sector; current costs for these range from £533 per week for a residential bed to over £1,000 per week for a nursing care bed. As the average age of the population increases, there is likely to be increased demand for more services enabling people to live in their own homes - as well as for more nursing and residential home beds.

41. General practice (GP) medicine is organised in three partnership groups on Guernsey and in two practices on Alderney. There are a number of surgeries spread geographically across Guernsey. An out-of-hours Primary Care Centre is located at the Princess Elizabeth Hospital (PEH), providing a joint out-of-hours service from Guernsey's three primary care practices. A combined primary care organisation provides the doctors for the Accident and Emergency (A and E) Department at the PEH. Alderney doctors will provide treatment in the A and E department at the Mignot Memorial Hospital when they are called in.

42. Payment for general practice is on a "fee per item of service" basis charged to individuals, many of whom offset this cost with insurance. The cost is reduced by a universal grant from the Social Security Department for each doctor and

nurse consultation and SSD also provides other financial assistance, in certain circumstances.

43. HSSD make a payment to primary care for A and E doctors in Guernsey, who provide 24 hour 365 day a year cover on site at the Princess Elizabeth Hospital. HSSD also provides other staff, facilities and consumables for Guernsey and Alderney A and E Departments.

44. As there is no on-Island specialist group in Alderney, there is also a contract paid for by SSD to cover medical treatment for inpatients at the Mignot Memorial Hospital.

45. The St John Ambulance and Rescue Service is a Guernsey-based charitable company, which operates the Island's only ambulance service. It operates 24 hours a day, providing accident and emergency cover and paramedic response - as well as a non-emergency patient transport service.

46. The Ambulance and Rescue Service also provides additional facilities which extend the range of care beyond that of road ambulances. These include the Island's cliff rescue team, the inshore rescue boat services, a marine ambulance and a hyperbaric recompression centre. Most of these additional services rely on public donations for their funding. In addition, community schemes are provided, such as training in health and safety related subjects, a treatment room open to the public and the largest centre for home health care equipment in the Channel Islands. They also arrange and co-ordinate emergency off-Island travel.

47. In addition to the professional ambulance service there is a separate voluntary arm which is one of the hundreds of other charitable, not for profit, or non government organisations operating in Guernsey and Alderney. These organisations are collectively referred to as the third sector in this report.

48. The third sector organisations have different purposes and agendas. Some of them will help financially with the costs of items or services. Others provide the services themselves. Many provide a collective voice or lobby group and more provide a combination of information, support, advocacy and services to meet the individual or collective needs of the people they represent. All the organisations in the third sector working in the Islands play important roles in providing the infrastructure needed in the overall health and social care system.

49. It is impossible to quantify the amount of resources the third sector contribute to the health and social care system, but they will be significant and must not be overlooked.

50. States partnerships with these organisations and more collective working with and between them needs to be developed and strengthened to achieve a more joined up approach and in some cases economies of scale.

Key point 6: Partnership and joint working with and between the third sector needs to be developed and strengthened.

51. At the present time there is inconsistency in information about the quality of the services provided within the health and social care system and this needs to be addressed. The States of Guernsey will be asked, as part of the development of future strategy, to consider how it might be able to ensure that all services provided to the population, whether public or private, meet agreed minimum standards and that the authority to practice on Guernsey and Alderney will depend on demonstrating consistent delivery of those standards. New legislation may be required to support this approach.

Key point 7: The system of regulation for all parts of the health and social care system needs to be reviewed.

52. The total health and social care economy, including States, individual, insurance company, charity and other third sector provision, can be assessed as consuming over £300m of resources per annum for Guernsey and Alderney. States funding meets 60% (£180m) of this assessed cost with the remainder met by the individual or the wider economy. The current configuration of the health and social care system in Guernsey and Alderney is a complex mixture of organisations and organisational inter-relationships - which make quality difficult to assess and creates some inconsistencies in the way services are delivered and funded. This, combined with a significant, but not always suitable, estate infrastructure, creates inefficiencies in the way services are delivered.

KEY ISSUES FOR NOW AND THE FUTURE

Patterns of health and illness

53. At 31 March 2009 the population of Guernsey was 62,274 (Guernsey Population Bulletin 2009). During the same year there were 329 marriages 162 divorces, 690 live births and 536 deaths of which 256 were male and 280 were female.

54. In considering the strategic vision for Guernsey and Alderney it is important to be clear of the top causes of death for our population, which will help to inform the key targets for health improvement. Figure 1 demonstrates the causes of death during 2005 to 2009 in Guernsey. It can be seen from this figure the top three causes of death over these years are diseases of the circulatory system (heart disease), neoplasm (cancer), and respiratory system (chest).

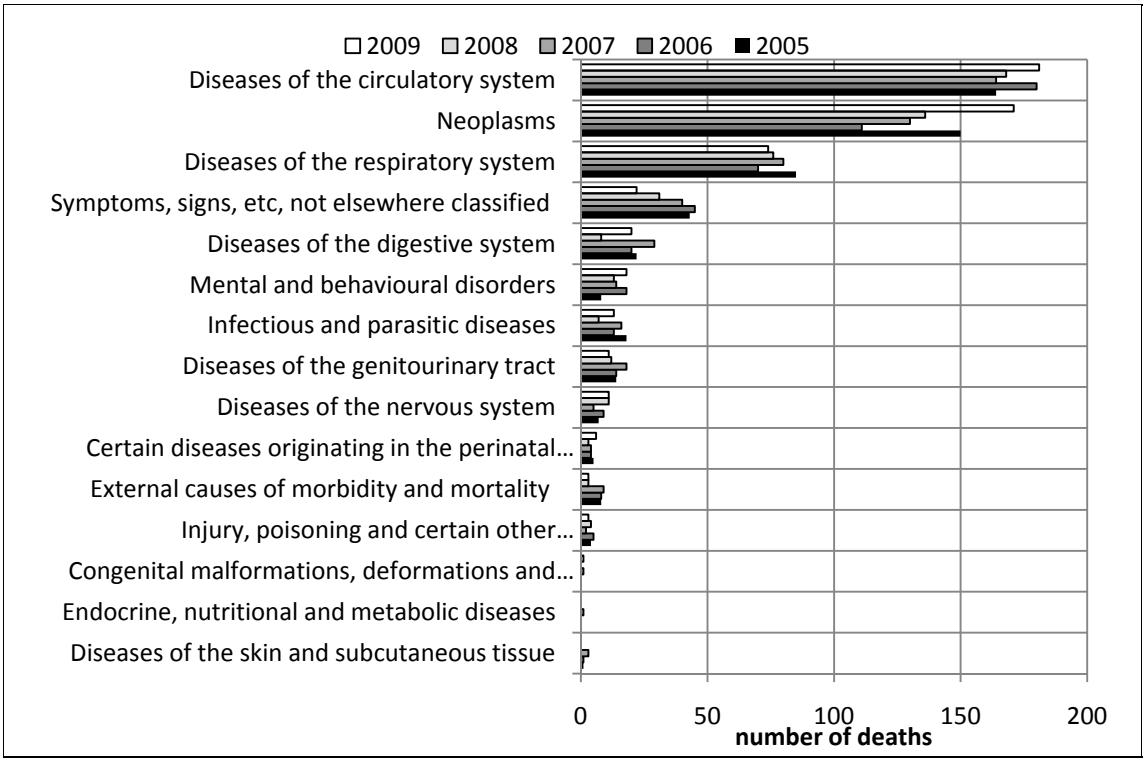


Figure 1. Summary of Causes of Death 2005 to 2009 (Source: MoH Reports)

55. We know from world wide studies that the main causes of poor health are:

    i. Smoking

    ii. High levels of alcohol consumption and abuse

    iii. Lack of physical exercise

    iv. Poor eating habits

    v. High levels of obesity

56. The States of Guernsey has already made some notable progress in tacking these issues. There has already been States approval for strategies relating to:

    i. Anti poverty;

    ii. Drug and alcohol misuse;

    iii. Obesity and;

    iv. Tobacco control.

57. It is very difficult, however, to determine at this stage what the impact of these strategies might have on the longer term need for the provision of health and

social care services (as well as other public services like criminal justice which have similar determinants).

58. We also know that the main contributory factors to poor health and low levels of social wellbeing (the determinants) include, amongst other things;

i. Poor housing;

ii. Poor educational attainment; and

iii. Poor employment prospects.

59. A more comprehensive summary of this is illustrated in figure 2.

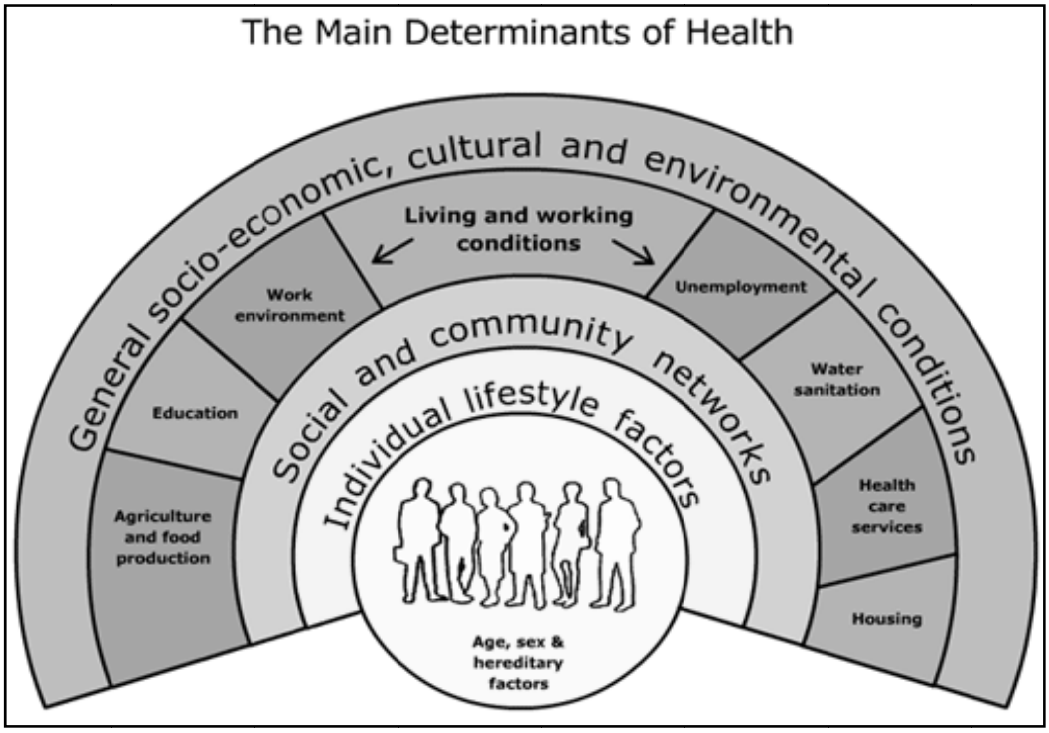


Figure 2. Wider Determinants of Health (Dahlgren and Whitehead, 1991)

60. The cost to society of poor health and poor social circumstances is ever increasing. The estimated annual economic cost of sickness absence and worklessness associated with working age ill-health are estimated to be over £100 billion in Britain – equivalent to £100m in Guernsey.

61. The ability to understand what drives poor health and poor social circumstances is increasingly complex. Guernsey has a unique health and social care system, and understanding where we are compared to other jurisdictions is very difficult to quantify. Historically, information about the health and social care system as a whole in Guernsey is limited. One of the key elements of work for developing the future vision will be to ensure that more information is available for all parts of the system, both in terms of cost and quality.

Key point 8: More research and financial modeling needs to be undertaken on the impact of preventative measures. This will enable the States of Guernsey to make more informed and prioritised decisions about funding allocations.

62. These issues do not only apply to physical illness. Mental health problems are also a consequence of these key determinants, and huge benefits to the overall economy can be realised if we can improve the mental wellbeing of the population. Early intervention and good early years education are crucial to this agenda. The States of Guernsey has already agreed to fund a new Mental Health Strategy and this will be developed as part of this framework.

63. There is no comprehensive disability register which covers all forms of impairment in Guernsey and few statistics available on disabilities kept by the States of Guernsey. A piece of important work is currently being undertaken to establish the current range of disability services. There is a need to understand what services will be needed in the future, particularly in respect of respite, education, accommodation, employment and support for disabled people. The future vision work will need to encompass the needs of disabled people and ensure that where possible these needs are met.

Key point 9: Disability and Mental Health issues are areas which require specific strategies to be developed to improve service provision and enable people to live as productive and independent lives as possible.

Current States objectives

64. The States Strategic Plan sets out what it aims to achieve and many of the objectives are ones which will have a direct influence on the future health and social wellbeing of the Islands. For example, the Fiscal and Economic Objectives include *"continuing full employment"*, the Social Policy Objectives include *"meet welfare needs and reduce poverty", "Improve housing availability, quality and affordability"* and *,"Maintain a healthy society and safeguard vulnerable people"*.

Key point 10: Any future strategy for health and social care must align with the States objectives.

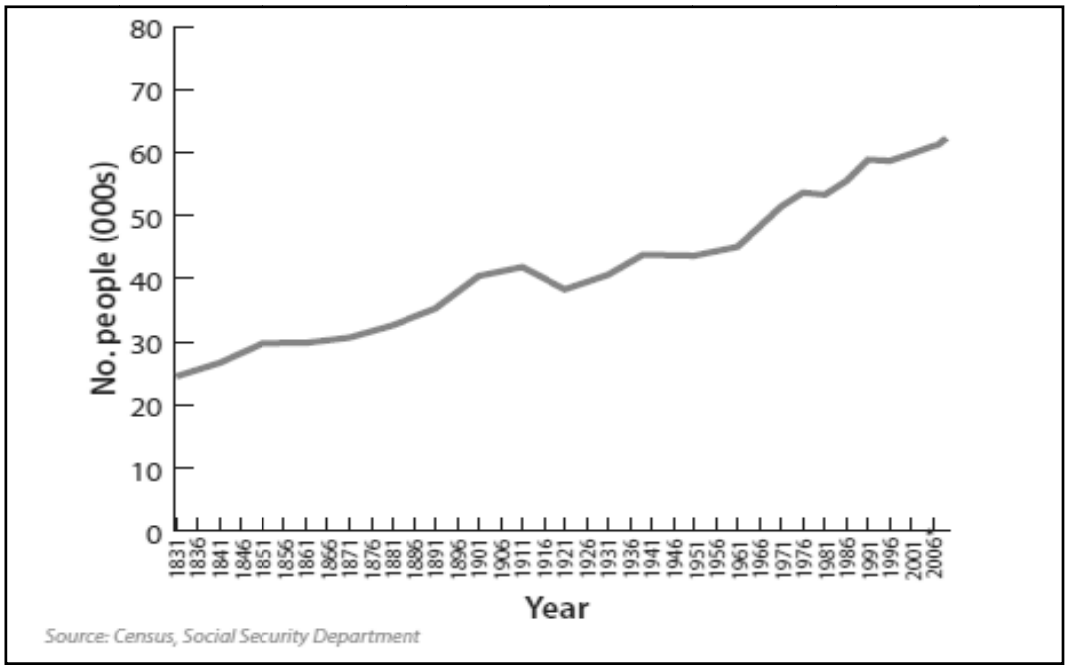
65. In summary, the main drivers of demand for health and social care services are often linked to the determinants of poor health and poor social wellbeing, such as housing, education and employment. These determinants are heavily influenced by the policies of Government and have to be considered alongside funding decisions for the provision of health and social care services as one often impacts directly on another over time.

Key point 11: The States of Guernsey will need to prioritise its resources and decide how much should be invested in supporting the determinants of good health and social wellbeing (education, employment, housing etc). This should be considered against the costs of maintaining the status quo.

66. Whilst there are a number of important factors that will affect health and social care over the next 10 years one of the most significant is the affect on population and this can be projected. The demographic projections are therefore described in more detail below.

Demographic projections

67. The population of Guernsey has been increasing for many years as shown in Figure 3.



68. However, the total population growth will slow down and is projected to go into decline, by the Government Actuaries Department, by 2040.

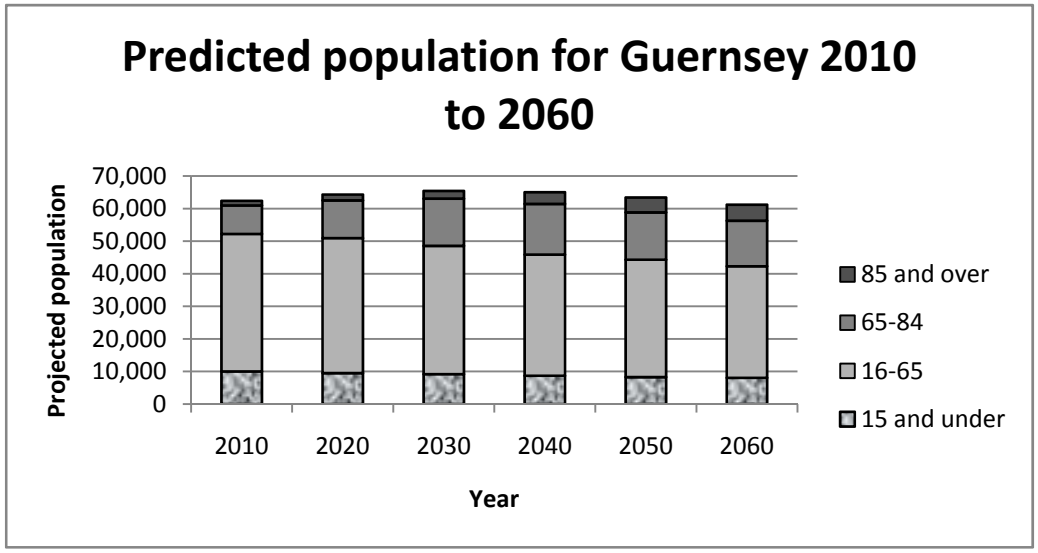


Figure 4. Projected population for Guernsey 2010 to 2060 (Source: Guernsey Population Bulletin 2009)

69. As figure 4 shows, the projected decline in population is the result of a continual reduction in the number of working-aged men and women. At 2040 the number of people between 65 and 84 would reduce as the effects of the "baby boom" generation passed. However, the number of over 85 year olds would continue to increase during this whole period. This means that more services are generally required for the increased total population up to 2030, but need to be targeted for those over 65, with those for the over 85s becoming increasingly in demand as dementia prevalence rates and disability ratios increase exponentially with age.

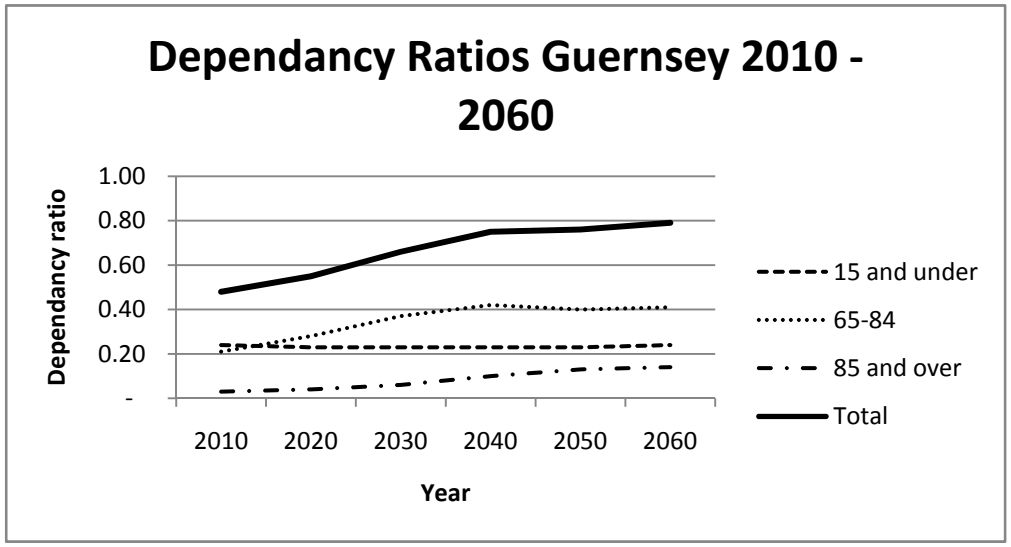


Figure 5 Dependency ratios for Guernsey 2010 to 2060

70. Due to a longer average life span, the proportion of the population over 65 years of age is increasing - which in turn increases the ratio of the retired population

and those still at school under the age of 15 years to the working population. This is known as the dependency ratio. This ratio will also be influenced by changes to the school leaving age and the statutory retirement age.

71. As can be seen in figure 5, the total dependency ratio reaches 0.79 - which means that for every 100 people who are of working age, there will be an estimated 79 people who fall into the dependant categories. This is the core problem of providing sustainable services - as the demand increases, the ability to pay for them through general taxation or Social Security contributions reduces.

Key point 12: The health and social care system needs to promote self care and independence and this should be through more of a social care and prevention model than a health care model.

72. Figures from a report on the Long Term Care Fund show not only how the 'over 65' population is projected to increase, but also how the requirement for long term benefit, which is for nursing and residential homes, is likely to increase as there are more people living longer. This will also be indicative of the increases in numbers of people who will require extra care at home.

Year	Population aged 65 and over	Projected number receiving a benefit	Percentage receiving a benefit
2005	10,457	443	4.2%
2010	11,096	586	5.3%
2015	13,060	655	5.0%
2025	15,835	876	5.5%
2035	18,653	1,203	6.4%
2045	18,926	1,511	8.0%
2055	18,769	1,702	9.1%
2065	18,705	1,702	9.1%

Figure 6. Population aged 65 and over compared with the number receiving one of the Long Term Care Benefits (Billet D'Etat VI 2007)

73. Whilst men in Guernsey do not have as high a life expectancy as women - for example in March 2009, 76.2% of the population who were 90 years old or older were women - the life expectancy in Guernsey is better than many other countries, but can still be improved through personal lifestyle choices. The responsibility for health and wellbeing is ultimately the individual's, but help can be provided on making these choices in relation to smoking, dietary choices, exercise, etc.

74. There could be improvements in life expectancy at 60 – for example Guernsey is currently 1.4 years less than Japan. Having a larger proportion of older people who are mentally, physically and even economically active will be more sustainable than having the same, or even a fewer, number of people who are

more dependent on services and will provide individuals with a better quality of life for longer.

75. Overall life expectancy at birth for Guernsey residents for the period 2006-2008 was 81.9 years (79.6 years for males and 84.1 years for females). Life expectancy at 65 years was 18.4 (i.e. live to 83.4) years for males and 21.5 (i.e. live to 86.5) years for females.

76. When the Guernsey life expectancy values for 2006-2008 are compared with values previously calculated for the periods 1995-1997 and 1999-2003, an increase with time is revealed (see figure 7). The line graph in figure 7 shows a general trend of increasing life expectancy for both men and women, with males having experienced a marginally faster rate of increase than females. Between 1995-97 and 2006-08, male life expectancy increased by 3.9 years, or 4.8%. Over the same period, female life expectancy increased by 3.5 years, or 4.4%.

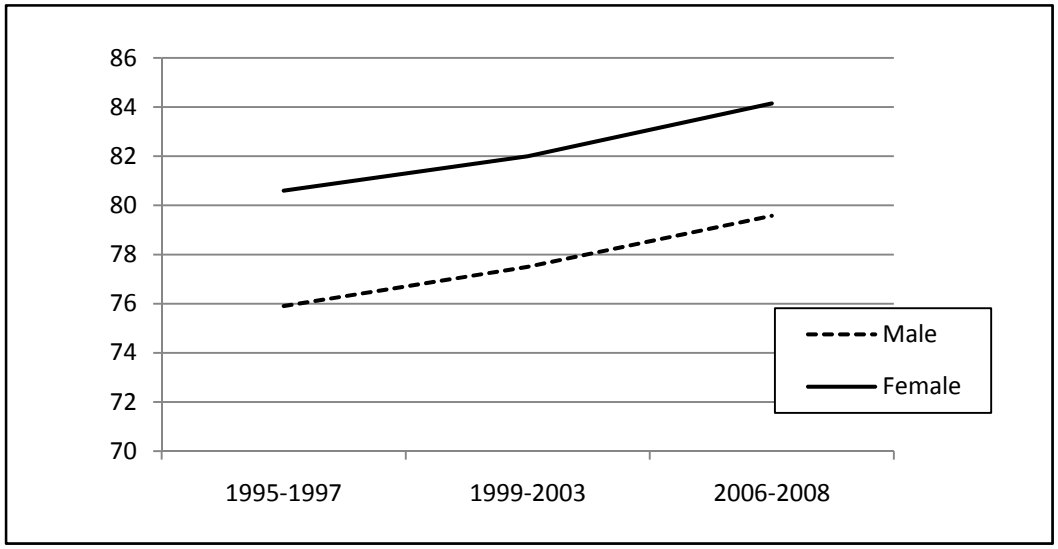


Figure 7. Change in life expectancy for Guernsey males and females over time.

77. All of these demographic factors are putting pressures on services at a time when fewer people in the population will be of working age to provide funds to sustain them.

78. Concern has already been expressed over the sustainability of HSSD's spending. Financial controls will help to keep the department in budget only in the short term.

Key point 13: a complete review of the direction taken in health and social care is needed to ensure that the impending demographic demand can be met without financially over burdening the working population.

79. In summary, future trends and projections indicate that the current model of health and social care is not sustainable. Demand on services, and therefore expenditure, will outstrip the Islands' ability to pay for them if nothing changes. The current system is more suited to acute, episodic responses to disease and impairment.

Key point 14: In order to provide a more sustainable framework for the provision of health and social care, services must move towards models of care more suited to responding to chronic, long term conditions and disability.

80. From the projections, people will be living much longer and more people will need to access greater levels of care and support for longer. Budgets will need to be prioritised and services will need to target areas where the biggest benefits can be achieved.

Key reasons why change is necessary

81. The costs of health and social care, as funded by the States of Guernsey, have increased over the last 5 years by an average of 7.5% per annum, although this trend has been significantly reversed in 2010.

82. In making decisions about the future the States of Guernsey may well be faced with a choice of further investment in health and social care or alternative forms of funding. We also have to be clear about what is funded, because it is effective, and what is not funded.

Key point 15: There is a need to know more, and make careful decisions about, what works and what interventions are most effective. We need to know what level of quality of service is being provided and what outcomes we are getting for the investment being made by the public.

83. Work has already begun on a methodology for prioritising new service developments, with the Oxford Prioritisation Support Unit. This will produce a clear and ethical framework within which the HSSD can make decisions.

84. HSSD, as other Departments, is committed to ensuring that the services it provides are as efficient and cost effective as possible. Considerable progress has been made to return HSSD finances into line with its allocated budget. It is also striving to improve its efficiency through both the Financial Transformation Programme and the benefits realisation of the Electronic Health and Social Care Record system. There are also infrastructure issues which will, in the longer term and given the appropriate level of capital investment, also release significant efficiency savings. It is highly unlikely that efficiency alone will meet the future demands for health and social care. We will have to do things differently. The status quo is therefore not an option.

85. As well as the impact of health and social care trends - the key determinants of health and the demographic projections - there are a number of other reasons why the health and social care system in Guernsey and Alderney needs a clear strategy for the future.

86. There are a number of fiscal issues. These include:

i. Reduced income from taxation due to a reducing number of working age people compared to those in retirement. This will have the double effect of increasing the demand, and therefore the cost of health and social care, and at the same time reducing the amount of money raised through taxation and Social Security Contributions to pay for it.

ii. The rate of health and social care inflation is always greater than the increases in standard inflation. This is mainly due to things like the costs of new drugs, new technologies, new procedures and new equipment, although it is recognised that a large proportion of costs locally are due to staffing costs which increase with wage inflation.

iii. The current decision to keep the overall amount of money spent on public services frozen and not to increase direct personal taxation.

87. There are a number of social issues. These include:

i. People living longer –

a) Guernsey and Alderney have higher life expectancies than the UK average by about 2 years. If there is a reduction in preventable early death from cancer, circulatory disease and respiratory disease, then there will undoubtedly be an increase in the diseases of older age, such as dementia.

b) Therefore people may require more health or social care for a longer duration than their parents or grandparents.

c) People with disabilities are living longer, fuller and more independent lives - which requires different types of care than may have been provided historically.

d) The impact on carers of people living longer, who themselves may become dependent on others.

ii. Increasing numbers of people suffering from a mental health problem. The estimated cost of mental health problems to the Guernsey economy is £105m (based on "No health without mental health" – UK Government – February 2011).

iii. The possibility that low earners, who often are the most needy and vulnerable, do not seek primary care services as it is on a "fee for item of service basis", which may reduce access to healthcare.

iv. The growing level of inequality in health which, to some extent, is related to the increasing division between low earners and high earners.

v. Changing expectations as society changes and technology progresses. Expectations of services will change as people demand more integrated, flexible and personal service tailored to themselves rather than to the staff providing it. Service users should be the core around which services are developed to meet individual needs.

vi. Expectations that children are treated differently and afforded more protection than adults.

vii. Complexities of modern life, with different types of family structures and family economics.

viii. People want simple, straightforward and transparent systems for decision making and service provision that are fairly provided.

88. There are a number of service issues. These include:

i. Emerging gaps in service, such as for autism spectrum disorders, respite care, end of life care and dementia services.

ii. Advances in technology allow people to have procedures or treatments that keep them independent, provide better quality of life or prolong life that were not previously available. New technologies and treatments are continually being developed.

iii. Providing a full range of services on-Island will become more difficult as clinicians are required to become increasingly specialised. This will make some on-island services extremely difficult to maintain and will require closer partnership working with other jurisdictions such as Jersey, the UK and Europe.

iv. Continuously striving to provide the best possible services to the Islands.

v. The need to promote and support independence and reduce the level of dependence on health and social care services.

89. There are a number of organisational issues. These include:

i. Ageing HSSD estate and properties - some of which are not fit for purpose and requires rationalisation or upgrading.

ii. The contract with the GPs to provide cover for the Accident and Emergency department is due for renewal in December 2018.

iii. Contracts with the Medical Specialist Group, Guernsey Physiotherapy Group and Alderney doctors are due for renewal in 2017.

90. In summary, the case for change is clear. The current pattern of expenditure is not sustainable. Being more efficient will not be sufficient to contain expenditure within allocated levels. The ageing population and the potential for an overall decline in tax revenue will exaggerate this problem.

Key point 16: The solution to the problem is as much about prevention and careful decision making regarding areas of investment as it is about delivering high quality services when needed. The current funding and organisational structure is unlikely to be able to meet future demands in the most efficient and effective way.

ESTABLISHING THE STRATEGIC DIRECTION

Setting the vision and objectives

91. The HSSD Board believes that to set out a plan of work for taking health and social care for Guernsey and Alderney forward, we have to establish some clear objectives for the future. After consultation with staff and other professional groups, this can be summarised as follows:

What we are trying to achieve	Enable people to live healthy, independent lives
What we are here to do	To promote, improve and protect the health and social well being of all
What we need to do	1. **Promote** healthy lifestyle choices and social well being 2. **Improve** services, continuously striving for safety, quality, efficiency and effectiveness 3. **Protect** and support the community

Healthy, independent lives

92. The adoption of a deliberate and carefully worded vision for the Department will provide a strategic direction against which all investment can be measured. This will enable consistent and thoughtful targeting of resources and funding.

93. It is acknowledged that not all people in Guernsey and Alderney will be able to live healthy, independent lives, but adopting this as an aspiration will enable the Department to identify any investment in services and resources needed to achieve a new vision of health and social care.

94. This new vision acknowledges that, historically, early States support services were targeted at the very young, at the very old, at people with learning disabilities and people with mental health problems – generally, people who were already in crisis.

95. The Board of Health, when it diversified from public health matters, concentrated on hospital and institutional care, while the community nursing service served the Island communities. The community nursing service was taken over by the Board of Health around 40 years ago.

96. Commitment to, and involvement in, the provision of social and community services has had a relatively short history in Guernsey and has only been incorporated into the core business of the Health and Social Services Department since the reform of the Machinery of Government in 2004.

97. It is this history which illustrates the current approach to health and social care in Guernsey – the overriding focus of which is on treating disease and responding to crises and is accordingly oriented to hospitals and institutions.

98. We must design a new and enduring health and social care system for Guernsey and Alderney, where hospitals and institutions are not the only real alternatives to family support.

99. It is against this backdrop that the Department has crafted a new direction for the health and social services system - one which will enable and support everyone, irrespective of age or ability, to live as independently as possible and to make choices which support healthy lifestyles.

Outcome of the recent work with key professionals

100. The HSSD has, for the last 18 months been running a project examining the current range of services provided on the Islands and asking the question from a professional perspective of whether services must, should, could or cannot be provided.

101. A number of groups were established and covered the areas of Primary Care,

Emergency Care, Medicine, Surgery, Obstetrics, Paediatrics, Mental Health, Critical Care, Oncology, Palliative Care and Diagnostics.

102. The outcome of this work is currently being analysed and will be used to inform the future work plan described in the next section. This creates a solid platform on which to develop the future framework.

103. The themes emerging from these groups in summary conclude that - social care should be assessed and delivered on the basis of need; primary care should be quick and easy to access; a wide range of diagnostic and secondary care services must be available on Island; systems should be in place to deliver as much care to people in their own homes including end of life; and finally recruitment and retention of high quality staff with the ability to work across a range of areas will be the key to a successful service. (See Appendix 3 for more details).

104. All of these emerging themes are consistent with our vision and strategic objectives for the future.

Other future opportunities

105. Guernsey is very well placed to become a centre of excellence for the future development of more private health facilities and rehabilitation provision many people from other jurisdictions may find Guernsey an attractive place to come for treatment of non-government funded procedures and interventions.

Key point 17: There is considerable potential for increasing the commercial aspects of health care provision which shall be further explored.

Identifying the benefits and work needed to achieve the objectives

106. To convert our aspirations into deliverable outcomes, it is important to understand what benefits we are trying to achieve.

Objective 1 – Promote healthy lifestyle choices and social wellbeing

107. The benefits of achieving this objective will include:

i. Increase in life expectancy.

ii. Reduction in incidence of cancer, cardiac disease and respiratory disease.

iii. Reduced sickness levels in employment.

iv. Early intervention and prevention of Mental Health problems.

v. Reduced need for expensive secondary and tertiary care services.

108. The plan to achieve these benefits will include:

i. An overarching health improvement strategy which will continue to implement strategies already supported by the States of Guernsey for:

a) Reducing obesity.

b) Reducing the use of tobacco products.

c) Reducing the misuse of drugs and alcohol.

ii. Developing a healthy workplace;

iii. Producing the Strategy for Mental Health Services, already funded by the States of Guernsey.

iv. Joint working with the Education Department, the Culture and Leisure Department, the Guernsey Sports Commission and Guernsey Arts Commission on mental and physical health promotion.

v. Joint working with the Commerce and Employment Department on the Skills Strategy.

vi. A health protection strategy.

Objective 2 – Improve services, continuously striving for safety, quality, efficiency and effectiveness

109. The benefits of achieving this objective will include:

i. Maintaining expenditure within agreed allocations.

ii. Delivering a sustainable system.

iii. Delivering an efficient system.

iv. Delivering services to the public that meet recognised standards of quality.

v. Delivering services to the public which demonstrate good value for money.

vi. Using only techniques, medicines and interventions that are proven to work.

vii. Improving health outcomes.

110. The plan to achieve these benefits will include:

i. Developing and supporting the development of strategies and services for the following:

a) Primary Care.

b) Services for people with disabilities and impairments.

c) Cancer.

d) Cardiovascular and Respiratory Disease.

e) Stoke.

f) The wheelchair service.

ii. Measuring what the system does and how well it does it.

iii. Rationalising, upgrading and investing in the estate.

iv. Joint working with Jersey, the UK and Europe.

v. There is also a need to undertake a major piece of work to consider the funding and organisational options for the future. This is covered in more detail in the next section.

vi. Agreeing the range of services delivered to Alderney.

vii. Developing quality standards and a regulatory framework for health and social care services across the public, private and not for profit sectors.

viii. Progressing the integrated approach to the Financial Transformation Programme.

ix. Realising the benefits from the EHSCR implementation.

x. Establishing a clear and transparent prioritisation process for service investment.

xi. Completing the replacement of the Castel Hospital.

Objective 3 – Protect and support the community

111. The benefits of this objective will include:

i. Enabling people to exercise choice where possible.

ii. Enabling community organisations to maximise their contribution.

iii. Increasing the numbers of people living independently or with minimum support.

iv. Protecting the public.

v. Protecting vulnerable people.

vi. Supporting, developing and implementing the Children's plan.

vii. Supporting those with dementia.

viii. Developing an end of life care strategy.

ix. Supporting carers.

x. Supporting business.

112. The plan to achieve these benefits will include:

i. Developing strategies and services for the following:

a) Community social care, including day services, respite services, sitting services, befriending services, and partnerships with the third sector to deliver these.

b) Intermediate care.

c) Assistive technology.

d) Mental Health (referred to in objective 1).

e) End of life.

ii. Joint working with the following departments:

a) Housing Department on the development of supporting living and extra care housing.

b) Home Department and others on:

- developing a vulnerable adult's policy.

- the Criminal Justice Strategy.

- support to those in prison and on probation.

c) Policy Council, Home, Education, Housing and Social Security Departments on supporting reduction in domestic abuse.

d) Social Security Department and Commerce and Employment Department on

- the Supported Employment Scheme.
- reducing sickness levels at work.

iii. Joint working with the voluntary and charitable sector to support people in the community.

iv. Supporting the States of Guernsey on Emergency Planning.

v. Planning for potential future pandemics.

vi. Establishing a clear and accountable governance framework and structure.

vii. Implementing new Mental Health Legislation.

The enabling plans to support this work

113. In addition to the work identified above, there will be a need to ensure that our key corporate functions of Finance, Business Intelligence (including IT) and Human Resources develop long term plans to support the delivery of these key pieces of work. This will be done in partnership with the Financial Transformation Programme. We will also be developing a comprehensive communication and public engagement plan so that the public, professional and other interested parties can express their views at the appropriate points in the delivery of this framework. This will commence with seeking views of the public, professionals and services users on the principles and key objectives contained in this framework.

114. With all good strategies, progress and development will be kept under constant review. It will also be important to review this work in line with other States strategies including managing Guernsey population. Following a period of consultation, an update on progress with the framework and an opportunity to confirm the key principles set out in this report will be bought back to the States in 2012.

FUNDING AND ORGANISATIONAL OPTIONS

Funding options –resourcing HSSD's 2020 Vision

115. If the health and social care system continues to be funded at current levels, it is unlikely that it will be able to continue to deliver the same range and/or quality of services in the future, even with significant efficiency improvements.

116. A considerable amount of economic and financial modeling will be required to substantiate that assertion. This modeling is also needed to create a clear picture of what Guernsey will need to do in the next few years to ensure that it has an affordable health and social care system.

117. The outcome of the modeling work will lead to a number of scenarios, which the States of Guernsey will need to consider. These scenarios will review alternative methods of funding which may include:

i. a fully tax and/or Statutory Health Insurance (SHI) funded system (including Primary Care);

ii. a partial tax/SHI funded system where secondary care is free;

iii. a partial tax/SHI funded system where acute hospital care is charged (or means tested) but social care, mental health and disability services are free (or means tested);

iv. a fully private insurance based system;

v. a fully insurance based system through the Social Security Department.

Key point 18: A process for reviewing and establishing appropriate funding options to support the development and implementation of HSSD's 2020 Vision will be established and led by HSSD in close liaison with Policy Council, Treasury & Resources, Social Security Department and other stakeholder agencies.

Organisational options – delivering HSSD's 2020 Vision

118. This would consider options for the organisational form of delivery to ensure the most efficient model of service delivery and care and could include:

i. Continuing to organise the health and social care system in the same way, recognising the inefficiencies and inconsistencies this brings with it.

ii. Consider alternative organisational forms ranging through:

a) a fully employed model where all aspects of health and social

care are provided by HSSD or another States Department;

b) a mixed economy of States employed and independent sector organisations (including the voluntary sector);

c) a fully devolved model where no States Department employs health and social care staff.

119. It is critical that work begins now on looking at alternative organisational forms, or maintaining the status quo, so that an early decision can be made on the future of the MSG, GPG and A&E contracts.

120. In summary it is very clear that the current model of health and social care cannot be sustained. It is essential that there is open debate with all stakeholders on the future model of health and social care that should be implemented. Some examples demonstrate ways of enabling change to occur but there may be other unexplored solutions. Having identified the options the following road map helps to outline a broad time scale and key activities that will need to occur to deliver the key elements of this framework and realise the benefits.

ROAD MAP FOR DELIVERING THE KEY ELEMENTS

121. If this framework is agreed it will provide a new direction for HSSD to steer change. By having an explicit common vision it will allow HSSD and the States as a whole to prepare its operations and processes for future demands with sustainable funding. As one of the main drivers is the demographic changes, action needs to be taken sooner to enable individuals to take responsibility for their own health as soon as possible to ensure they are fit and active in their retirement.

122. The pathway to the Health and Social Services Department's 2020 Vision will require a range of help and expertise in developing these proposals. Some of this may require consideration of short term funding, but this will follow the States Strategic Planning process.

123. In terms of identifying priorities for areas of investment and disinvestment, the HSSD must comply with the States overall strategies, plans, timetables and controls.

124. The States has recently introduced a new process for prioritisation of new projects using the 5 Case Model, one of the cases being strategic fit. The States debates future funding of projects in September each year and will be assessing business cases using the criteria in the 5 Case Model. The projects going forward for the September submission would need to be sent to the Policy Council for evaluation by April. The HSSD intends to review its own projects in 2011 using the strategy being developed within this report. By reviewing the submissions in this way, feedback can be given to developing the strategy for the 2012 submissions.

125. The HSSD's 2020 Vision strategy is rooted in the States Strategic Plan (SSP) and will deliver against the Department's corporate strategic commitments described within the SSP.

126. There is only a minimal amount of health and social care legislation at the present time. Some of these work streams may well require future legislation, but at this point in time limited new legislation is being prepared.

The HSSD 2020 Vision road map

Plan	Target completion
Objective 1 – Promote Healthy Lifestyle choices and Social Wellbeing	
i. Health improvement strategy which encompasses the strategies already supported by the States of Guernsey for:	
• Reducing obesity – phase I	Q4 2011
• Reducing obesity – phase II	Q4 2013
• Reducing the use of tobacco products	Q4 2012
• Reducing the misuse of drugs and alcohol	Q4 2014
ii. Developing a healthy work place	Q4 2014
iii. Producing the Strategy for Mental Health Services	Q4 2011
iv. Mental and physical health promotion joint working	Q2 2012
v. Joint working on the Skills Strategy	Q2 2012
vi. A health protection strategy including	Q4 2012
• Immunisation and vaccination	
• Sexual health	
• Environmental health issues	
• Screening services	
Objective 2 – Improve services, continuously striving for safety, quality, efficiency and effectiveness	
i. Developing a strategy for Primary Care services	Q3 2012
ii. Support the development of the strategy for those with Disabilities	Q4 2014
iii. Developing a strategy for Cancer	Q3 2011
iv. Developing a strategy for Cardiovascular and Respiratory Disease	Q1 2012
v. Developing Stoke services	Q2 2013
vi. Measuring what the system does and how well it does it	Q1 2012
vii. Rationalising, upgrading and investing in the estate.	Q4 2015
viii. Joint working with Jersey, the UK and Europe	Q2 2012
ix. Funding and organisational options for the future.	Q3 2012
x. Agreeing the range of services delivered to Alderney	Q1 2012

Plan	Target completion
xi. Developing quality standards and a regulatory framework for health and social care services across the public, private and not for profit sectors	Q1 2013
xii. Progressing the integrated approach to the Financial Transformation Programme	Q4 2014
xiii. Realising the benefits from the EHSCR implementation	Q4 2014
xiv. Establishing a clear and transparent prioritisation process for service investment.	Q4 2012
xv. Developing the wheelchair service.	Q4 2011
xvi. Completing the replacement of the Castel Hospital.	Q1 2015
Objective 3 – Protect and support the community	
i. A community social care strategy, including day services, respite services, sitting services, befriending services, partnerships with the third sector to deliver	Q2 2013
ii. An intermediate care strategy	Q4 2013
iii. An assistive technology strategy	Q4 2013
iv. Production of the Mental Health Strategy (as mentioned in objective 1)	Q4 2011
v. Production of an end of life strategy	Q3 2011
vi. Joint working with the Housing Department on the development of supporting living and extra care housing	Q1 2014
vii. Joint working on developing a vulnerable adult's policy	Q4 2011
viii. Joint working on the Criminal Justice Strategy	Q4 2011
ix. Joint working on support to those in prison and on probation	Q2 2012
x. Joint working on the Supported Employment Scheme	Q2 2012
xi. Joint working on reducing sickness levels at work	Q3 2013
xii. Joint working to support people in the community	Q2 2014
xiii. Supporting the States of Guernsey on Emergency Planning	Q3 2012
xiv. Planning for potential future pandemics	Q4 2012
xv. Establishing a clear and accountable governance framework and structure.	Q4 2012
xvi. Implementing new Mental Health Legislation	Q2 2012
xvii. Supporting, developing and implementing the Children and Young People plan and reviewing on a 3 year rolling programme.	Q4 2011
xviii. Joint working to support reduction in domestic abuse.	Q4 2014
Key enabling plans	
i. Consultation on the 2020 framework	Q4 2011
ii. Revision of the 2020 framework following consultation	Q2 2012

Plan	Target completion
iii. The infrastructure plan;	Q3 2013
iv. The business information plan;	Q1 2012
v. The long term financial plan;	Q2 2012
vi. The long term workforce plan (including contributing to the managing Guernsey's population work);	Q2 2012
vii. The knowledge, research and learning plan;	Q2 2012
viii. The communication and engagement plan • Service users/patients • Staff and professionals • The public • Key stakeholders	Q4 2011
ix. The governance structure.	Q4 2011
Key client strategies	
i. Services for children and young people;	Q4 2013
ii. Services for disabled people;	Q4 2013
iii. Services for working age adults;	Q4 2012
iv. Services for older people, including States report;	Q3 2011
v. A carers strategy;	Q3 2012
vi. Supporting staff;	Q2 2012
vii. Working with the third sector;	Q4 2012
viii. Working with the independent business sector.	Q2 2013

127. **NOTE:** The dates in the road map are only indicative and will be amended following consultation and as the framework develops. Some elements of the framework will depend on available resources and priorities. Some elements of work will require additional short term funding and, where appropriate, this would be sought as part of the States Strategic Planning process. Other elements of this Road Map will not need further States approval as they will be within the current mandates of Departments to deliver. These dates may only indicate a milestone to report progress rather than a completed project and there is no guarantee that these time scales will be met at this stage.

RECOMMENDATIONS

128. The HSSD is keen for debate on this report to address the general policy issues contained, without taking a definitive position on any of those issues. The HSSD wishes to have the opportunity to reflect on all feedback from the debate and to consult further before returning to the States with more detailed proposals on each of the areas of work identified in the road map. The HSSD, therefore, requests that the recommendation which follows be considered by the States without amendment - in accordance with Rule 12 (4) of the Rules of Procedure of the States of Deliberation.

The Health and Social Services Department recommends the States:

1. Directs the HSSD to pursue the plans outlined in this report to ensure the future health and social care needs of the population of Guernsey and Alderney are met with a financially sustainable model.

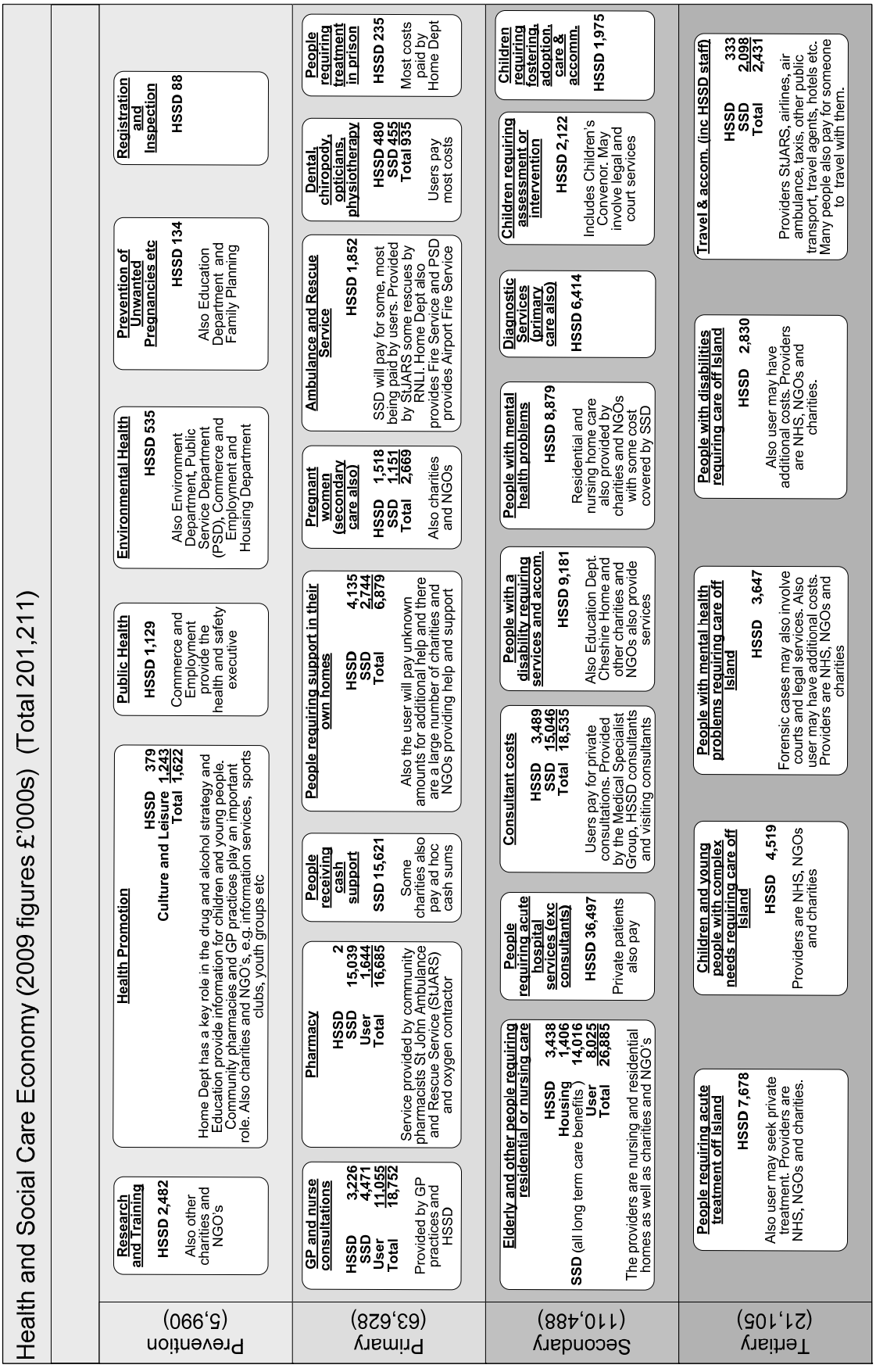
2. Directs all States Departments to contribute, where relevant, to each area of the plan which makes up this framework and for the HSSD to establish a suitable governance framework with which States Departments can engage.

3. Directs the HSSD to consult the public, professionals and other interested parties on the main objectives and the key elements of the framework (noting that each element will also have its own engagement and consultation plan, due to the size and complexity of the whole system).

Yours faithfully

A H Adam
Minister

Appendix 1


Health and Social Care Economy (2009 figures £'000s) (Total 201,211)
Prevention (5,990)
Primary (63,628)
Secondary (110,488)
Tertiary (21,105)
Research and Training
HSSD 2,482
Also other charities and NGO's
Health Promotion
HSSD 379
Culture and Leisure 1,243
Total 1,622
Home Dept has a key role in the drug and alcohol strategy and Education provide information for children and young people. Community pharmacies and GP practices play an important role. Also charities and NGO's, e.g. information services, sports clubs, youth groups etc
Public Health
HSSD 1,129
Commerce and Employment provide the health and safety executive
Environmental Health
HSSD 535
Also Environment Department, Public Service Department (PSD), Commerce and Employment and Housing Department
Prevention of Unwanted Pregnancies etc
HSSD 134
Also Education Department and Family Planning
Registration and Inspection
HSSD 88
GP and nurse consultations
HSSD 3,226
SSD 4,471
User 11,055
Total 18,752
Provided by GP practices and HSSD
Pharmacy
HSSD 2
SSD 15,039
User 1,644
Total 16,685
Service provided by community pharmacists St John Ambulance and Rescue Service (StJARS) and oxygen contractor
People receiving cash support
SSD 15,621
Some charities also pay ad hoc cash sums
People requiring support in their own homes
HSSD 4,135
SSD 2,744
Total 6,879
Also the user will pay unknown amounts for additional help and there are a large number of charities and NGOs providing help and support
Pregnant women (secondary care also)
HSSD 1,518
SSD 1,151
Total 2,669
Also charities and NGOs
Ambulance and Rescue Service
HSSD 1,852
SSD will pay for some, most being paid by users. Provided by StJARS some rescues by RNLI. Home Dept also provides Fire Service and PSD provides Airport Fire Service
Dental, chiropody, opticians, physiotherapy
HSSD 480
SSD 455
Total 935
Users pay most costs
People requiring treatment in prison
HSSD 235
Most costs paid by Home Dept
Elderly and other people requiring residential or nursing care
HSSD 3,438
Housing 1,406
SSD (all long term care benefits) 14,016
User 8,025
Total 26,885
The providers are nursing and residential homes as well as charities and NGO's
People requiring acute hospital services (exc consultants)
HSSD 36,497
Private patients also pay
Consultant costs
HSSD 3,489
SSD 15,046
Total 18,535
Users pay for private consultations. Provided by the Medical Specialist Group, HSSD consultants and visiting consultants
People with a disability requiring services and accom.
HSSD 9,181
Also Education Dept. Cheshire Home and other charities and NGOs also provide services
People with mental health problems
HSSD 8,879
Residential and nursing home care also provided by charities and NGOs with some cost covered by SSD
Diagnostic Services (primary care also)
HSSD 6,414
Children requiring assessment or intervention
HSSD 2,122
Includes Children's Convenor. May involve legal and court services
Children requiring fostering, adoption, care & accomm.
HSSD 1,975
People requiring acute treatment off Island
HSSD 7,678
Also user may seek private treatment. Providers are NHS, NGOs and charities.
Children and young people with complex needs requiring care off Island
HSSD 4,519
Providers are NHS, NGOs and charities
People with mental health problems requiring care off Island
HSSD 3,647
Forensic cases may also involve courts and legal services. Also user may have additional costs. Providers are NHS, NGOs and charities
People with disabilities requiring care off Island
HSSD 2,830
Also user may have additional costs. Providers are NHS, NGOs and charities.
Travel & accom. (inc HSSD staff)
HSSD 333
SSD 2,098
Total 2,431
Providers StJARS, airlines, air ambulance, taxis, other public transport, travel agents, hotels etc. Many people also pay for someone to travel with them.

Appendix 2

Current Constitution, Mandate and Membership of the Health and Social Services Department.

"Constitution

- *a Minister, who shall be a sitting member of the States;*
- *four members, who shall be sitting members of the States; and*
- *up to 2 non-voting members nominated by the Department for election by the States, who shall not be sitting members of the States.*

Mandate

a) To advise the States on matters relating to:

- *The mental, physical and social wellbeing of the people of Guernsey and Alderney;*

and to be responsible for:-

i. Promoting, protecting and improving personal, environmental and public health;

ii. Preventing or diagnosing and treating illness, disease and disability;

iii. Caring for the sick, old, infirm and those with disabilities;

iv. Providing a range of social services to all age groups including ensuring the welfare and protection of children, young people and their families and ensuring that the best interests of the child shall be a primary consideration.

b) To contribute to the achievement of strategic and corporate objectives, both departmentally and as part of the wider States organization, by:

i. Developing and implementing policies and legislation, as approved by the States, for the provision of services in accordance with this mandate; and

ii. Actively supporting and participating in cross departmental working as part of the Government Business Plan process and ensuring that public resources are used to best advantage, through co-operative and flexible working practices.

c) To exercise the powers and duties conferred on it by extant legislation.

d) To exercise the powers and duties conferred on it by extant States resolutions, including all those resolutions, or parts of resolutions, which relate to matters for the time being within the mandate of the Health and Social Services Department and which conferred functions upon the former:-

- *Board of Health*
- *Children Board*
- *Public Assistance Authority.*

e) To be accountable to the States for the management and safeguarding of public funds and other resources entrusted to the Department."

The current membership of the HSSD is:

Minister:	Deputy A H Adam
Deputy Minister:	Deputy A R Le Lièvre
Other Members:	Deputy B L Brehaut
	Deputy M M Lowe
	Deputy P L Gillson

Appendix 3

Themes from Recent Work with Key Professionals

a. Social care should be assessed and delivered on the basis of need, rather than rules.

b. The choices and control of the funding should be with the service user not the provider or funder.

c. Primary care should be organised to give the public quick and easy access to a range of medical services.

d. Primary vaccination services should be provided to all in our community

e. Validated screening programmes have the potential to prevent the necessity for more serious interventions; these should be delivered in/with primary care.

f. A very wide range of diagnostic services should be accessible locally - not only pathology and radiology, but also optometry, audiology etc.

g. Patient choice must be built into the delivery of primary care.

h. There must be equity and access for all.

i. Emergency care should be delivered safely and competently, using the best evidence methodology wherever the patient is.

j. A comprehensive secondary care service must be available on-Island, which is able to deliver:

- Obstetrics
- Paediatrics
- General Surgery
- Dental Surgery with anaesthesia
- Gynaecology
- Medicine
- Critical care
- Trauma care
- Diagnostic Support.
- Mental Health

k. Paediatrics and Mental Health should be delivered in the community not as secondary care, with a preventative and supporting remit, involving primary care, third sector, etc.

l. A range of expertise must be maintained on-Island to enable most care to be delivered locally.

m. Good links with an off-Island centres are essential, along with methods for timely transfer (includes inter-island).

n. End of life and community support at home should be accessible to all.

o. Systems should be in place to deliver as much care away from the hospital as is possible, keeping people in their own homes and communities for as long as possible.

p. Institutional care is to be considered as the last resort, not the first.

q. Social and health care is for delivery in our community, the place where people wish to live.

r. Optimisation of health and social wellbeing is the essence of the objectives of the service.

s. Quality of life, not necessarily quantity, is the key measure.

t. The system must be competent and comprehensive enough not to be seen as a dissuader for new businesses to come to the Islands.

u. Recruitment and retention of high quality staff with the ability to work across a range of areas will be the key to a successful service - and this is one of the big sources of risk.

v. The resources needed - human, physical and financial - will all be at a premium.

w. Disinvestment from any part of the existing service configuration will prove a real challenge - as all groups want a very wide service remit.

x. We (service users and providers) need to recognise our limitations in the range and depth of service which can be delivered in our community.

y. The use of all agencies, minimising barriers and use of the third sector should be included in any service plan.

z. Preventing the development of ill health would be better than treating it.

(NB The Policy Council strongly supports this piece of work from the Health and Social Services Department. Fully understanding the cost of the current health and social care system and alternative projected models in order to move to a more sustainable framework for the provision of health and social care services is fundamental to achieving the States objectives for social, fiscal and economic policy.)

(NB The Treasury and Resources Department congratulates the Health and Social Services Department on this very comprehensive and comprehensible States Report which sets out a framework for the future development of the health and social care system in Guernsey and Alderney and a delivery model that is financially sustainable.

It particularly welcomes the commitments to review existing services to ensure that the most effective use of resources is made and to making better information available, both in terms of cost and quality and to ongoing monitoring.

However, a note of caution should be raised at this stage as, even if very justifiable business cases are made for developing services, it simply may not be possible, at least in the short-term, to make sufficient General Revenue funding available and comply with the target within the Fiscal and Economic Plan for *"a real terms freeze on aggregate States expenditure".* Therefore, any proposals for increasing States expenditure should be considered within the existing corporate governance framework for prioritising service developments through the mechanism of the States Strategic Plan.)

The States are asked to decide:-

IV .- Whether, after consideration of the Report dated 9th March, 2011, of the Health and Social Services Department, they are of the opinion:-

1. To direct the Health and Social Services Department to pursue the plans outlined in that Report to ensure the future health and social care needs of the population of Guernsey and Alderney are met with a financially sustainable model.

2. To direct all States Departments to contribute, where relevant, to each area of the plan which makes up this framework and for the Health and Social Services Department to establish a suitable governance framework with which States Departments can engage.

3. To direct Health and Social Services Department to consult the public, professionals and other interested parties on the main objectives and the key elements of the framework (noting that each element will also have its own engagement and consultation plan, due to the size and complexity of the whole system).

(NB The Health and Social Services Department has requested that this matter be debated in accordance with Rule 12 (4) of the Rules of Procedure of the States of Deliberation which provides

*"Where a Department or Committee originating a matter for debate before the States is of the opinion that the proposals it is submitting to the States are ones of general policy, and where it is desirable that the general principles of that policy should be considered, the Department or Committee may request that its propositions be considered by the States without amendment, on the understanding that if the propositions are accepted, the Department or Committee would return with detailed proposals which could be accepted or rejected, together with any amendments…"**)***

HOUSING DEPARTMENT
HEALTH AND SOCIAL SERVICES DEPARTMENT

PROVISION OF 'EXTRA CARE' HOUSING
AT MAISON MARITAINE AND LONGUE RUE

The Chief Minister
Policy Council
Sir Charles Frossard House
La Charroterie
St Peter Port

15th March 2011

Dear Sir

EXECUTIVE SUMMARY

1. This States Report outlines proposals for the replacement of the Housing Department's two residential care homes for older people - Longue Rue House and Maison Maritaine – with purpose-built 'extra care' housing. It also outlines proposals to provide 'extra care' housing to accommodate younger Islanders with care and support needs, who would otherwise be accommodated in residential homes managed by the Health and Social Services Department (HSSD).

2. The Housing Department's two homes provide residential care for 99 residents – 46 at Longue Rue House and 53 at Maison Maritaine; each of whom has their own small, single bedroom. However, contrary to accepted modern standards of residential care – as prescribed by the Guernsey Care Standards - toilets and bathroom facilities are shared; there are no en suite facilities. Social interaction in each home is focussed on the communal lounges, the communal dining room and the immediate outside spaces.

3. Largely unchanged in configuration since they were first opened, the upgrading of accommodation at Longue Rue House and Maison Maritaine has become an increasingly high priority for the Housing Department, as the homes are ageing and require significant investment to bring them up to modern day standards. A detailed condition survey has identified a three year window during which the Housing Department must take remedial action to ensure that the homes can each continue to provide a safe and habitable accommodation for their occupants.

4. It is against the strategic background of the emerging **Older People's Housing, Care and Support Strategy**, the **Supported Housing Strategy** and the HSSD's

'2020 Vision' framework for the future of health and social care - which is being presented for consideration in conjunction with this Report - that the Departments propose to replace Longue Rue House and Maison Maritaine with a form of accommodation that promotes independence for those people with a care and support need, known as 'extra care' housing.

5. In addition, as part of these plans, 'extra care' accommodation will be provided for persons with a learning disability on the Longue Rue site.

6. In order to set the strategic context for these proposals, the Report provides a brief résumé of the aforementioned strategies, which, together, aim to develop housing, health and social care services that: (i) are delivered in a responsive and 'person centred' manner; and (ii) provide a housing, health and social care system that is financially sustainable in the light of the Island's increasing demographic pressures.

7. However, contrary to this, the Report highlights that current provision in Guernsey reflects traditional models of care and support which engender a culture of dependence and which focus on doing things for people, rather than on enabling people to be supported to do things for themselves. This increases the chances that more people will enter into more expensive forms of institutional, bed-based care. Perpetuating historic models of provision for people with relatively low to moderate care and support needs in bed-based, institutional environments is not sustainable.

8. With particular relevance to the proposals for the future of the Housing Department's two residential homes, the Report highlights that there is a dearth of accommodation in the Island that is designed to a common design standard which enables 'ageing in place'. Consequently, although enabling a person to continue living in their own home is the ideal, where this is not possible, as an alternative to entering residential care, the Older People's Strategy will outline the need to provide more **'specialised'** housing to allow older Islanders to live independently for as long as possible, whilst receiving the care and support they require. Examples of specialised housing would include **sheltered housing**, **supported housing** or '**extra care' housing**.

9. These forms of specialised housing are equally suitable for young people with a care and support need (people with a learning or physical disability, or with a mental health problem, for example) to live independently in the community, with on-site care and support.

10. 'Extra-care' housing marries built form with the provision of care and support services, delivered on a 24/7 basis according to the needs of the individual. 'Extra-care' is increasingly seen as an alternative to residential care provision, as it enables people to retain as much of their independence as possible, whilst receiving a care package that is tailored to meet their individual needs.

11. The Report is primarily concerned with a first phase of development on the sites of the Housing Department's two residential homes. Specifically, it proposes the 'on site' development of rental accommodation to enable existing residents of Longue Rue House and Maison Maritaine to move from their current bedrooms within a residential care setting into their own self-contained unit of accommodation in an 'extra-care' scheme, without the need for transitional accommodation to be provided elsewhere.

12. It is also proposed to include 15 units of accommodation in Phase 1 of the redevelopment of the Longue Rue site to provide independent living for persons with a learning disability who would otherwise live in more dependent residential home settings provided by HSSD.

13. Phase 1 of each development will also include all of the intrinsic communal facilities required to support each 'extra care' scheme. At both locations it is proposed to include a communal lounge, restaurant/café and dining areas, a treatment room/s, together with well-designed external spaces for use by tenants.

14. The inclusion of a 20 placement day centre for the wider community is also proposed at the Maison Maritaine site, to provide a hub to meet the needs of other community based services, for which a need has been identified by HSSD.

15. The design of both sites will adopt a 'core and cluster' approach, with the communal areas and services being provided from a central 'core', and accommodation being provided in a number of 'clusters' off the main building. This type of design is proven to work well where there are a number of client groups with a wide range of care and support needs being accommodated within one scheme and, from an environmental perspective, will also help to 'break up' the developments in terms of their scale and massing.

16. It is the aim for Phase 1 of these two 'extra care' schemes to be completed and commissioned by March 2014, i.e. within three years.

17. The **Guernsey Housing Association (GHA)** has been selected as the development partner for these projects. Following the model that has resulted in the successful delivery of general needs social housing in recent years, the GHA will act as developer and will manage the building projects on behalf of the States. Upon completion of the schemes, the GHA will also become responsible for all aspects of tenancy and property management on an ongoing basis.

18. In addition to the transfer of States-owned land, to finance these two developments there will be a requirement for a capital grant from the States' Corporate Housing Programme (CHP) Fund. For the Phase 1 redevelopment of both sites, capital grant funding (excluding the value of the transferred land) is **estimated at an amount not to exceed £22 million**. This represents 65% of the total development costs for both projects (Phase 1 only), which, combined, are not expected to exceed **£32 million in total**. The remaining capital sum required

for these two developments will be raised by the GHA from a private banking source.

19. However, it is important to note that, ahead of having fully designed 'extra care' schemes prepared for both sites, **these figures are indicative only at this stage**.

20. In addition to this "cash" contribution, the States is asked to note the value of a number of property assets transferring to the GHA, which comprise the residential care home buildings themselves; 'Valderie', which is currently owned by HSSD; together with various other properties currently managed as social rented housing by the Housing Department, that need to be redeveloped to provide the new 'extra care' accommodation 'on site'.

21. Calculating the value of the land which comprises both of these sites on a residual basis (i.e. as if they had been acquired commercially, after all development costs have been applied) and adding this to the requirement for capital grant funding indicated above, brings the total value of the contribution from the States to approximately 72%, although no additional monies are transacted.

22. The Report explains that the capital grant required from the States for these 'extra-care' schemes is higher than other recent general needs social housing schemes completed by the GHA. This is because the 'extra care' projects will include a range of specialist design features and also have a very significant proportion of communal spaces which need to be included in the schemes and maintained on an ongoing basis; but these will generate little or no rental income to support the overall project financing.

23. However, the addition of communal spaces for the residents and community spaces for use by other Islanders will provide a 'hub' from which 'outreach' services can be delivered into the wider community; and a 'hub' for 'inreach' services into which the wider community will be invited to take part in day services, luncheon clubs, health therapies, etc.

24. The design and delivery of such schemes will thus offer an opportunity for HSSD to re-orient its services from institutional, hospital-based settings, to community settings, using the 'extra care' schemes as 'hubs' for the delivery of such services. It is this synchronicity of purpose which strengthens the partnership between the Housing Department and HSSD, and demonstrates how the investment of monies from the CHP Fund can have wider benefits for the community.

25. The Report also explains that, on each site, these capital costs are 'front-loaded', because all of the communal spaces for the developments will need to be incorporated into Phase 1, so that they are of sufficient size to support the occupants of additional 'extra care' accommodation that could be delivered in a second phase of development.

26. With this in mind, the costs of demolishing the two residential homes, upon their vacation, have also been included in the financial appraisals for each Phase 1 development, albeit that the parts of the site upon which they are physically located will not be developed unless there are second phases of development.

27. In its report to the States on the CHP in May 2010[1], the Housing Department signposted that CHP expenditure would generally be targeted towards more specialist forms of housing, in particular 'extra care' housing. At that time, the projections of expenditure from the CHP Fund anticipated that £31 million would be dedicated to the delivery of specialist accommodation during the 5-year period 2010 to 2014, to deliver part of the objectives of the Older People's Strategy. Budgetary provision has been made in the CHP Fund to grant fund Phase 1 of the redevelopment of both of these sites as part of the Older People's Strategy.

28. **The Report therefore seeks States' approval to release monies from the CHP Fund to support Phase 1 of the redevelopment of both sites to provide 'extra care' housing, for a total sum not to exceed £22 million.**

29. **However, in line with the existing procedures for general needs social housing, it is recommended that the actual grant sum required be approved, on behalf of the States, by the Treasury and Resources Department.**

30. **A further cost relating to the need to provide furniture and fittings for the initial occupants of the new 'extra care' accommodation has also been identified.** This is because the existing residents of Longue Rue House and Maison Maritaine, and those persons with a learning disability currently accommodated by HSSD, will not have such possessions having lived in residential care and given them up when moving into the care homes. **States' approval is thus sought to use the CHP Fund for this purpose, for a sum not to exceed £900,000**.

31. **Arising from these proposals, there are also various financial issues for individuals, and revenue and budgetary implications for Housing, HSSD and the Social Security Department. The Report identifies all such issues and asks the States to direct that these be addressed through inter-departmental discussions between the aforementioned departments and the Treasury and Resources Department, as part of the preparation of the robust business case that will be required to be presented to the latter department before it will give approval to the release of funds for these developments.**

32. The Report goes on to show that the scope for redevelopment on the Longue Rue and Maison Maritaine sites is significant, offering a long-term opportunity

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[1] Housing Department – *'Corporate Housing Programme – Progress against the 2009 Action Plans and Future Strategy'* – Billet d'État XI 2010.

to provide additional 'extra care' housing for a wide range of people with a care and support need, not just older people. A 'masterplan' for each site is thus being prepared to identify the scope that exists on both sites to ensure that, if a further phase of development is completed, it will integrate effectively with the facilities to be provided by Phase 1 on each site. **The States is asked to note the possibilities for the Phase 2 development of the Longue Rue House and Maison Maritaine sites and the associated funding consequences.**

33. However, whilst there are no firm proposals relating to Phase 2 at this time, **the Report highlights that there are a number of issues that need be resolved prior to a commitment being made to proceed with a subsequent phase of development. These relate primarily, but not exclusively, to finding a sustainable long-term funding model for 'extra care' housing; one that is not at odds, for example, with the existing funding arrangements for residential or nursing home care, through the Long-term Care Insurance Scheme.**

34. **This reinforces the recommendation that the States direct that these funding issues be addressed inter-departmentally by the Housing, Health and Social Services, Social Security and Treasury and Resources Departments.**

35. **Furthermore, the States is asked to note that in resolving these funding issues, there is likely to be a need for a redistribution of monies in revenue budgets from one department to another.**

36. Returning to the proposals for Phase 1 on each site, when announcing the proposals to residents of Longue Rue House and Maison Maritaine and their families in February 2011, the Housing Department made a commitment to each resident that in the new 'extra care' housing they would continue to receive exactly the same care and support that they currently receive in residential care. Furthermore, that care and support would be delivered by staff with whom they are familiar, in virtually the same location (because the new 'extra care' housing is to be built adjacent to the existing care homes).

37. Whilst the Departments are confident that residents will, if they choose to do so, be able to 're-learn' some of the skills they require to live independently, the Departments also appreciate that many residents will have become accustomed to living in a care home and may be concerned about making the transition. Care and support services will thus be tailored to meet individual needs, and will be delivered in such a way as to encourage and support tenants to do as much for themselves as they feel comfortable doing. The development of individual assessment and care plans to manage the transition period will be personal to each resident and will reflect their wishes.

38. New residents will continue to be welcomed to Longue Rue House and Maison Maritaine until the 'extra care' schemes are complete. Prospective new residents

will be made aware of the proposals and will thus be making an informed choice about how they will receive their care and support in the future.

39. The Departments recognise that the staff employed within Longue Rue House and Maison Maritaine will also be directly affected by these proposals, and that the plans outlined in this Report may have created some uncertainty regarding their ongoing employment.

40. Whilst the Housing Department has assured all members of staff that their **existing** positions of employment are secure, at this stage it is premature to be able to say, with any certainty, which roles are likely to be retained and which will no longer be required in new 'extra care' housing. However, it is anticipated that there is likely to be less, or possibly no need, for domestic and catering staff and a reduction in the number of managerial posts. On the other hand, there will be a greater need for skilled care and support staff.

41. **However, in line with the procedures that apply to the restructuring of States' services, <u>every</u> member of staff affected will be given support to retrain for a new role in the 'extra care' schemes or to secure an alternative post in the States through the redeployment procedures.** (This has been discussed and agreed with the relevant unions – Unite and the Association of Guernsey Civil Servants – who are fully conversant with the proposals and their implications.)

42. Similar issues may also arise in respect of the staff employed by HSSD in its Learning Disability Service, as a result of the change in provision from residential care to 'extra care' housing for some of its clients.

43. In conclusion, the Departments present the initiatives described in this States Report as a means of promoting and implementing a long overdue change in strategic direction in the provision of housing, health and social care services in Guernsey, which are focused on providing greater choice and independence for Islanders of all ages with care and support needs. Joint working between the Housing and HSSD, in partnership with the GHA, will enable this outcome for people currently institutionalised by both departments through the Phase 1 developments on the Longue Rue and Maison Maritaine sites.

1) INTRODUCTION AND BACKGROUND

44. The Housing Department's two residential homes – Longue Rue House and Maison Maritaine – were opened in 1963 and 1971 respectively, to provide care to older Islanders within a 'sheltered' setting. (NB To aid understanding of the proposals outlined herein, a glossary of terms used in this Report is provided at Appendix 1.)

45. Together the two homes provide residential care for 99 residents - 46 at Longue Rue House and 53 at Maison Maritaine - each of whom has their own small,

single bedroom. However, contrary to accepted modern standards of residential care, toilets and bathroom facilities are shared – there are no en suite facilities. Social interaction in each home is focussed on the communal lounges, the communal dining room and the immediate outside spaces.

46. To provide care for these residents, across the two homes, the Housing Department employs 9 members of Established Staff and 82 Public Sector Employees: the majority on a part-time basis. These posts include care assistants, handymen/gardeners, domestic and catering staff. Totalled together, staffing numbers equate to 58.53 whole time equivalents (see Section 9 below).

47. Largely unchanged in configuration since they were first opened more than 40 years ago, the upgrading of accommodation at Longue Rue House and Maison Maritaine has become an increasingly high priority for the Housing Department, as the homes are ageing and require significant investment to bring them up to modern day standards. A detailed condition survey has identified a three year window during which the Housing Department must take remedial action to ensure that the homes can each continue to provide a safe and habitable accommodation for their occupants.

48. After much careful consideration, and with the full support of HSSD, the Housing Department has concluded that rather than refurbish or rebuild the existing homes to modern standards, the best option for both the residents and the States will be to provide purpose-built 'extra care' housing adjacent to the existing care homes. Once that new accommodation is available, the residential homes will be closed and demolished to make way for the provision of further 'extra care' housing in a later phase of development – funds permitting.

49. Not only will this re-provide accommodation for the existing residents of the homes, but the Departments have also identified an opportunity to meet the immediate needs of some of those people with a learning disability who are currently accommodated in a residential group home by HSSD.

50. HSSD currently manages seven group homes for 53 persons with a learning disability with varying degrees of need. The current accommodation is not effective in providing an 'enabling' living environment for residents, nor do they allow for ease of care provision. Many group homes are standard residential dwellings with some adaptations, but they were not purpose-built.

51. It is acknowledged that many of those people being cared for by historic 'medicalised' models could, with the appropriate care and support, live independently in the community.

52. In addition, there are in the region of 150 individuals with a learning disability living in the community who, in the future, unless alternatives are provided, will require accommodation in residential homes provided by HSSD.

2) THE STRATEGIC FRAMEWORK

Developing an Older People's Strategy

Introduction

53. In order to understand why these plans are being proposed, it is necessary to put the redevelopment projects at Longue Rue House and Maison Maritaine into their strategic context. Accordingly, a résumé of some aspects of the forthcoming Older People's Housing, Care and Support Strategy (hereafter referred to as the 'Older People's Strategy') is included in this States Report, as this provides the rationale for the proposal to change the model of provision on these sites from residential care to 'extra care' housing.

54. Updates are also provided on the development of a Supported Housing Strategy and the '2020' Vision framework for the future provision of health and social care services, which is being developed by the Health and Social Services Department.

55. The Departments had initially planned to bring the proposals in this Report to the States after the Older People's Strategy had been debated. However, the Strategy is wide-ranging and multi-faceted, and thus it has taken considerable time to complete the research, assemble all of the material, and to work with other departments to finalise its recommendations[2].

56. Added to this, the time pressures associated with providing replacement facilities at Longue Rue House and Maison Maritaine have meant that it was not possible to wait until after the Older People's Strategy had been debated by the States before submitting this Report for consideration. However, the proposals in this Report are very much informed by the learning from the development of the Older People's Strategy and aim to meet some of its many strategic objectives.

57. Nonetheless, in order that the States can appreciate the breadth of the forthcoming Strategy and be confident that these proposals are in accord with what the Strategy will recommend, Appendix 2 to this Report provides details of its provisional objectives. It also includes a summary diagram of the range of services and housing options that are required to meet the needs of older Islanders in the future, to be recommended in the forthcoming Strategy.

Background

58. In Guernsey, the population of persons aged over 65 years is expected to almost double over the next 30 years and the number of those persons aged over 100 years is expected to increase by 166% during the same time period.

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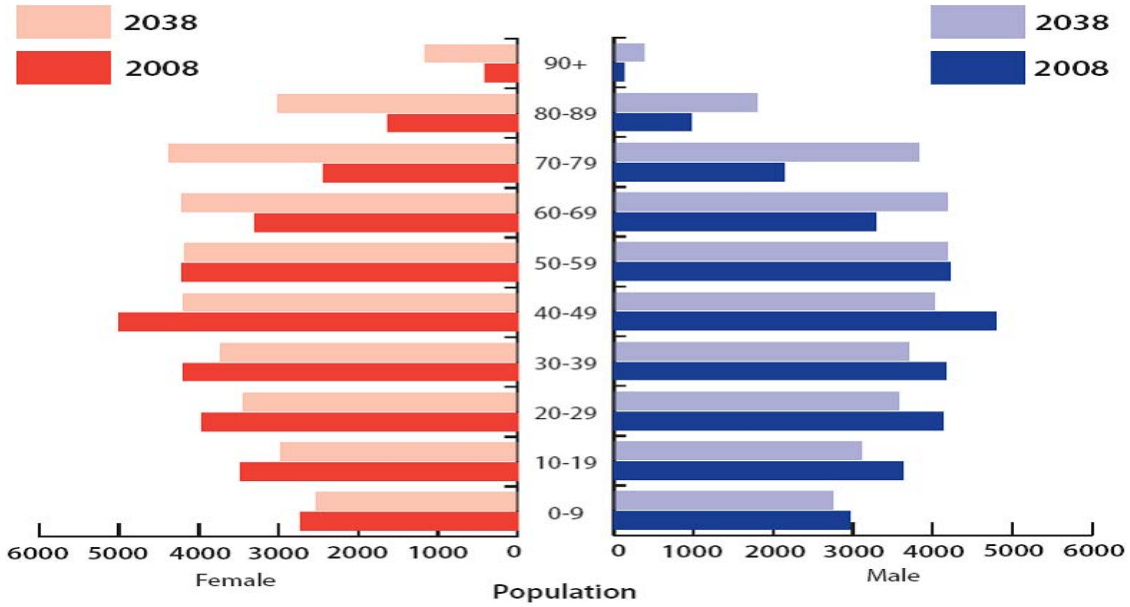
[2] It is envisaged that the Older People's Strategy will presented to the States for consideration later this year.

Figure 1: The Island's anticipated changing demographic profile from 2008 to 2038



(2008 date was obtained from the Social Security Department)

59. However, not only will there be more people in Guernsey who are old, but this will be coupled with a reduction in the numbers of economically active people, thus reducing States' revenue at a time when additional funding will increasingly be required to pay for older people's services.

60. Against this background, it is clearly important for the States to plan now for how it is going to deliver housing, health and social care services for its resident population.

61. Housing and HSSD have thus been leading on the development of an **Older People's Strategy.** This has been undertaken through a process of active engagement with older Islanders, voluntary groups and organisations, and with other States' departments, so that the Older People's Strategy can respond to the needs of Islanders; and to ensure that its recommendations are evidence-based and appropriate for Guernsey residents. For as the numbers of older people grow, so more must be done to show our older citizens that we value their views, their knowledge, their experience and their contribution to our community.

62. As a result of this process of engagement, the Departments have concluded that the overall aim of the Strategy should be:

'To improve the quality of life of older Islanders by promoting a positive view of ageing and supporting independence and choice.'

63. Key to this conclusion was an Island-wide survey carried out in 2008, of all older Islanders aged 60+. Entitled: "What's most important to you?", the aim of the survey was to seek the views of older Islanders to inform the development of the Older People's Strategy. 13,644 survey forms were distributed and 3,820 responses were received (a response rate of 28%). This revealed that the top five most important issues for older Islanders were:

- to receive personal care in their own homes when they need it;
- to live independently in their own homes for as long as possible;
- to retain control of their lives;
- to have more choices about how they live in older age; and
- to be valued.

64. However, contrary to what Islanders tell us they want – to be supported to remain living independently in the community - Guernsey's traditional models of providing care and support engender a culture of greater and greater dependence, and increase the chances that more people will enter into expensive forms of institutional care. The Strategy will thus highlight, in greater detail than is possible in this Report, that currently in Guernsey:

- care and support is provided predominantly in residential and nursing homes, and in hospital settings;
- care and support services are institutionalised and '*medicalised'*, i.e. they are focussed on doing things for people rather than enabling them to be supported to do things for themselves;
- services are bed-based, not community-based;
- the needs of the individual are not at the centre of service provision/delivery – services are organised around staffing issues rather than around the persons who will receive them; and
- generally, there is very little choice in how to receive care and support.

65. Of particular relevance to this Report, the Older People's Strategy will aim to bring together all of the key strands associated with developing community-based health and social care services to meet the needs of older Islanders in a responsive and 'person-centred' manner.

66. At its core, the Strategy will recommend changing the emphasis from institutional or bed-based care, to care in community settings. The Strategy will outline that a range of services are required to meet a diverse range of needs.

For example, the Strategy will recommend enhancing the range of community services so that, ideally, care and support can be provided to people within their own homes.

67. However, of especial relevance to this Report, for those who are unable to continue to live in their own homes, the Strategy will highlight the need to widen the housing options available to support older people to live independently, as far as they are able, in accommodation that is built to a common design standard that enables 'ageing in place'.

68. Of particular importance, the Strategy will examine the social and financial implications of an ageing population, and recommend how best to address the predicted additional demands on housing, health and social care services. It will demonstrate how the demographic pressures associated with an ageing population and a shrinking workforce make it essential to promote better the independence and well-being of older Islanders.

69. The Strategy will thus encourage a move away from funding services and buildings designed to meet acute needs, in favour of preventative social care services and early intervention measures, which are proven to be more cost-effective over the longer-term.

70. Whilst, inevitably, there will be heightened costs associated with delivering more community services to a growing number of older people – the magnitude of which is currently being explored – the Strategy will identify that effective partnership working with Third Sector organisations - housing associations, community and voluntary groups - offers an opportunity to mitigate the financial impact on States' funds.

71. However, the motivation for changing the way that housing is provided and services are delivered, does not arise solely from the need to provide for an increasing population of older people in Guernsey in more cost-effective ways: it is because, as noted above, older Islanders themselves have also told us that this is their preference.

72. It is acknowledged that not only will there be a burgeoning population of older Islanders, but people will increasingly value their independence and will want to exercise more choice about how they are housed and how they are cared for. Current and future generations of older Islanders have a consumer mentality: they will not be prepared just to accept what has always been on offer; rather they will expect and demand services that not only meet their needs but also, very significantly, are attuned to their more active lifestyles.

73. In this respect, historic models of housing and care will need to change to meet the demands of the future – both in terms of the growing numbers of older people and their changing attitudes and aspirations.

Developing appropriate forms of housing

74. Of particular significance to the proposals outlined in this States Report, the Older People's Strategy will recommend the development of appropriate housing and neighbourhoods, which enable 'ageing in place' and which help to reduce referrals into institutional care.

75. The provision of appropriate housing is a key component in changing the emphasis from institutionally based care into care in community settings. Care in the community begins with housing.

76. The Strategy will highlight that housing in Guernsey is not developed enough to support or contribute to the provision of care and support services in the Island in a way that can reduce the resource pressures on the provision of future community care services. In particular, many Guernsey houses are not suitable for adaptation as a person develops care and support needs, with the result that, for many older Islanders, it is not possible for them to remain living in their family home; and, as a consequence of the lack of alternative housing options (see below), a move into a residential home environment becomes the only option available.

77. To address this, a central recommendation in the Strategy will be that more **'specialised housing'** needs to be provided to contribute to the overall care continuum in the Island.

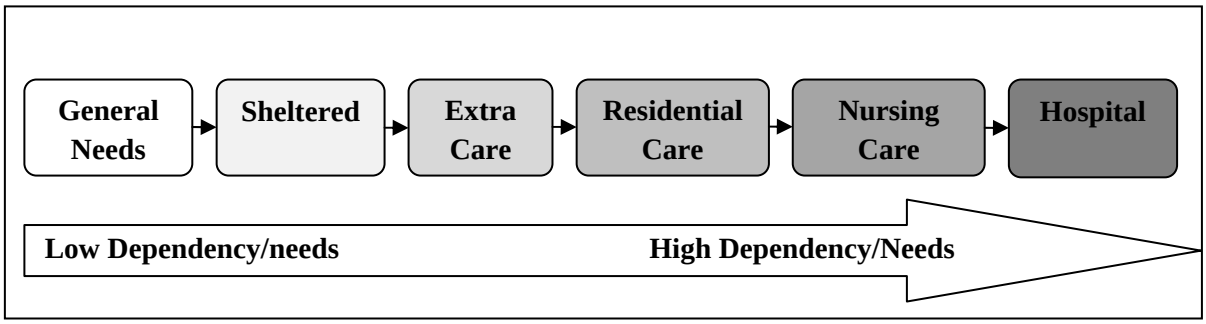
78. Specialised housing in this context describes any housing which is specifically designed to meet the needs of identified groups of people, to enable them to live independently in homes that they can call their own, for as long as possible. Specialised housing consists of building design that enables people to 'age in place', together with care and support services that promote independent living. Examples of specialised housing would include **sheltered housing**, **supported housing** or '**extra care' housing**.

79. When compared with the UK, Guernsey has very limited numbers of sheltered and 'extra care' housing that are designed to meet a range of care and support needs; on the other hand, Guernsey is well-provided with residential care beds. This gap in provision is shown diagrammatically in Figure 2 below.[3] (Appendix 3 provides an overview of the provision of accommodation for older people in the Island.)

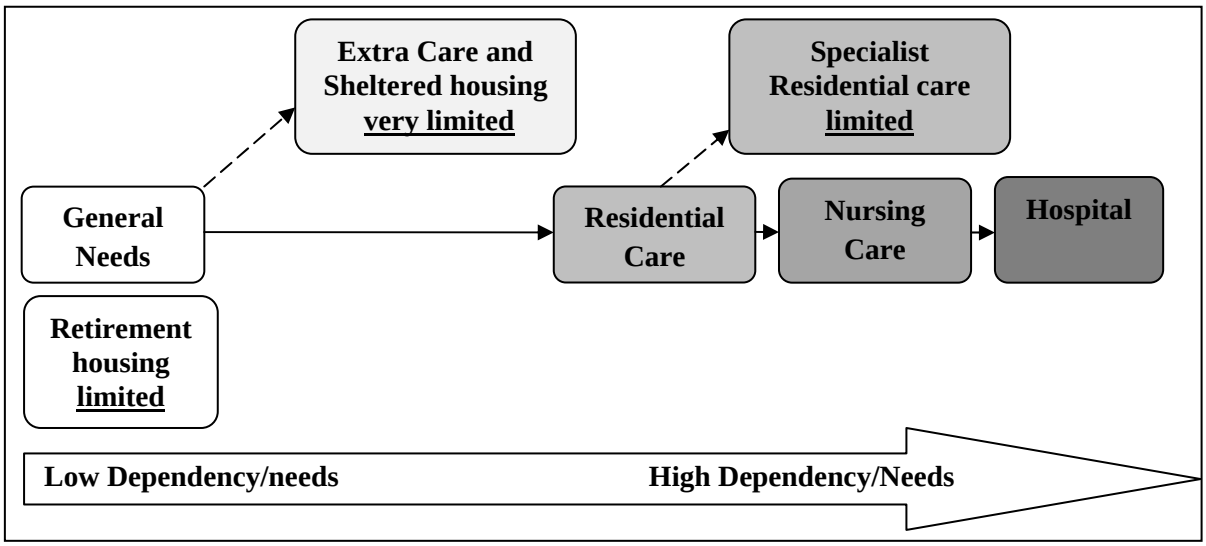
[3] Guernsey also has a dearth of specialist residential care for the needs of persons with a particular care and support needs. The recent opening of Maison de Quetteville to provide specialised residential care for Islanders with dementia is a positive development in meeting this shortfall.

Figure 2: A diagrammatical representation of the housing options provided in the UK and in Guernsey.

Provision in the UK:



Existing provision in Guernsey:



80. The Strategy will highlight that in the absence of a range of housing options for older and other younger Islanders with care and support needs in Guernsey, it is very often the case that, given this lack of choice, people with low care and support requirements are "inappropriately" referred into residential care when their needs could be met more adequately and more cost-effectively by community-based solutions.

81. The Strategy therefore identifies that this lack of specialised housing provision requires older people to move permanently from their homes in the community directly into residential care - perhaps following what should be a short-term crisis event, such as a trip or fall, for example - when with the appropriate care and support in a well-designed housing environment, they could have continued to live independently in the community.

82. This causes a domino effect in that because the model of residential care is to look after people and to do most things for them, individuals can lose their skills to live independently prematurely and become increasingly dependent on others to carry out even the most basic of daily living tasks.

83. To evidence this, data from the Needs Assessment Panel[4] revealed that:

- During 2008 and 2009, 291 people were referred to residential care.
- **Approximately <u>one-third</u> of those referred to residential care could have had their needs met in 'extra care' housing had any units been available.**
- This equates to **97 people** (almost 50 people per year) who were inappropriately referred to residential care due to the lack of alternative housing options within this time period.

84. Not only is this a tragedy for the Islanders involved, but it is also extremely costly for the taxpayer. It is estimated that, over this two-year period, these "inappropriate" admissions to residential care resulted in £1.6 million of additional expenditure from the Long-term Care Insurance Scheme Fund.

85. These inappropriate referrals are made in the absence of a suitable alternative. Limited availability of community services and poor availability of specialised housing has contributed to much higher costs of providing housing with care and support in institutional settings.

86. With the projected growth in the Island's ageing population and increasing disability levels, this trend is likely to increase, together with the costs. **Thus, whilst residential care will continue to be appropriate for people with higher level or more complex needs, the Older People's Strategy will recommend that new build developments should focus on the provision of more specialised housing, most specifically 'extra care' housing, as this will help to reduce unnecessary residential care referrals, prevent people becoming institutionalised prematurely, and reduce the associated costs.**

87. Nevertheless, it must be stressed that this is not a 'one size fits all' solution: to complement the need for specialised housing, the Older People's Strategy will strongly recommend the further development of community services that are designed to enable people to remain in their own homes, as this is not only the ideal option, but also the most cost-effective. (Among the services requiring development are the enhancement of the range of community services provided

[4] The Needs Assessment Panel is a multi-disciplinary team of health and social care professionals who determine individual care needs for the purpose of the Long-Term Care Insurance Scheme. They may determine an individual's needs to be met appropriately through community care, sheltered housing, 'extra care' housing, residential or nursing care.

by HSSD, establishing housing repair and maintenance services, travelling warden services, etc. – see Appendix 2.)

The Supported Housing Strategy

88. The latest report to the States on the CHP[5] also outlined how, in partnership, the Housing Department and HSSD were leading on the development of an integrated **Supported Housing Strategy** for Islanders who require help to live independently.

89. 'Supported housing' is defined as a set of care/support services delivered by multiple agencies and intended to develop a person's capacity to live independently in accommodation.

90. The Supported Housing Strategy is being developed to meet the housing and support needs of potentially vulnerable or excluded groups who are at risk of becoming homeless or reliant on institutionalised care. These groups include:

- Adults with a learning disability or mental health problems;
- Adults with physical and/or sensory disabilities;
- Older people;
- Young people leaving statutory care;
- Victims of domestic abuse; and
- The homeless – i.e. those people who do not fall into any of the categories above but who, because of their age, health, income or family circumstances, may otherwise struggle to find somewhere to live.

91. The Strategy will also address accommodation problems experienced by people who exhibit challenging behaviour, such as offenders, people leaving prison, and people with substance misuse issues.

92. Although the development of the Strategy is in the early stages, it has already been identified that many of the objectives of the Older People's Strategy equally apply to other Islanders with care and support needs, who would also benefit from sheltered or 'extra care' housing, rather than being accommodated in institutional settings.

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[5] Housing Department – *'Corporate Housing Programme - Progress against the 2009 Action Plans and Future Strategy'* - Billet d'État XI 2010

The States Housing Strategy, the Corporate Housing Programme and the States Strategic Plan

93. One of the prime objectives of the **States Housing Strategy** agreed in 2003[6] is:

- *'To enable the provision of supported accommodation for persons with special needs including accommodation for older persons, young people, people with a learning disability, persons with a mental illness, ex-offenders, etc.'*

94. The CHP is the means by which the objectives of the States Housing Strategy are implemented.

95. Both the Older People's Strategy and Supported Housing Strategy are workstreams forming part of Action Area E of the CHP. This is focused on developing appropriate housing options for persons requiring supported accommodation, in accordance with the strategic objective quoted above.

96. In a Report to the States in May 2010, the Housing Department outlined how the CHP was integrated with the **States Strategic Plan** (SSP). Whilst the CHP is sufficiently wide-ranging to justify a separate States Report every two years, the CHP's objectives and workstreams are referenced either in the SSP or in departments' operational plans.

97. With specific reference to the SSP, the proposals outlined in this Report are fully in accord with the objectives of the Social Policy Plan[7], which include:

- Improve housing availability, quality and affordability
- Foster an inclusive and caring society which supports communities, families and individuals;
- Promote active and engaged citizenship;
- Promote, and remove barriers to, equality, social inclusion and social justice;
- Meet welfare needs and reduce poverty;
- Maintain a healthy society and safeguard vulnerable people.

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[6] States Advisory and Finance Committee and States Housing Authority – *'The Development of a Housing Strategy and Corporate Housing Programme'* – Billet d'État II 2003.

[7] Policy Council *'States Strategic Plan 2010-2015'* – Billet d'État XIX, September 2010

Developing a strategic vision for the future of health and social care

98. HSSD is developing a **strategic framework for the provision of health and social care services** in the Bailiwick over the next 10 years through a process called **'2020 Vision'**. It is intended that the development of this framework will create a process that will enable HSSD to respond to the changing health needs of the population, whilst working within an environment of increasing financial and demographic challenges.

99. To initiate a process of public consultation, at the time of writing, HSSD intends to present a 'green paper' report to the States on the proposed framework for this strategy at the same meeting as this Report is debated.

100. Similar to both the Older People's Strategy and the Supported Housing Strategy, the '2020 Vision' will espouse a vision for the health and well-being of Island residents that will emphasise a strategic shift away from current models of provision which engender dependence within institutional and bed-based environments, towards independence and the provision of care and support in community settings. The revised strategic framework will also re-focus service delivery and the investment in health and social care services away from responding to sickness, to the promotion of well-being and good health.

101. In this respect, the 2020 Vision being formulated by HSSD, the Older People's Strategy and the Supported Housing Strategy are overlapping initiatives all working towards the aim of delivering person-centred care and support in community settings. By enabling greater independence and more choice, services will be provided in a more flexible way than at present, with benefits for the people affected and for the quality of their lives.

102. Thus, as will be demonstrated later, the proposals for the redevelopment of the Longue Rue and Maison Maritaine sites are fully in accord with the emerging vision for the future of health and social care services in the Island.

103. Appendix 4 is a diagrammatical representation of the interrelationship between all the various strategies referenced in this Section.

3) THE CONDITION OF LONGUE RUE HOUSE AND MAISON MARITAINE

104. It is against this strategic background that the Departments have considered the future of Longue Rue House and Maison Maritaine.

105. Longue Rue House and Maison Maritaine were opened in 1963 and 1971 respectively; both homes are thus ageing and, despite considerable investment over their lifetime, the fabric of each of the buildings is deteriorating.

106. Of particular concern is that their mechanical and electrical systems are fast becoming obsolete, so much so that significant sums of money are required just to keep the homes a safe place to live.

Capital costs

107. Significant capital expenditure would be required to enable the homes to meet modern-day standards of residential care and to provide the facilities required by the newly introduced Guernsey Care Standards. (More information about the Care Standards follows in paragraphs 114 – 117 below.)

108. A stock condition survey of Longue Rue House and Maison Maritaine was commissioned by the Housing Department in 2008. Carried out by the Treasury and Resources Department's States Property Services (SPS), the survey assessed the extent of the work required to both properties, and estimated the cost and priority of the work identified.

109. The survey highlighted that major works were required to both homes; specifically, it identified that Longue Rue House and Maison Maritaine could no longer function as modern-day residential care homes without substantial remodelling and upgrading. Whilst the structure of the buildings was generally found to be sound, some essential and urgent work was identified. This included, but was not limited to, the following:

Required at both homes:

- renewed electrical wiring throughout
- additional fire safety precautions, to include installing radiator covers and fire resistant self-closing doors to all bedrooms

Additional works required at Longue Rue House:

- enhancements to the roof insulation to minimise heat loss
- a new lift, to replace the existing lift which is too small for wheelchairs
- installing handrails on stairways

Additional works required at Maison Maritaine:

- replacement boilers, pumps and heating system
- installing ramps and handrails
- improved fire safety signage

110. The report from SPS further advised that the condition of both homes was such that their future needed to be considered simultaneously; one home could not reasonably be prioritised over the other due to the nature, extent and urgency of the work identified.

111. Two options for the future of the homes for the ongoing provision of residential care at both locations were outlined by SPS in its survey report. These options and their estimated capital cost are as follows:

(i) To remodel and refurbish both residential homes - estimated cost £10-15 million

This represented the minimum spend required to enable the Housing Department to manage safely the risks of keeping the two residential care homes open in the long-term. However, whilst investment of such a significant sum of money would result in improved care environments, due to the restrictions imposed by the physical structures of the internal and external spaces at both homes, a full refurbishment would not meet all current physical requirements of the Guernsey Care Homes Standards, in terms of ensuring the minimum spaces required for residents. Compliance with the standards would thus still be lacking in some respects.

Remodelling would also not overcome many of the issues about the suitability of the design of spaces for residents with increasing confusion and frailty and would, therefore, not be the optimum solution for meeting residents' needs.

(ii) To redevelop both sites as residential homes - estimated cost £20-25 million

This sum was calculated on the basis of rebuilding a residential care facility within the footprint of the existing buildings. Option (ii) was acknowledged to have an advantage over option (i), as it would allow for replacement facilities to be designed to fully meet the requirements of the Guernsey Care Home Standards. However, as explained in more detail below, it would be an inefficient use of States' funding as the number of beds would have to be reduced significantly to meet these Standards.

112. Allowances were made in these calculations for project management costs, managing various risks during the life of the project, such as the increasing cost of materials, etc. and for contingencies.

113. The calculations also made provision for a substantial re-housing programme to manage the transition for residents to an alternative location/s during the period of work, as it would not be possible for the full extent of the works required to be carried out whilst the properties were occupied. As this would necessitate residents being dispersed into other residential care homes (depending on the availability of beds), this would be extremely disruptive and disturbing to the residents, particularly those most frail or with dementia. Furthermore, if the buildings were not emptied, it was considered that there would be unacceptable risks to hygiene, health and safety, and care standards, during the period of works.

Guernsey Care Home Standards

114. The Guernsey Care Home Standards were introduced in 2009 to provide a regulatory environment for all public and private care homes in the Island. They have had implications for the care and the standard of accommodation provided at Longue Rue House and Maison Maritaine.

115. The changes have predominantly related to the way that staffing resources are deployed across the homes. For example, the new standards introduced more stringent training requirements, necessitating that at least 50% of trained care staff – those holding an NVQ Level 2 or equivalent - are on duty at any one time. The new standards have also required the Housing Department to prepare new documentation and care policies, which resulted in the production of a Care Manual to satisfy these requirements.

116. However, by far the most challenging impact of the introduction of the Guernsey Care Home Standards in respect of the Housing Department's residential homes is the minimum physical space standards. While, because they pre-date their introduction, the existing facilities may continue to operate as residential homes although they do not meet these Standards, this would not be the case if the homes were to be rebuilt or refurbished.

117. This is challenging because the scope of the modernisation of the existing buildings that would be required to meet these Standards is virtually impossible to achieve within the current building envelopes without spending considerable sums of money. For example, the Standards require that all bedrooms within residential care homes are provided with en-suite facilities, but this is not possible at the homes due to the constraints of the physical buildings.

Revenue implications

118. With regard to the revenue implications, whether remodelled or rebuilt, the number of beds provided under options (i) and (ii) above were calculated to reduce from 46 beds to 30 beds at Longue Rue House and from 53 beds to 34 beds at Maison Maritaine; a net reduction from 99 beds to 64 beds across both sites. This would be necessary, where feasible, to be able to include the additional facilities required by the Guernsey Care Standards - such as en suite bathrooms to all bedrooms - and to make further improvements to provide better support to frail residents and those with more complex conditions living within the homes.

119. It was estimated that this reduction in the number of beds would result in a 38% decrease in annual revenue income; however, it was not expected to be accompanied by a similar reduction in operating costs. Building maintenance costs for a 30-bed home were anticipated to be roughly the same for a 50-bed home of the equivalent size.

120. It was also noted that ongoing operating costs for refurbished premises were likely to be greater than if the accommodation was rebuilt, as the existing buildings could not be adapted or altered to achieve best practice, in terms of managing heat loss and ensuring energy efficiency, for example.

121. Similarly, although it would be expected that there would be a reduction in the number of staff to support a lesser number of residents, this would not be in proportion to the reduction in people being cared for, due to the operational requirements of staffing rotas and the need to maintain minimum levels of cover, etc.

122. As a result, the reduction in the number of beds associated with either rebuilding or refurbishment would yield less income to meet equivalent costs for current building sizes. Running the two residential homes would, therefore, be significantly more costly per resident than at present.

Other works required

123. A separate, independent review of the environmental standards within both homes also resulted in a list of essential and priority areas requiring attention. The works specified included:

- provision of low temperature radiators;
- upgrading of bathrooms;
- providing shower rooms;
- enlarging the smaller WCs;
- providing assisted toilets; and
- providing additional laundry rooms.

124. In respect of health and safety within the homes, additional works identified which remain outstanding, include:

- installing sluice machines (now in progress); and
- upgrading boilers, electrical and mechanical systems.

Works undertaken

125. In the period since the results of the SPS survey and the environmental standards report were received, the Housing Department has targeted expenditure at Longue Rue House and Maison Maritaine towards managing any identified health and safety risks, such as improved fire safety precautions and other measures to ensure the well-being of residents. This has included some new fire doors in the communal areas; upgrading the fire alarm system; and introducing

fire separation in the roof voids at Longue Rue House. The boilers at Longue Rue House have been replaced, and some improvements to the hot water cylinders at Maison Maritaine have also been required.

126. In total, since 2007, in addition to routine maintenance expenditure, the Housing Department has spent £344,647 on essential works and a further £131,000 is committed for works currently in progress.

127. In light of the findings reported above, the Department knew that the solution to the difficulties presented by the properties was unlikely to be as residential care homes. While, therefore, the proposals set out in this Report were under investigation, all expenditure on the two residential homes has been carefully managed and targeted. However, it is important to state that **monies have been invested, and will continue to be invested**, to keep the buildings habitable and functional for residents while they remain operational as residential homes.

Conclusions

128. The introduction of the Guernsey Care Standards in 2009, together with a general need to improve health and safety with the homes, has required the Housing Department to consider, with some urgency, the future of its two residential homes. It has been estimated that the homes have a life of up to three years, after which time significant investment of several million pounds will be required to replace the essential services.

129. The stock condition survey from SPS has provided much of the information underpinning the proposals for the future of the residential homes. The findings reinforce the Department's view that determining a way forward for the homes is both urgent and essential.

130. However, the need to address the problem of the ageing care homes also presented an opportunity for the Housing Department, working closely with HSSD, to re-evaluate how accommodation and care services should be delivered on these sites, not only to meet the needs of the existing residents, but also for future generations and for client groups other than just older people.

4) THE CARE NEEDS OF EXISTING RESIDENTS

131. Before determining what to do with the existing care homes from a buildings perspective, it was also vitally important for the Departments to consider the needs of the existing residents.

132. Longue Rue House and Maison Maritaine currently cater for residents with varying degrees of dependency and care needs. Some residents are generally very able, whilst others have complex and specialist needs.

133. The types of personal care tasks provided to residents are as follows:

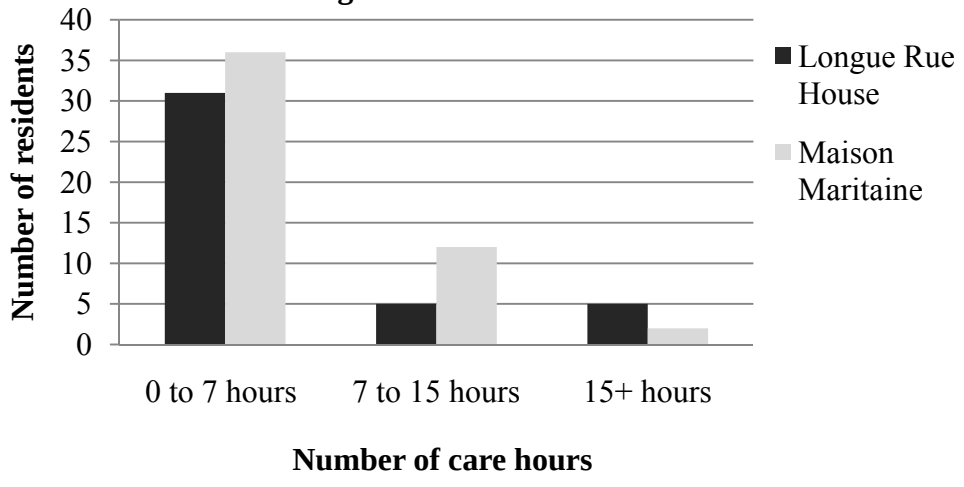
- assisting to wash, dress and undress residents who are unable to manage independently;
- toileting residents throughout the day;
- bathing residents;
- assisting residents with walking;
- dispensing medication throughout the day;
- checking and updating residents' care plans;
- applying treatments as prescribed;
- attending to minor dressings; and
- putting residents on oxygen and nebulisers.

134. The levels of dependency and care needs of residents are measured by the number of care hours required by an individual per week. This is broken down as follows:

Low dependency	Medium dependency	High dependency
0-7 hours per week	7-15 hours per week	Over 15 hours per week

135. Figure 3 below shows the number of weekly care hours required by the residents of Maison Maritaine and Longue Rue House, as at February 2011.

Figure 3: Comparison of weekly care hours provided to residents of Longue Rue House and Maison Maritaine



136. Although dependency has increased in recent years with a number of residents now requiring moderate levels of care, over 72% of residents have low dependency care needs and require less than 7 hours of care per week. Of these, over 56% currently have a requirement for less than 4 hours of care per week.

137. This is significant because for Rosaire Court, the first 'extra care' housing scheme in Guernsey, an Islander needs to have a requirement for a minimum of 4 hours of care and support per week to be eligible to be housed there. Over half of the residents of Longue Rue House and Maison Maritaine thus have lesser care and support needs, but are accommodated in a residential care environment that assumes they need round the clock attention[8].

138. This proves what was stated above; namely: that in the absence of other more suitable housing options, such as sheltered or 'extra care' housing, people with relatively low needs are accommodated in residential care – in this case, at Longue Rue House and Maison Maritaine.

139. Figure 3 also shows that 72% of residents across both homes require less than seven hours of care per week. As will be explained below, they too could be supported to live independently in sheltered housing or 'extra care' accommodation, if it were available.

140. At the other end of the dependency spectrum, there are a small number of residents that have relatively high care needs, requiring in excess of 15 hours of care per week.

141. There are just over 7% of residents who have more complex needs, including both physical needs and mental health needs. However, at present, the homes are not staffed to meet the increasing care requirements of people with more complex needs, nor are care staff trained to deliver the kind of specialist care required by people with on-set dementia and other specialist needs. A move into nursing care for most residents presenting with complex needs is therefore inevitable.

142. However, part of the reason for this is that as Longue Rue House and Maison Maritaine have increasingly been required to manage more complex cases, it has become clear that the care environments of both homes do not enable residents to 'age in place'. The fabric of the buildings and their design do not support residents with increasing fraility, disability and confusion.

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[8] This is not to say that anyone who has care needs of less than four hours is inappropriately accommodated in residential care and should be being cared for in their family homes. The requirement for four hours of care and support at Rosaire Court was introduced for two reasons: (i) because this guaranteed a minimum number of care hours to be provided, enabling Housing 21 to staff up accordingly; and (ii) as a means of 'rationing' the demand for the limited number of 'extra care' flats available, ensuring that those persons with a greater need were prioritised for the new accommodation. However, one consequence of the dearth of 'extra care' housing has been that older people with lesser care needs have been accommodated in residential care environments, such as Longue Rue House and Maison Maritaine.

143. Current staffing levels are in the main intended to support residents with a requirement for low level, generic forms of care, rather than those with specialist needs. However, while staffing levels could be addressed, the physical limitations of the buildings would compromise this investment, providing a further incentive to consider the future of the two residential homes.

5) 'EXTRA CARE' HOUSING

144. The paragraphs above have made frequent references to 'extra care' housing.

145. 'Extra care' housing has many similarities to residential care, but the major difference is that the emphasis in 'extra care' housing in on enabling individuals to live as independently as possible.

146. There are two major underlying themes that define 'extra care' housing:

i) persons living in 'extra care' housing live in self-contained accommodation and are **tenants** and maintain a tenancy; and

ii) there is access to a range of on-site **care and support services**, which are delivered **flexibly**, according to needs.

147. 'Extra care' is a specialised housing model which marries built form with the provision of care and support services, which are delivered on a flexible basis according to the needs of an individual. 'Extra care' housing is increasingly seen as a community-based alternative to residential care provision, as it enables tenants – even those with high level care and support needs - to retain as much of their independence as possible, whilst receiving a tailored care package. Individuals do not receive less care and support than they would within a residential care home, for example, it is just that services are delivered in a more flexible way.

148. 'Extra care' housing is becoming more and more popular as a solution to providing specialist care in community locations for persons of all ages. For example, people with dementia and people with learning disabilities can often be accommodated and supported to live independently within an 'extra care' setting, where extensive care and support services are available if needed, and where housing is designed to meet specialist needs.

149. It is also possible – as is recommended in this Report - for the same 'extra care' housing scheme to accommodate both older people and people with learning disabilities or people with mental health problems. The key to enabling mixed groups of vulnerable people to live in the same location is the careful

management of support services to mitigate any risks[9]. Risk assessments need to be undertaken and support services must be carefully designed to ensure the safety and well-being of residents.

150. 'Extra care' housing is characterised by:

- the provision of private, self-contained apartments, with access to on-site care and support, which enables individuals to live independently within the community;
- access to primary health and social care and support services which are delivered in a flexible way according to the needs of the individual, in their own flat or elsewhere on-site;
- the provision of a range of communal services and facilities in an environment which is designed to make it easy for tenants with mobility problems, and a range of other specialist needs, to move around the internal and external spaces. Spaces are also designed for ease of personal and social care delivery; and
- access to a range of communal facilities, such as a cafe/restaurant, computer room, exercise room, library, hairdresser, day centre, for example, which ensures that tenants are not isolated from community events and that social activities are accessible.

151. In terms of physical form, 'extra care' housing can take many variants. It could be:

- a single building of flats;
- a building of flats with communal facilities;
- a 'core and cluster' scheme, where there is a central 'core' building from which services are managed and delivered with housing units adjacent to the main building. (This is the model proposed in this Report.);
- remodelled residential care buildings; or
- remodelled tower blocks.

[9] For the avoidance of doubt, it is not intended for the redevelopment of Longue Rue House and Maison Maritaine to meet the needs of all groups requiring a supported living environment, as identified by the Supported Housing Strategy – such as those of ex-offenders or those with substance abuse problems, for example – where other options will need to be further explored.

152. ‘Extra care’ housing schemes can also be characterised by the inclusion of accommodation offered for a range of tenures: for social rent; on a lifetime lease basis; for partial ownership; or for outright sale.

153. There are a number of characteristics which differentiate ‘extra care’ housing from other forms of accommodation-based care provision, such as residential care:

- living ‘at home’ – not in ‘a home’;
- having one’s own front door;
- flexible care delivered according to need, which may increase or decrease as a tenant’s circumstances change;
- opportunities to rebuild or preserve the skills required for independent living;
- accessible, purpose-designed buildings, which can include a range of assistive technologies[10] to enhance independent living for people with a range of needs; and
- opportunities to build a community with a range of tenures and facilities, and the opportunity to enhance and contribute to existing communities.

154. The above contrasts with residential care provision where:

- residents live in a bedroom;
- have meals provided in a dining room at specific times of day;
- have access to lounges and televisions; and
- have staff on hand to provide care on a 24 hours a day, 7 days a week basis.

155. Some residents may not require 24/7 care services (as is the case for the majority of residents at Longue Rue House and Maison Maritaine), but within a residential care environment services are paid for on this basis irrespective of need.

156. As care plans are tailored according to need, and are paid for on this basis, ‘extra care’ housing is generally more cost-effective than residential care where care is paid for on a 24/7 basis, irrespective of need. **It is this distinction between ‘extra care’ and residential care provision which makes ‘extra care’ housing more cost-effective.**

[10] Assistive technologies, such as community alarms (e.g. Lifeline) or the use of motion sensors within the home can help to increase safety and promote independent living.

157. Other benefits of 'extra care' housing include:

- **It can facilitate better rehabilitation and re-enablement following an emergency or critical event.**

  Very often, admissions into a care home environment are made following an emergency or critical event, because it is perceived to be the lowest risk environment for an older person, and the older person agrees to avoid being a burden on family and friends.

  'Extra care' housing offers a real alternative in such cases as it provides a supported living environment, while at the same time it promotes continued independence. In an 'extra care' scheme, staff are available when needed, but there are also opportunities for rehabilitation and re-enablement in order for an older person to regain their confidence to live independently, after a trip or fall at home, for example.

- **It can offer an opportunity to provide respite for informal carers.**

  One unit of rental accommodation at Rosaire Court is available as a respite flat, paid for by HSSD (see paragraph 158 below).

- **It can provide support to informal carers and prevent the separation of married couples.**

  In residential care, generally only those persons requiring care services are admitted, which often results in the separation of married couples. Within 'extra care' housing, care and support is available when needed to support someone who requires care, but can also provide support and respite to an informal carer. As the accommodation offered is an independent living unit, there is no exclusion of spouses or partners or, indeed, ageing disabled children who meet the criteria for 'extra care'.

- **It is a more lifestyle focused form of provision.**

  'Extra care' housing allows tenants the flexibility to make their own choices about how they wish to structure their day; they are not required to follow any regimented pattern – they can get up and go to bed when they like, and they can have meals when they like – a direct contrast to how a residential home generally operates; in particular a large home such as either Longue Rue House or Maison Maritaine.

'Extra care' housing in Guernsey

158. The Island has one 'extra care' scheme known as Rosaire Court and Gardens, which is owned and managed by Housing 21 (Guernsey) Ltd. Rosaire Court and

Gardens provides 50 units for social rent; 9 units on a lifetime lease basis; and 25 owner-occupied units. All residents are entitled to receive assistance from the care and support which is provided on site from Rosaire Court.

159. The Departments have learnt much from this first 'extra care' scheme, both in terms of building design and service delivery; and all the lessons learnt (see Appendix 5) will be applied to the proposed schemes at Longue Rue and Maison Maritaine. However, of most significance, the completion of Rosaire Court in early 2007 has contributed meaningfully to reducing admissions into residential care, which demonstrates clearly the effect that this kind of housing with care provision has on reducing reliance on institutional forms of provision.

160. The forthcoming Older People's Strategy will, therefore, conclude that the provision of more 'extra care' accommodation in the Island would have significant benefits in enhancing the well-being of individuals and reduce residential care referrals.

161. **In particular, the Strategy will recommend that the emphasis should be on the development of 'extra care' housing, which is built to an agreed design standard.**

162. In the light of the changing strategic focus for the provision of more specialised housing in the Island to meet the changing needs of older Islanders, the Departments consider that it would be inappropriate for proposals for the future of the care home sites to recommend the re-provision of residential care on these sites, when the Strategy will recommend that new build development should provide more specialised housing, in particular 'extra care'. The proposals outlined in this States Report are, therefore, considered to be fully aligned with the recommendations of the forthcoming Older People's Strategy and an early opportunity to implement one of its key findings and recommendations.

163. Moreover, it is to be recalled that the Housing Department's commitment to providing more 'extra care' housing schemes in the Island in the future was signposted in the most recent CHP Report to the States, approved in May 2010[11]. The CHP Report highlighted the need for an extensive build programme over a 5-year period (2010 to 2014) to meet the immediate and ongoing need for specialised housing for older people.

164. In particular, the CHP Report estimated that there was:

- *'An immediate need for 100 units of specialised housing – sheltered or extra care housing – to meet the needs of older people currently accommodated in social rental housing;*

[11] Housing Department – *'Corporate Housing Programme – Progress against the 2009 Action Plans and Future Strategy'* – Billet d'État XI 2010

- *An additional 30-50 units of specialised housing each year, over the next 5 years, to meet the needs of older people who would otherwise be referred to residential or nursing home care, or supported at home by social services.'*

165. Whilst the proposals to redevelop the residential care home sites will, therefore, go some way towards meeting the demand for extra care housing in the Island, as identified in the CHP Report, there will still be a demand for more specialised housing to meet the ongoing needs which have been identified. In other words, **whatever is provided on these two sites, there will be a requirement for further such 'extra care' schemes to be developed to meet the care and support needs of the ageing population and other younger persons that would benefit from such accommodation.**

6) REDEVELOPMENT PROPOSALS

Scope of redevelopment

166. Appendices 6 and 7 show site plans of the existing residential care homes and surrounding land administered by the Housing Department and HSSD. The area outlined in bold demarcates the 'developable' land in States' ownership and shows that the extent of these sites present significant development opportunities.

Longue Rue site

167. At Longue Rue House, in addition to the replacement of the existing care home building, it is proposed that the developable area will include:

- land to the east, known as **'Courtil Jacques Phase 3'**, which has been designated for housing development in the Rural Area Plan for many years;

- **'Les Caches Cottage'**, which is a standalone roadside property currently offering a three-bedroom unit of accommodation for social rent; and

- a property to the north-east of the residential care home, known as **'Valderie'**. This property is administered by HSSD and is presently vacant pending refurbishment. (More information about Valderie follows in paragraphs 170-175 below.)

168. The site plan also shows 'Courtil Jacques' to the south of the existing residential care home. Courtil Jacques provides 20 units of much-needed sheltered housing for social rent. The accommodation is in good order having been upgraded in the last decade. It is popular and effectively meets the needs of its existing tenants, who are also older people, and will therefore be retained.

169. The proximity of Courtil Jacques to the new 'extra care' scheme will mean that tenants accommodated there will also benefit from the facilities and services to be delivered by the new development.

Valderie

170. It had previously been agreed by the States[12] that Valderie could be redeveloped as part of proposals to provide residential homes for adults with a learning disability and thus it is part of the approved States' capital programme.

171. Valderie was purchased by the Treasury and Resources Department on behalf of HSSD for £430,000 and included as part of a capital programme intended to re-house residents of Oberlands House, which would in turn facilitate the re-provision of mental health facilities on the Oberlands' site.

172. The total sum of £5.6 million was earmarked in the capital programme for the redevelopment of Valderie and a further property - 'The Oaks', Baubigny, St Sampson's – to provide residential homes for persons with a learning disability.

173. However, in the light of the homes' redevelopment projects and the potential to cater for some of these service users within the new 'extra care' schemes, the HSSD has reappraised these proposals and agreed that Valderie should be included in the curtilage of the Longue Rue site for redevelopment. With the sanction of Treasury and Resources, its redevelopment will thus now become a project cost in the overall scheme appraisal for the Phase 1 redevelopment of the Longue Rue site.

174. **In the light of this decision, it will no longer be necessary to use monies from the capital reserve that have been set aside for the refurbishment of Valderie to provide replacement residential accommodation for learning disability clients. The sum of £1.6 million which had been set aside for this purpose will, therefore, no longer be required.**

175. HSSD still intends to progress the proposed redevelopment of 'The Oaks', which was part of the same capital programme as the refurbishment of Valderie. It will provide specialised residential care for people with conditions that require higher levels of dependency and more complex needs, some of whom may be in an off-island placement in the UK, and who are unsuitable to be accommodated in 'extra care' housing. This development will be the subject of a separate States Report.

Maison Maritaine site

176. Maison Maritaine is surrounded by a number of buildings that accommodate Housing Department social housing tenants. In order to enhance the proposals

[12] Treasury and Resources Department – '*Capital Prioritisation'* – Billet d'État XXIV 2009.

for the redevelopment of the Maison Maritaine site, the developable area will also include:

- a property to the north – **'Maison Le Clement'** – which provides 16 bedsits with shared toilet and bathroom facilities and two one-bedroomed flats. These units are extremely outdated and are overdue for replacement;

- four bungalows forming part of **'Courtil Le Clement'** to the east of Maison Maritaine;.

- properties known as **'1 to 4 Les Granges'**, towards the southern boundary of the site: these are four one-bed flats; and

- the possible reconfiguration/redevelopment of **'Old Vale Rectory'**, which is situated on the roadside. Old Vale Rectory currently provides 4 one-bedroom flats and a two-bedroom flat.

177. The redevelopment of these social housing properties is regretted, but is necessary to provide more flexibility in the design of the replacement 'extra care' scheme. Indeed, without them, it would not be possible to re-house, on site, all of the existing residents of Maison Maritaine in the new 'extra care' accommodation to be built (see paragraphs 184-185 below).

178. The proposals to redevelop both residential care home sites will, therefore, also have implications for 23 Housing Department tenants in 20 households, who are currently being accommodated in the aforementioned properties on both sites. They will - subject to their continued eligibility for social housing - be offered an alternative property in the general social housing stock.

179. Acknowledging that many of these tenants are older people and/or have lived in these properties for some time, the Housing Department is committed to managing their re-housing with considerable sensitivity and care.

A phased approach

180. In the light of the significant scope for redevelopment identified above, it is proposed to deliver both schemes in two phases of development. For the reasons outlined in Section 3, it will be necessary for the Phase 1 redevelopment of both sites to take place simultaneously.

181. This will be guided by a 'masterplan' for each site, which is currently being prepared, to identify the total number of units that could potentially be delivered. This is estimated at 80 to 100 units at each location. It will also allow consideration to be given to the integration of a later phase of development with the communal facilities already provided by Phase 1.

182. Planning permission from the Environment Department will thus be sought on the basis of the 'masterplan' for both Phases 1 and 2. (More information about the potential afforded by a subsequent phase of development on each site is outlined in paragraphs 260-274.)

183. **However, at this time, the States is only being asked to approve proposals associated with Phase 1 of the redevelopment of each site; the priority of which is to re-provide accommodation for the existing residents of Longue Rue House and Maison Maritaine.**

184. By defining the developable area of both sites in the ways outlined above, the Housing Department has been able to make a commitment to residents of the care homes that purpose-built self-contained accommodation will be available for them in the new 'extra care' schemes **within their existing communities**. This will help to minimise disruption for the care home residents and, most importantly, to avoid the need for residents to be relocated to alternative accommodation during the construction period.

185. To achieve this, Phase 1 on each site will be built immediately adjacent to the existing residential homes and residents will remain in the care homes during this time. Upon completion and commissioning of the new accommodation, residents will move across to their new flats in the 'extra care' scheme: this is planned to take place during February and March 2014. Following this, the residential care home buildings will be demolished enabling, if agreed at a future time, a second phase of development to take place at a later date.

186. Whilst the actual numbers of units to be provided on the sites may be subject to change as the detailed design process evolves, it is currently envisaged that Phase 1 will deliver:

- **51 one-bed and 10 two-bed flats at Longue Rue; and**
- **44 one-bed and 9 two-bed flats at Maison Maritaine.**

187. Each flat will be self-contained, with its own lounge, kitchen and bathroom.

188. However, in preparing the masterplan for each site, it is envisaged that, compared with Phase 1, a higher proportion of two-bed flats will be provided by a subsequent phase of development on each site (see paragraph 260 below). This is to ensure that the accommodation is suitable to accommodate a range of household types and to offer maximum flexibility to meet future needs.

189. For example, a two-bed flat in an 'extra care' scheme could accommodate ageing parents with a care or support need, together with their adult son or daughter who may have a disability. Increasingly, there are also circumstances where it is necessary for older couples to sleep separately from each other, therefore necessitating accommodation with two bedrooms.

Communal facilities

190. In addition to providing purpose-built accommodation for tenants, Phase 1 will also include the majority of the communal facilities required to support each scheme.

General communal facilities

191. At both locations, there will be a communal lounge, restaurant/café and dining area, a hairdressing salon, therapy room, together with well-designed external spaces for use by tenants, such as a sensory garden, raised flower beds and seating areas. It is also planned to include other facilities such as an exercise room and a library, for example. Communal areas will be designed to have multiple uses for a range of social activities, and to encourage both formal and informal social contact and communication.

192. Well-designed and appropriately-located dining areas are at the heart of an 'extra care' scheme, encouraging tenants to meet together, and to sit with their family and friends.

193. With this in mind, consideration is being given to the nature of the catering service to be provided in the schemes. It is important for such a facility to be included in order to serve those tenants who unable to cook their own meals and for those who do not, on occasion, wish to cook. It is also a means of drawing other Islanders to the scheme, thereby integrating the scheme's tenants within the wider community.

194. Whilst the scale of the catering service provided in the 'extra care' schemes has not yet been agreed, it will be appropriate for each setting of the scheme and will also have regard to the amenities provided nearby. Provision may be different at each location.

195. However, there are many ways in which the service could be delivered:

- it could be managed by staff directly employed by the housing provider, i.e the GHA (see paragraphs 225-234 below);
- it could be provided by a private catering firm on a commercial basis; or
- a full meal service could be provided from an alternative catering facility off-site and delivered to the scheme.

196. At this stage, no firm decisions have been made, but the matter will be thoroughly investigated and a conclusion reached before the new accommodation is ready for occupation in three years' time.

Day Centre

197. The inclusion of a 20 placement day centre to serve the wider community in the north of the Island is also proposed at the Maison Maritaine site. This will be available for use by tenants and other complementary user groups. The need for such a facility was identified by HSSD; and the decision was taken to base the day centre at the Maison Maritaine site in the Vale, as St. Martin's is already well-served by such facilities. The inclusion of a day centre is also likely to make a catering service more commercially viable.

198. Making provision for a day centre at Maison Maritaine is also intended as a means of re-providing facilities for services currently being delivered by HSSD for a range of service users; for example, those with mental health problems, where it is more appropriate for the services not to be delivered on a hospital site.

Tenancy services

199. The housing provider, i.e the GHA, will have a dedicated housing management office at each location for tenants to seek help with any maintenance problems or query about their tenancy. This will also allow for close engagement between the tenancy management function and the Housing Department's care and support staff, to resolve any issues as they arise; particularly as former residential home residents are supported through the transition to independent living.

Additional facilities

200. In addition to the facilities outlined above, the 'extra care' schemes are also likely to incorporate:

- a Care Manager's Office
- photocopying room
- lifts
- staff overnight room, with en-suite facilities
- staff rest room with kitchenette
- staff locker/change room and toilets;
- communal WCs
- assisted bathrooms
- a guest room with en-suite

- laundry
- sluice room
- cleaner's storage
- general store
- buggy/scooter store

201. Some of these additional facilities, such as assisted baths, may also be used by other Islanders in the wider community.

202. There is also an opportunity to form partnerships with local community providers to deliver services from the communal facilities so that voluntary groups can develop their own presence in the 'extra care' schemes, thus embedding the schemes into the community. Indeed, since these proposals were made public, a number of community groups have expressed an interest in using the facilities to deliver services to Islanders in the north of the Island.

203. Finally, in determining the facilities to be provided by Phase 1 and the respective floor areas, it is important to note that the communal areas will be designed to have sufficient capacity to accommodate the people who will occupy the flats in a subsequent phase of development. This has an impact on the capital grant required from the States to support these projects, which is discussed further below (see paragraphs 244-252).

204. Appendix 8 sets out a full schedule of the accommodation and communal areas to be provided by Phase 1 of the redevelopment of both sites.

Specialist design features

205. 'Extra care' accommodation is purpose-built to be able to respond to a range of needs and incorporate a range of specialist design features, developed around the principles of 'Lifetime Homes'. Appendix 9 provides a summary of Lifetime Homes' principles.

206. The new homes will thus provide for:

- wheelchair access from the bedroom to bathroom;
- low window sills to enable tenants to watch what is happening outside their flats;
- level access thresholds;

- wet rooms;
- sufficient space to accommodate hoists;
- circulation spaces designed for wheelchair use; and
- dedicated outside space in the form of a balcony or terrace.

207. The 'extra care' schemes will also incorporate various assistive technologies, such as alarm-based technologies, which can be used to deliver a service to tenants, to improve safety within the home and promote independent living.

208. The schemes will also be designed to be fully wheelchair friendly.

209. Designing for people with dementia will also be incorporated into the design features to enable people who dement *in situ* to enjoy further years of independent living. Design details such as the use of open plan layouts to increase visibility, landmarks to aid 'way finding', the use of contrasting colours to aid understanding, avoidance of shiny finishes, etc. will all be integrated into a dementia friendly approach to designing both the inside and outside spaces.

210. A wide range of consultations in respect of both the interior and exterior design have already taken place with various health and social care professionals employed by HSSD. These will continue with residents and staff as the projects progress to consider how the housing, care and support needs of a wide range of individuals can be met most effectively by these new schemes.

Environmental impact

211. As a matter of policy, all new recent general needs social housing developments that have been sponsored by the Housing Department have incorporated a range of 'eco-technologies'. For example, the inclusion of solar panels for heating and hot water; an internal heat recovery system; and high levels of insulation; have proven to be very effective methods to reduce fuel costs for tenants.

212. The design of the 'extra care' schemes will also be developed to maximise energy savings through sustainable building methods and technologies. This will have positive benefits for the tenants of the schemes, both financially and otherwise.

The design approach – 'Core and Cluster'

213. It is intended that the design of both sites will adopt a 'core and cluster' approach.

214. The 'core and cluster' approach involves establishing a central 'core' which contains most of the communal facilities (restaurant/ café, library, lounge, etc.), together with the majority of flats. Additional accommodation is provided in

'clusters', which could be blocks of 10 to 20 flats linked to the 'core' building through either covered links or landscaped walkways, or they could also be 'wings' of flats attached physically to the 'core' central building. Tenants will have access to services and communal facilities from the 'core' central building as they need them.

215. This type of design has proven to work well where there are a number of client groups being accommodated within one scheme; and, from an environmental perspective, also helps to 'break up' the development in terms of scale and massing, providing a more domestic, rather than institutional, feel. It is also considered to be the most effective way to maximise flexibility of the accommodation and to ensure that it meets a wide range of needs.

216. 'Core and cluster' also allows for the addition of further 'clusters' in a later phase of development, which could be offered for different tenures, such as partial ownership, and for different client groups.

217. Consultation with health and social care professionals working within HSSD has confirmed that 'core and cluster' is the preferred form of design from a service delivery point of view.

Providing a 'cluster' for persons with a learning disability

218. HSSD currently manages seven group homes for 53 persons with a learning disability with varying degrees of need. The current accommodation is not effective in providing an 'enabling' living environment for residents, nor does it allow for ease of care provision. Many group homes are standard residential dwellings with some adaptations, but they were not purpose-built.

219. It is acknowledged that many of those people being cared for by historic 'medicalised' models could, with the appropriate care and support, live independently in the community.

220. In addition, there are in the region of 150 individuals with a learning disability living in the community who, in the future, unless alternatives are provided, will require accommodation in residential homes provided by HSSD.

221. Current provision is, therefore, not considered to be adequate, nor does it align with the core principles which underpin the Supported Housing Strategy and HSSD's '2020 Vision'.

222. Therefore, the redevelopment of the Longue Rue and Maison Maritaine sites to provide 'extra care' housing also presents an opportunity to meet the supported housing needs of some existing clients of HSSD who currently reside in a group residential home environment, and who could be assisted to live independently in specialist housing. Particular client groups include people with learning, physical or sensory difficulty, and people with mental health problems.

223. Thus, as noted above, it is proposed to include up to 15 units of accommodation in Phase 1 of the redevelopment of the Longue Rue site (in addition to those 46 units set aside for existing residents of Longue Rue House) to meet the needs of people with a learning disability currently accommodated by HSSD.

224. The decision was taken to locate these units at the Longue Rue site due to its proximity to St Martin's Community Centre, the disability day services and the Disability Service Headquarters. Whilst it is too early to identify individuals that will transfer into this accommodation, many potential residents also live in closer proximity to the Longue Rue House site in St. Martin's than to the Maison Maritaine site in the Vale.

A development partner – the Guernsey Housing Association

225. The GHA has been selected as the development partner for these projects.

226. The GHA was established in 2002 to work in partnership with the Housing Department to deliver high quality, affordable social housing. The GHA currently works in partnership with the Housing Department to deliver general needs accommodation for social rent and partial ownership, as part of a 5-year development programme that was approved by the States of Deliberation in December 2007[13]. At the time of writing, the GHA has 349 properties; the majority of which have resulted from the redevelopment of Housing Department estates which had reached the end of their economic life.

227. This development programme is funded by a combination of private borrowing, together with direct grant funding from the CHP Fund. Grant funding from the States is currently provided on a scheme by scheme basis. The actual grant sum for each scheme is based on the total cost of each development; the rental income to be generated by the scheme over a 30-year period; and the overall financial health of the GHA.

228. The GHA has a contractual relationship with the States through a Framework Agreement[14], which is managed by the Housing and Treasury and Resources Departments.

229. The GHA has a proven track record of delivering high quality general needs accommodation for social rent. It has provided a significant number of newly built and refurbished social housing units at a much reduced cost to the taxpayer, and in an arguably much shorter period of time than if the States had been the

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[13] Housing Department – *'Social housing under the Corporate Housing Programme – development programme for the period 2008 to 2012'* – Billet d'État XXV 2007.

[14] The Framework Agreement with the GHA is a legally binding document which sets out the contractual relationship with the States. It governs the type of business information that the GHA is required to provide to the States and outlines the 'step-in' rights that the States has to the GHA's property assets in the event that the GHA went into liquidation.

developer itself. All GHA schemes to date have been delivered on time and within budget.

230. The GHA has grown rapidly, but has proven itself as an organisation that is able to respond to changes and resource its services accordingly. As such, the Departments consider that the GHA's knowledge and expertise will be extremely valuable to the redevelopment of the residential care homes sites.

231. Accordingly, the GHA will oversee the building projects, with responsibility for bringing them in on time and on-budget. The GHA will raise part of the capital funds required for each scheme from a private banking source; and, following their completion, the GHA will become responsible for all aspects of tenancy and property management on an ongoing basis.

232. However, due to the specialist nature of the accommodation to be provided by these new 'extra care' schemes, it is important for the Housing Department and HSSD to have a much closer working relationship with the GHA on these particular projects, when compared with the general needs social housing that it has developed to date. The Departments have the service delivery expertise which the GHA does not.

233. The Departments will thus be responsible for working with a wide range of health and social care professionals to ensure that the developments deliver the right type of accommodation to meet the needs, not only of the first tenants, but also to meet a range of needs for the future.

234. It is therefore important that all parties in the development of these projects utilise their strengths to ensure their successful delivery.

Architect selection

235. In late 2010, the GHA carried out a selection process to engage a firm of architects with specialist experience in the design of 'extra care' housing. The GHA approached six UK-based architectural firms each with a proven track record of designing 'extra care' housing, there being no local firm with the appropriate expertise or experience (but see paragraph 237 below regarding local involvement). A brief to the architects was issued on a confidential basis and practices were asked to submit some preliminary sketch proposals for both sites, together with a fee proposal.

236. The design brief for the sites specified, in particular:

- the total number of units and unit sizes;
- a universal standard of design, i.e. building the accommodation to Lifetime Homes' standards;

- the need to phase the development to retain the existing residential homes until new 'extra care' housing was built;
- that 'core and cluster' was the preferred development approach;
- the range of communal facilities to include a day centre on one site; and
- a commitment to working in partnership with a local firm of architects.

237. Three shortlisted organisations were invited to make a presentation of their ideas in Guernsey during December 2010. As a result of this process, a Surrey-based firm – PRP Architects – was appointed to design these schemes. PRP will partner with a Guernsey-based architectural practice (at the time of writing, yet to be selected) to ensure that a responsive 'on the ground' service can be provided during the build phase, and also to facilitate knowledge transfer of 'extra care' design, with the intention that a local architectural firm can be involved in the design of future 'extra care' schemes.

238. PRP Architects are very experienced in the design and execution of 'extra care' housing. They have a Specialist Housing team with over 45 architects and technical staff dedicated to the design of buildings that are linked to care and support services, and which accommodate people with specialist needs. PRP also has extensive experience of public consultation in drawing up design proposals, and of working closely and sensitively with residents.

239. The Environment Department has appointed a project team of officers to support the design process. Regular meetings are being held with PRP Architects, the GHA, and staff of the Housing Department and HSSD to progress the designs. This is intended to highlight any issues so that they can be addressed at an early stage and to help accelerate the planning approval process.

Timetable

240. As noted above, the Phase 1 redevelopment of each site has been planned to take place simultaneously.

241. The timetable for providing the replacement 'extra care' facilities is undoubtedly ambitious. The aim is for Phase 1 of the 'extra care' schemes to be completed and commissioned by March 2014, i.e. within three years. Having said that, the Departments consider that this timetable is achievable, but it will require sustained and concerted effort by all parties.

242. The key milestones associated with the construction of these projects are outlined below:

- Engagement with PRP architects and the Environment Department to formulate a 'master plan' for both sites – from January 2011

- States' approval sought for the redevelopment proposals and the funding thereof – May 2011
- Submit planning application – by end of July 2011
- Planning permission received – by mid-November 2011
- Start of construction of Phase 1 on both sites – March 2012
- Commissioning of both schemes – from September 2013 onwards
- Relocation of residents to new accommodation – February/March 2014

243. Clearly all of the above milestones are dependent on receiving approval from the States for the proposals set out in this Report.

7) FUNDING REQUIREMENTS

Capital grant from the CHP Fund

244. In accordance with the arrangements that apply to the development of general needs social housing on Housing Department land, the Housing Department proposes to transfer the ownership of each of the homes sites to the GHA for the sum of £1. However, only the land to be developed as part of Phase 1 will be conveyed to the GHA at this time.

245. The financial value of the land which is transferred as part of these projects will be calculated on a residual basis, in order to determine the total value of the States' financial contribution (see paragraph 249 below).

246. In addition to the funds that will be raised by the GHA from a private banking source, there will also be a requirement for a capital grant from the States.

247. For the Phase 1 redevelopment of both of sites, the requirement for capital grant funding (excluding the value of the land) is **estimated not to exceed £22 million**. This represents 65% of the overall development costs for both projects (Phase 1 only), which, combined, are not expected to surpass **£32 million in total**. The remaining amount required for these two developments will be raised by the GHA from a private banking source, which will require the GHA to secure a fourth funding facility[15].

248. At the time of writing, and without having a fully designed 'extra care' scheme for either site, it is important to note that **these figures are only indicative at**

[15] The GHA currently has three private banking facilities to provide funding for the current Social Housing Development Programme. Having approached a number of lenders on an informal basis, the GHA is confident that it can secure an additional facility to develop these two 'extra care' schemes.

this stage. They are provided on the basis of constructing 61 flats at Longue Rue and 53 flats at Maison Maritaine (primarily 1-bed, but also some 2-bed, flats for rent)[16], together with associated communal facilities at each site. At Maison Maritaine, this includes the 20-placement day centre.

249. Calculating the value of the land which comprises both of these sites on a residual basis (i.e. as if it had been acquired commercially, after all development costs have been applied) and adding this to the requirement for capital grant funding indicated above, brings the estimated total value of the contribution from the States to approximately 72%. This is based on the land comprising Phase 1 having an asset value in the region of £9.7 million. (This method of accounting is encouraged by the Treasury and Resources Department as it recognises that the land being transferred has an asset value, although no additional monies are transacted.)[17]

250. It will be noted that the requirement for a capital grant from the States for these 'extra care' schemes is much higher than other general needs social housing schemes recently completed by the GHA, which have generally represented 10-20% of the total development costs (and 30-35% of total costs if the residual value of the land is included)[18]. **This higher grant requirement is because the 'extra care' projects will include a range of specialist design features and also have a very significant proportion of communal spaces, which need to be included in the schemes and maintained on an ongoing basis. However, these communal areas generate little or no rental income to support the overall project financing.**

251. **Further, as a result of the need to include all of the communal spaces in Phase 1, these costs are heavily 'front-loaded', as the communal facilities need to be of sufficient size to support the persons who will occupy the additional accommodation that could be delivered in a second phase of development on each site. Approximately 40% of the total development costs relate solely to these communal areas.**

252. However, this means that whenever a further phase of development on each site is carried out, the costs associated with that later phase will be more akin to the cost of developing general needs social housing built to Lifetime Homes Standards by the GHA, with an allowance made for some additional communal spaces, as appropriate (see paragraphs 260 to 274 below).

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[16] See paragraph 186.

[17] The Treasury and Resources Department has also requested that, because they are funded from General Revenue, the value of the two residential homes to be demolished are included as part of the full business case to be submitted to that Department in order for it to approve the final grant amount (see paragraph 379). The Housing Department, with the assistance of SPS, is therefore arranging for commercial market-based valuations of the residential homes to be obtained.

[18] Early general needs housing schemes completed by the GHA required a 75% capital grant from the States (excluding the value of the land).

Demolition costs

253. Although this Report seeks no commitment from the States in regard to the Phase 2 development of either site, upon the two residential homes being vacated it will be prudent, sensible and beneficial, for them to be demolished at the earliest opportunity.

254. With this in mind, **the development costs quoted in this Report include sums for the demolition of Longue Rue House and Maison Maritaine. The overall costs of the projects and the grant sum required from the States is thus 'inflated' by these demolition costs.**

Budgetary provision

255. In its report to the States on the CHP in May 2010[19], the Housing Department signposted that expenditure from that Fund over the next five years would generally be targeted towards more specialist forms of housing provision. At that time, the projections of CHP expenditure identified that £31 million would be dedicated to the delivery of specialist accommodation for older people during the 5-year period 2010 to 2014. It is thus proposed to use the monies set aside for this purpose in the CHP Fund to grant fund Phase 1 of the proposed redevelopment of the Longue Rue and Maison Maritaine sites.

256. The requirement for funding of up to £22 million for these two 'extra care' schemes will clearly require a significant proportion of the expenditure that had been set aside in the CHP Fund to grant fund the provision of specialised housing over this five year period, i.e. the funds that the Housing Department had provisionally budgeted for older people's housing will be two-thirds exhausted.

257. However, as emphasised above, the costs quoted in this Report are only indicative at this stage. Furthermore, the requirement for a capital grant from the States of £22 million is considered to be the maximum amount that will be required. The Departments will continue to work with the GHA to consider ways to reduce expenditure associated with these schemes in a way that does not compromise their service delivery objectives. This will be achieved by:

- considering opportunities to maximise rental income by renting out the communal areas to complementary groups or organisations (the hairdressing or treatment spaces, for example);
- ensuring that build costs are kept to a minimum without reducing the quality of the design or that of the buildings and their facilities.

[19] Housing Department – *'Corporate Housing Programme – Progress against the 2009 Action Plans and Future Strategy'* – Billet d'État XI 2010.

258. **This Report, therefore, seeks States' approval to release monies from the CHP Fund to support Phase 1 of the redevelopment of the Longue Rue House and Maison Maritaine sites to provide 'extra care' housing, for a total sum not to exceed £22 million.**

259. **It is further recommended that, in line with the existing procedures for general needs social housing, the actual grant sum required be approved, on behalf of the States, by the Treasury and Resources Department.**

Phase 2

260. As has already been identified in this Report, both sites offer the potential to provide more accommodation than has been proposed in Phase 1. In the absence of a 'masterplan' for both sites, which is currently being prepared, the number of additional units that could be delivered by a second phase of development is not yet known, although it is expected to be in the region of 45 additional flats on each site, notionally split as follows:

- 22 one-bed and 23 two-bed flats at Longue Rue; and
- 22 one-bed and 23 two-bed flats at Maison Maritaine.

261. Whilst Phase 1 will re-provide new accommodation for people who are currently being supported by the Departments (i.e. the existing residential home residents and those learning disability clients accommodated by HSSD), it is anticipated that the accommodation provided by subsequent phases of development could be used to meet a wide range of needs, not just those of older Islanders but also those of younger people in need of care and some support to live independently. There is also an opportunity to mix tenures on these sites (see paragraphs 269–271 below).

262. However, the Departments acknowledge that there are a number of issues that need to be resolved prior to subsequent phases of development taking place.

263. On such issue is who will be eligible to be accommodated in the second phase of development. For example, should there be a minimum care need as a pre-requisite, as required at Rosaire Court; will maximum income thresholds apply to the occupation of rented flats; and can occupants may be prior home owners?[20] There is also the issue of whether the Phase 2 developments could include a mix of tenures, i.e. with some flats to rent, some to purchase on a partial ownership basis, some to purchase on a lifetime lease, or some to purchase outright.

[20] These are also issues that need to be resolved in relation to the successors of the initial tenants in Phase 1, i.e. the current residents of Longue Rue House and Maison Maritaine.

264. These are all matters that will be considered further by the Departments upon the States giving the go-ahead for the Phase 1 proposals.

265. The Departments also recognise that the capital cost of redeveloping Phase 2 needs to be considered.

266. As highlighted above, the costs associated with Phase 1 - to include the purpose built self-contained flats and communal areas - are comparatively high in relation to other general needs housing schemes currently being delivered by the GHA. (As already explained, this is as a result of the need to include a high proportion of communal areas in each 'extra care' scheme, which will account for approximately 40% of the total development costs.)

267. However, as a result of 'front loading' the development costs in Phase 1, the costs associated with Phase 2 are expected to be more akin to developing general needs social housing built to Lifetime Homes Standards by the GHA, with an allowance made for some additional communal spaces in further 'clusters', as appropriate. **It is, therefore, expected that a second phase of development on each site would require a much reduced grant from the States than that required for Phase 1.**

268. Initial financial modelling shows if all of the 90 additional units across both sites were to be made available for rent, at today's prices Phase 2 could be delivered for a total development cost expected to be in the region of **£29.2 million**, of which the States would be asked to contribute in the region of **£10.4 million** in capital grant funding. This represents 36% of the total development costs and is based on capping combined rent and service charges for one-bed flats to £170 per week[21].

269. However, mixing tenures on the sites by including some partial ownership homes, accommodation on a lifetime lease arrangement or some for sale units, would allow for additional revenue to be brought into the schemes, thereby reducing the grant sum required from the States.

270. To illustrate this, if one-third of the accommodation in Phase 2 was offered for partial ownership (30 units), the value of the capital grant from the States could be reduced by £2 million to **£8.4 million**, representing 29% of the total development costs. This is based on each of the partial owners acquiring 60% of the equity in their property, whilst paying a discounted rent to the GHA for the 'unowned' portion[22].

271. Currently the GHA's Partial Ownership Scheme is aimed at first-time buyers; however, research informing the forthcoming Older People's Strategy has

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[21] This issue is given further consideration in Section 10 of the Report – paragraphs 327–378.

[22] The Partial Ownership Scheme allows purchasers to acquire between 40% and 80% of the equity in a property.

revealed that there are many older Islanders living in the community who would wish to downsize from their accommodation to a more manageable property. The opportunity to purchase a home within an 'extra care' scheme on a partial ownership basis would thus allow them to downsize and to have access to on-site care and support as required.

272. **However, it is important to stress that, ahead of having a fully designed 'masterplan' for both sites, these figures are no more than early estimates at this time.**

273. Nonetheless, based on these early projections of the costs associated with Phase 2, and **on the assumption that the CHP Fund continues to receive an annual allocation of £8 million until 2014[23], it would be possible for a second phase of development on these sites to be funded from the CHP Fund.**

274. However, at this time, **the States is asked to do no more than note the possibilities for the Phase 2 development of the Longue Rue House and Maison Maritaine sites and the associated funding consequences.**

Other costs associated with the Phase 1 developments

275. Returning to the Phase 1 developments, there will be additional associated "one-off" expenses; these relate to providing furniture and white goods for all of the apartments.

276. This is because the existing residents of the residential homes, and those persons with a learning disability currently accommodated by HSSD, will not have such possessions having lived in residential care and given them up when moving into the homes.

277. It has been estimated that a sum of £7,500 would be sufficient to furnish and equip each flat. The total cost to furnish all 114 units in Phase 1 is, therefore, not expected to exceed £855,000, at today's prices. It would, however, be prudent to make an allowance for price inflation for when it will be necessary to provide such furniture in three years' time.

278. It is not appropriate to include this expenditure as a project development cost to be incurred by the GHA. The Departments, therefore, propose that this cost is met from the CHP Fund.

279. Furthermore, there are also expected to be additional costs, albeit nominal, associated with relocating residents from residential care to 'extra care', for which a provisional sum of money should be set aside.

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[23] The 5-year plan for the CHP approved by the States in May 2010 provided a projection of anticipated expenditure from the CHP Fund, which was based on the assumption of receiving an annual allocation of £8 million per year from 2010 to 2014.

280. To take account of this, and to include an allowance of 3% for inflation, **the States is asked to agree that a separate sum of money, not to exceed £900,000, be provided from the CHP Fund towards furniture and fittings in the flats to be provided by Phase 1.**

281. It would not be expected that the States would meet the costs of furniture and fittings for future tenants, as the presumption is that they will be moving from their own homes and would be expected to own their own pieces of furniture. However, it is possible that some future tenants will be moving from unfurnished accommodation or have furniture that is unsuitable for the 'extra care' flats.

282. One matter, therefore, that requires further consideration is who is responsible for providing this furniture, etc. – the tenant or the GHA. If the former, they may well require financial assistance with the purchase costs.

283. In the UK, there are welfare grants available to address this issue. The Housing Department will thus discuss this matter with the GHA and the Social Security Department to ensure a suitable policy is in place to address this issue before these 'extra care' schemes are occupied in three years' time.

8) MANAGING THE TRANSITION PERIOD FOR RESIDENTS

284. The Departments recognise that the proposals outlined in this States Report will primarily affect the residents of the existing homes who will making the transition from living in residential care home to a more independent lifestyle in 'extra care' housing.

285. With this in mind, in announcing the proposals to residents and their families in February, the Housing Department made a commitment to all residents that in the new 'extra care' housing they would continue to receive the care and support that they currently receive in exactly the same way in as they do in residential care. Furthermore, that care and support would be delivered by the staff with whom they are familiar, in virtually the same location.

286. Whilst the Departments are confident that residents will, if they choose to do so, be able to 're-learn' some of the skills they require to live independently, the Departments also appreciate that many residents will have become accustomed to living in a care home and may be concerned about making the transition. Care and support services will thus be tailored to meet individual needs, and will be delivered in such a way as to encourage and support tenants to do as much for themselves as they feel comfortable doing.

287. Furthermore, although their moves are some three years away – in February/March 2014 - in order to help to smooth the transition to 'extra care' housing, the Housing Department will begin now to encourage residents to regain some of their independent living skills whilst they continue to reside at

Longue Rue House or Maison Maritaine. Depending on the abilities of the individual, this may include, for example, staff providing assistance to residents to prepare themselves a drink, rather than making a drink for them.

288. Overall, the relocation of care home residents will be managed through the development of individual assessments and care plans. Two key members of staff will provide support over an extended period of time to assist the resident during the transition. A 'key worker' will be responsible for managing the move, and liaising with the resident, family members and other health care professionals to ensure continuity of care provision during this time. Separately, a 'key enabler' will organise packing and transfer of personal effects in consultation with the resident and their family, and will provide assistance to help them to begin to re-learn skills they may have lost so that they can live in their own apartment.

289. The development of a care and support plan to manage the transition period will be personal to each resident and will reflect their wishes. For example, if a resident would like to continue to receive meals at a certain time of day, they will do so; if they currently receive assistance with bathing in residential care, they will receive the same assistance in 'extra care' housing.

New residents

290. The Housing Department will continue to welcome new residents to Longue Rue House and Maison Maritaine until the 'extra care' schemes are complete. Prospective new residents will be made aware of the proposals and will thus be making an informed choice about how they will receive their future care and support.

291. New residents will also be supported to preserve their independent living skills as far as possible within the limitations of the care home buildings.

9) STAFFING IMPLICATIONS

292. The Departments recognise that the staff employed within Longue Rue House and Maison Maritaine will also be directly affected by these proposals, and that the plans outlined in this Report may have created some uncertainty regarding their ongoing employment.

293. Whilst the Housing Department has assured all members of staff that their **existing** positions of employment are secure, at this stage it is premature to be able to say, with any certainty, which roles are likely to be retained and which will no longer be required in new 'extra care' housing. However, for the reasons set out below, it is anticipated that there is likely to be less, or possibly no need, for domestic and catering staff and a reduction in the number of managerial posts. On the other hand, there will be a greater need for skilled care and support staff.

294. **What is universal is that, in line with the procedures that apply to the restructuring of States' services, <u>every</u> member of staff affected will be given support to retrain for a new role in the 'extra care' schemes or to secure an alternative post in the States through the redeployment procedures. (**This has been discussed and agreed with the relevant unions – Unite and the Association of Guernsey Civil Servants – who are fully conversant with the proposals and their implications.)

295. For example, the Departments will explore the potential of redeploying, within the wider health and social care service, members of staff whose roles may no longer be required within an 'extra care' setting. (For example, HSSD has a number of long-standing vacancies within its Housekeeping team that it has typically struggled to recruit staff for: there are synergies in terms of the skills it requires and those of the Housing Department's domestic staff at the homes. There may also be opportunities for staff to be employed in different ways; through a different enterprise to provide a more commercially based catering service, for example.)

296. **The Housing Department is, however, committed to retaining as many of its existing staff as possible in the 'extra care' schemes, albeit that their roles may change. Indeed, this was a key message when the proposals were first announced in February– same care; *familiar staff*; same location.**

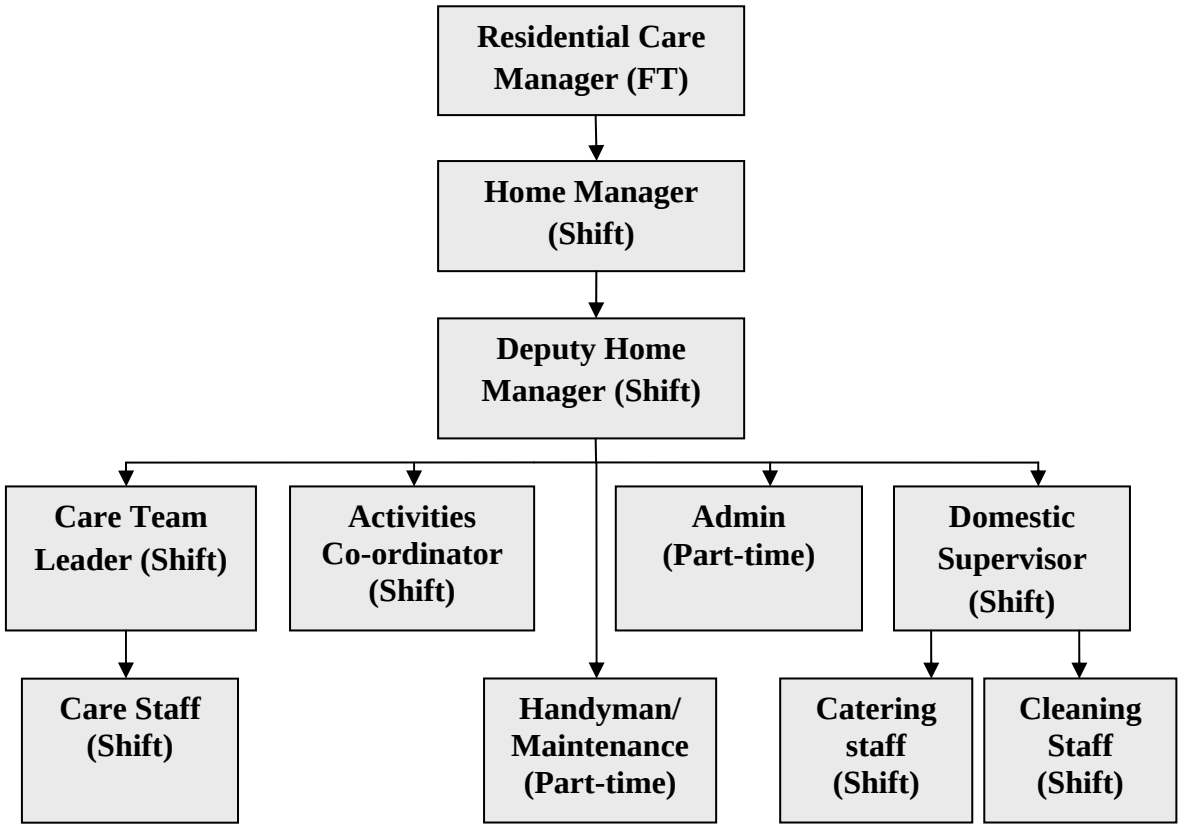
297. Nonetheless, it is important to understand that the way in which a residential home is staffed and operated is not the same as how 'extra care' housing is staffed and operated. This is explored in detail below.

<u>Staffing the existing residential care homes</u>

298. The staffing of the existing residential homes is structured in such a way so as to support the dependent lifestyles and needs of residents, in an environment where residents do not generally self-care.

299. The existing staffing structure of each of the residential homes is shown below.

Figure 4: Existing staffing structure at Longue Rue House and Maison Maritaine:



NB: The Residential Care Manager manages both homes; in addition, each home has its own Manager.

300. Across the two homes, the Housing Department employs 9 members of Established Staff (7.84 WTE) and 82 Public Sector Employees: the majority on a part-time basis. Of the latter, 46 are care staff (25.96 W.T.E.), 34 are domestic and kitchen staff (23.67 W.T.E.), and two handyman/gardeners (1.06 W.T.E.).

301. Totalled together, staffing numbers equate to 58.53 WTE.

Care staff:

302. Care staff are employed in both homes on a rota basis to provide 24/7 cover and are deployed as follows:

- Three carers on duty working between 8 am and 2 pm;
- Two carers on duty working from 2 pm to 10 pm; and
- Three carers who work overnight from 10 pm to 8 am.

303. A Manager also works during the day time shifts at both homes, although they do not provide hands on care.

304. The staffing rota at both homes is structured to deliver:

- **191 hours and 20 minutes** of hands on care per week during the hours of 8 am and 10 pm; and
- **210 hours** of care overnight, between the hours of 10 pm and 8 am, each week.

305. This equates to **401 hours and 20 minutes** of care being provided each week.

Catering and domestic staff:

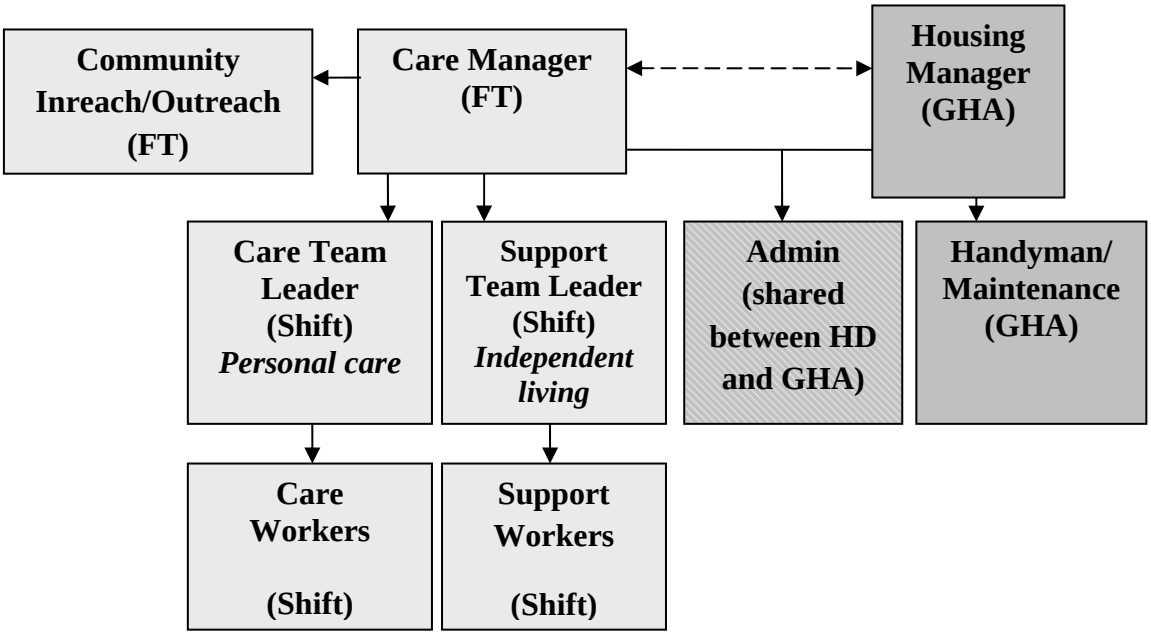
306. Catering and domestic staff at the homes also work the above shifts. Indeed, the number of catering staff employed within daytime hours during the working week, from Monday to Friday, is almost double that of the number of care staff and is also higher at weekends.

307. This highlights the direct cost of providing services that engender a culture of dependence and goes some way to explaining why residential care is an expensive model of provision.

Staffing the new 'extra care' schemes

308. By comparison, the proposed staffing structure of the 'extra care' schemes is shown in Figure 5 below.

Figure 5 - Proposed staffing structure at each extra care scheme



309. Under this structure, there is clear division of responsibility between the housing provider – under these proposals, the GHA – and the care and support service - under these proposals, the Housing Department.

310. The GHA will provide all housing and tenancy management services, including all aspects of property maintenance, and the Housing Department's care home staff will provide the care and support services. Whilst this split in responsibility is common in 'extra care' housing, in terms of providing a seamless service to scheme tenants, it will be fundamental that dialogue between the GHA and Housing Department is effective; in particular between the Care Manager and the Housing Manager.

311. Unsurprisingly, the above staffing structure highlights that the main area of difference between residential care and 'extra care' housing is the absence of teams of dedicated domestic and catering staff. This is because the assumption in 'extra care' housing is that tenants will live independently and clean and cook for themselves; where they are not able to do so, they will receive support to do so from the care team and support workers.

312. Cleaning of the communal areas will the responsibility of the housing provider, i.e. the GHA, which is likely to contract with an external cleaning company to provide this service.

Care and support provided in 'extra care' housing

313. The kind of care and support services delivered into an 'extra care' scheme can only be undertaken by trained domiciliary care workers. Personal care services might include:

- helping someone to get dressed or undressed;
- helping someone to feed if they can't manage themselves;
- washing or bathing someone who can not manage alone;
- toileting; and
- assisting with medication.

314. Although the same types of care tasks are undertaken in both residential homes and 'extra care' housing, the ethos and approach to the delivery of care is completely different. The key outcomes of 'extra care' housing are:

- to support tenants to live independent lifestyles;
- to encourage tenants to have their own daily routines; and
- to exercise choice about how they live.

315. Services must thus be provided in such a way as to enhance choice and independence, and to have respect for the autonomy of residents.

316. Existing care and management staff employed within the residential homes will, therefore, be required to develop new care and support skills to understand the difference between residential care and 'extra care'. In order for this to happen, new roles and job specifications will be required, and there will also be changes to the staffing patterns associated with delivering services in a different way.

317. The approach to risk is also completely different in that residential care takes a risk averse approach, starting from the position that the resident is incapable of doing a task without risk of harm or injury; whereas in 'extra care' the tenant makes their own decisions about how they live their life, and care and support workers are on hand to enable them to do whatever is necessary to achieve them.

318. The new 'extra care' service will thus be "outcomes-focused" instead of "task-focused". It will identify activities which the scheme's support workers will perform, and activities which each tenant will be encouraged to perform themselves.

Managing the transition from residential care to 'extra care' housing

319. As referred to above, it is expected that most tenants transferring from the residential homes to the new 'extra care' schemes will require additional support, particularly during the transition phase, to re-learn life skills that have been lost whilst living in a more dependent, institutional environment. Support Workers will play a crucial role in ensuring the effective transition for residents during this period. The staffing structure shown in Figure 5 is designed to reflect this.

320. In similar vein, although it is not possible to determine the numbers of staff required at this time, it is anticipated – but by no means certain - that the staffing requirements of the new schemes will be higher during the early years of their inception.

321. In recognition of the above, the Housing Department will review the staffing numbers and structure of each scheme, two years after each scheme is fully operational.

Staff employed by the Health and Social Services Department

322. There will also be staffing implications for HSSD's Learning Disability Service as a result of the proposal to relocate a number of the clients they support to the new 'extra care' scheme at Longue Rue.

323. Currently learning disability clients receive generic care and support from highly trained specialist staff, but in the 'extra care' schemes the majority of services

required would be delivered by support workers: these will primarily be members of staff transferred from the Housing Department's residential care homes. This staff group may, however, need to be enhanced by additional care and support staff from HSSD, who may also provide additional support required by other tenants as well.

324. An added benefit for HSSD is that it is anticipated that the transition of a number of clients with a learning disability to the new 'extra care' schemes will release specialist nursing resources to provide specialist oversight and expertise, with an opportunity to enhance the provision of community care, thereby contributing to a the wider aims of the forthcoming '2020' Vision and the Older People's and Supported Housing Strategies.

325. The redeployment of highly trained and specialist staff within HSSD may also provide the ability to repatriate at least some of the 23 Islanders who are in off-Island placements.

Conclusions

326. As the opening of the new 'extra care' schemes is still some three years away, it is impossible to predict with any certainty exactly who will be accommodated in the new schemes and what the level of their care and support needs will be. As a result, it will not be until much nearer the opening of the schemes that the Departments will be able to firm up the number and skill mix of the care and support staff required for each.

327. Nonetheless, during the intervening period, the Departments will continue to work with staff, with union representatives, and with the Policy Council's Human Resources Unit, to ensure that all staffing matters are handled sensitively and that members of staff are kept fully informed as the projects progress.

10) FINANCIAL IMPLICATIONS FOR DEPARTMENTS' REVENUE BUDGETS AND FOR INDIVIDUALS

Introduction

328. Section 7 outlined the capital cost to the States of the proposals outlined in this Report. However, when the new 'extra care' schemes become operational in 2014, this will also have implications for the revenue budgets of the Housing Department, HSSD and the Social Security Department.

329. There will also be implications for the existing residents of: (i) Longue Rue House and Maison Maritaine; and (ii) HSSD's residential homes for people with a learning disability; who will be the first tenants of the new 'extra care' schemes.

330. These implications are outlined in this section of the Report.

Housing Department

331. Currently the Housing Department's residential homes are funded partly by General Revenue and partly from fees paid by their residents.

332. As a result of a decision made at the time of the introduction of the Long-term Care Insurance Scheme, the fees paid by residents are "capped", so that they are equivalent to the so-called "co-payment" – in 2011, £170.45 per week - which a resident of a private residential home would pay from their own resources to meet the fee charged by the private residential home. Long-term care benefit – to help a person pay the fees charged by a private residential home - is not payable to a resident of any public sector residential home, leading to a shortfall between income received and expenditure incurred[24].

333. In respect of Longue Rue House and Maison Maritaine that shortfall is funded from the Housing Department's General Revenue Budget. For 2011, that shortfall is budgeted at £1.514 million[25]. This means that each resident contributes no more than 35% of the cost of them receiving accommodation and care at Longue Rue House and Maison Maritaine; put another way, at least 65% of that cost is subsidised by the States[26].

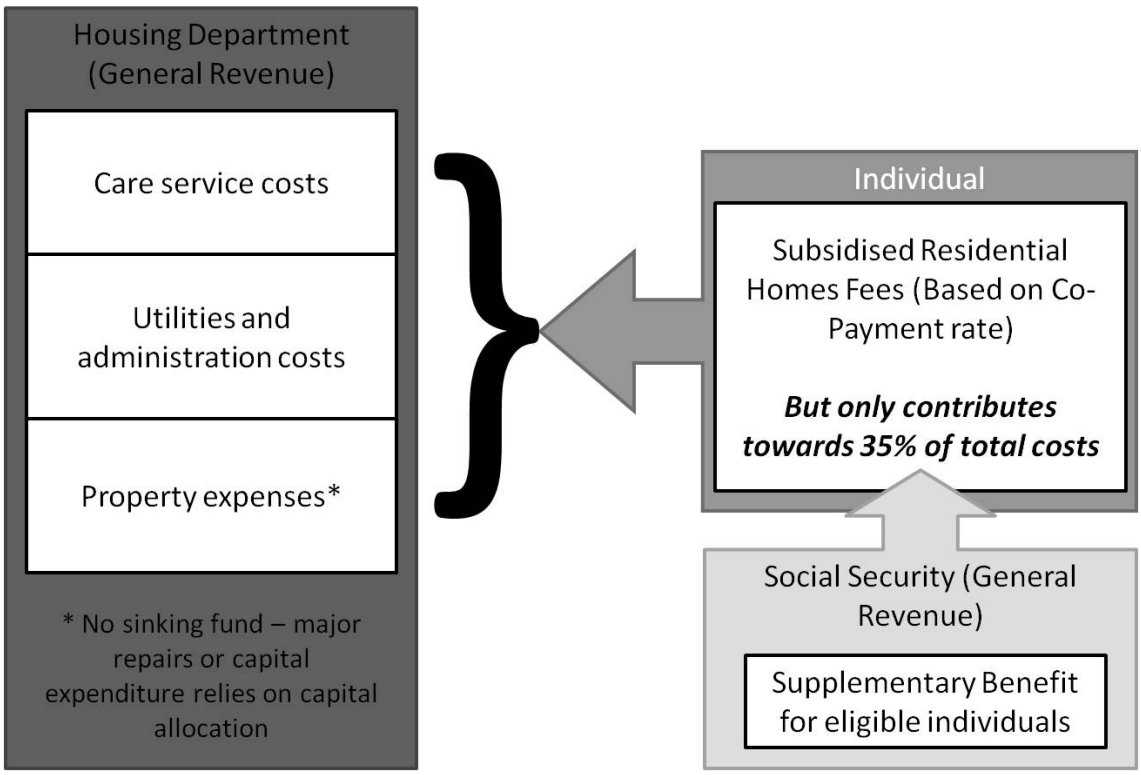
334. This is shown diagrammatically in Figure 6 below:

[24] It was agreed not to include public sector long-term care provision within the Long-term Care Insurance Scheme as this would have increased the level of contributions required to be paid by individuals to fund the scheme.

[25] This calculation ignores the cost of any exceptional capital expenditure, such as that referred to in paragraph 126. Residents make no contribution towards this cost: any major repairs or other capital expenditure on the residential homes is funded entirely by the Housing Department from its capital allocation.

[26] The subsidy from the States is even greater than this because a number of residents are currently assisted by Supplementary Benefit to pay the co-payment, by sums of varying amounts.

Figure 6 - The existing funding model for Longue Rue House and Maison Maritaine



Health and Social Services Department

335. Those persons with a learning disability who are currently accommodated by HSSD pay a rental charge to that Department towards the cost of their accommodation. Whilst this varies by property, generally speaking rents are in line with social housing rents (but less than the fee payable by a resident of Longue Rue House and Maison Maritaine).

336. If a learning disability resident is unable to meet this rental charge, they are able to seek Supplementary Benefit assistance from the Social Security Department.

337. The costs of their care and support are met in full from HSSD's General Revenue budget unless they live in a 'supported living environment' whereupon they pay a weekly charge of £70 towards their living costs.

Meeting the revenue costs of 'extra care' housing

338. Under the proposals outlined in this States Report:

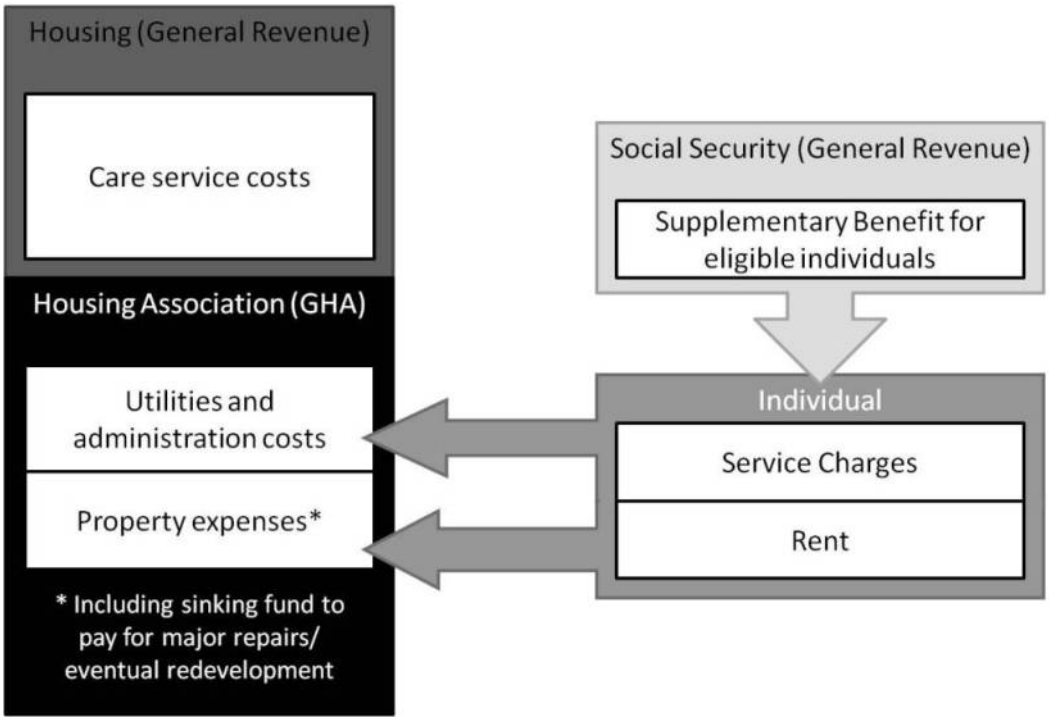
- all tenants of the 'extra care' schemes – whether an older person or a person with a learning disability - will pay a rent and service charge to the GHA;

- Supplementary Benefit assistance will be available, where necessary, from the Social Security Department;

- care and support costs for all tenants will be met **in full** by the Housing Department.

339. This funding model is summarised in Figure 7 below.

Figure 7 – The proposed funding model for the GHA's extra care schemes



340. It will be evident that this is fundamentally different to the existing funding models:

(i) for the Housing Department's residential care homes as described above in paragraphs 330-333 and Figure 6;

(ii) for the HSSD's residential homes for people with learning disability as described above in paragraphs 334-336.

Residents of Longue Rue House and Maison Maritaine

Funding of care and support costs

341. In the new 'extra care' housing, the costs of providing care and support to the tenants of the scheme will be funded by the Housing Department from its General Revenue Budget, i.e. former residents of the two care homes will not

pay for the care and support they require as the tenants of the 'extra care' housing.

342. However, rather than having a budget to provide for 24/7 service for all, regardless of individuals' assessed need, in the 'extra care' model the Housing Department will be staffed to pay for the actual number of care and support hours these residents require as tenants of the new scheme.

343. At face value, it would appear that the transition from providing residential care to 'extra care' will, therefore, lead to a *potential* revenue budget saving for the Housing Department.

Funding of property costs

344. Under these proposals, all property expenditure associated with 'extra care' housing will be the responsibility of the GHA, whereas the maintenance of the two residential homes is currently the budgetary responsibility of the Housing Department.

345. Again, at face value, it would appear that the transition from providing residential care to 'extra care' will lead to a *potential* revenue budget saving for the Housing Department.

Combined revenue expenditure impact for the Housing Department

346. As result of the above, it is reasonable to expect that on completion of the 'extra care' schemes, overall the Housing Department's General Revenue expenditure *could* reduce (but see paragraphs 346 and 347 below).

Impact on revenue income for the Housing Department

347. Currently, the residents of Longue Rue House and Maison Maritaine pay a heavily subsidised all-in-one fee for their care and accommodation (including all utility costs)[27].

348. From these fees, the Housing Department receives approximately £800,000 of income per annum. When the residents of Longue Rue House and Maison Maritaine become tenants of the GHA, the Housing Department will cease to receive any of this fee income.

Payment of rent and service charges for 'extra care' housing

349. As part of this proposed change in provision, the primary responsibility for paying for accommodation costs switches from the Housing Department's General Revenue budget to the individual tenants (erstwhile residential home residents).

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[27] The reasons for this were explained in paragraph 331 and footnote 24.

350. At this time, it has not been decided what the rent and service charges for the new 'extra care' housing will be, but the proposals in this Report have been modelled on a rent of £130 per week and service charge of £40 per week for a one-bed flat. This means that, when combined - £170 per week, a single tenant will pay no more than a Longue Rue House or Maison Maritaine resident would currently pay for their residential care bed - £170.45 per week.

351. The intention behind this has been to limit the financial impact on the existing residents of Longue Rue House and Maison Maritaine who will make the transition to 'extra care'. However, there are a number of issues associated with setting the rents for the new accommodation in this way; namely:

(i) the rents (as opposed to the service charges) for the 'extra care flats' will not be 'benchmarked' against the GHA's general needs social housing of equivalent size. The weekly rent for an equivalent GHA one-bed flat would be £162 per week - £32 higher;

(ii) this has the effect of increasing the capital grant funding required, because there is less rental income to service the GHA's commercial borrowing; and

(iii) in all likelihood, this subsidised rental level would be perpetuated into the future for new tenants who had no connection to the existing homes and, therefore, the amount their residents currently pay.

352. On the other hand, if the rents are set by reference to equivalent GHA properties the capital grant payable by the States will decrease, but the current residents of Longue Rue House and Maison Maritaine:

(i) will be required to pay more for their accommodation than they are used to doing, (notwithstanding that this payment is, as noted above, substantially subsidised); and

(ii) it will increase the chances of them requiring Supplementary Benefit assistance, which will add to the Social Security Department's revenue expenditure.

Meeting the costs of food and other household expenses

353. This latter point is exacerbated because, in addition to rent and service charges, when the residents of Longue Rue House and Maison Maritaine transfer to be 'extra care' tenants they will now be required to meet the costs of their food, heating, hot water and other household expenses, which currently are met partly through the fees they pay but, in the main, are paid for from the Housing Department's General Revenue budget[28].

[28] As the residents of Longue Rue House and Maison Maritaine pay a heavily subsidised all-in-one fee for their accommodation and care, including all utility costs; in practice it is impossible to disaggregate who pays for exactly what.

354. By building flats with high insulation levels, use of solar panels and other energy efficient technology, the GHA will be working on keeping the tenants' heating, hot water and other costs to a minimum; however, these will still be a new and "additional" expense for the residents of Longue Rue House and Maison Maritaine.

The budgetary impact upon: (i) the Social Security Department; (ii) individuals seeking Supplementary Benefit assistance

355. In relation to all these personal expenses - rent and service charges, and other daily living expenses - where a tenant household is unable to pay them in full, it is proposed they will be able to seek Supplementary Benefit assistance from the Social Security Department, as would any other low income householder in the Island.

356. (The Housing Department's Rent and Rebate Scheme will not be extended to tenants of these 'extra care' schemes, as the Housing and Social Security Departments are currently working on bringing forward proposals to amalgamate the Rebate Scheme within a reformed Supplementary Benefit scheme.[29])

357. The Departments acknowledge that this has the potential to have an adverse impact on the Social Security Department's Supplementary Benefit expenditure, which is funded by formula-led expenditure from General Revenue.

358. To explain this further: insofar as 'extra care' housing is concerned, Social Security draws no distinction between rent and service charges but combines them as 'rent'. For the purposes of this Report, rents and service charges for the new 'extra care' housing have been set at £130 and £40 respectively, i.e. the combined 'rent' for Supplementary Benefit purposes is £170 per week,

359. However, if the rents for the new 'extra care' units were to be set by reference to GHA one-bed flats of equivalent size at £162 per week, the combined rent and service charge would be £202 per week (£162+£40).

360. As noted above, charging these higher rents would mean that current residents of Longue Rue House and Maison Maraitaine would pay more for their accommodation that they do now and, as a result, they will be more likely to require financial support from the Social Security Department, increasing Supplementary Benefit expenditure.

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[29] The Rent and Rebate Scheme provides assistance to social housing tenants who are not able to meet the full cost of the full Standard Weekly Rent for their property. A discounted rent is charged with reference to the financial circumstances of the tenant. Tenants in 'extra care' housing at Rosaire Court are also not eligible for a rent rebate but seek assistance to meet their expenses from Supplementary Benefit, if necessary.

Rent setting for the two-bed flats

361. These issues become even more problematic when one considers the two-bed flats proposed for these 'extra care' schemes.

362. Logically, the rents for the two-bed flats in the new 'extra care' housing should be set at higher levels than for the one-bed flats. The modelling has thus assumed that these rents be set in line with GHA rents for an equivalent two-bed flat, i.e. £190 per week (excluding the £40 service charge).

363. However, a couple occupying a two-bed 'extra care' flat will, under present rules, be out of pocket because of the effect of the Supplementary Benefit 'benefit limitation'.

364. In theory, any Supplementary Benefit claimant should be paid what they need, but in practice the maximum amount of Supplementary Benefit payable is capped by the 'benefit limitation'. Without going into detail, a couple occupying a two-bed 'extra care' flat could receive up to £40 less benefit than they need per week as a consequence of applying the 'benefit limitation'.

365. This will not be an issue for any of the existing residents of Longue Rue House or Maison Maritaine, as these are all single people; however, it will be any issue for any married couples or other households comprising more than one person who newly occupy the 'extra care' housing having moved from a private residence elsewhere in the community.

Persons with a learning disability currently accommodated by HSSD

366. Similar considerations to those identified in paragraphs 340-365 will apply in respect of existing residents of HSSD's residential homes for persons with a learning disability. To avoid repetition, they are summarised in Appendix 10.

Resolving the funding and payment issues

367. There are a number of possible solutions to the above funding issues; for example: the Social Security Department could:

(i) set a specific rent allowance for 'extra care' accommodation; or

(ii) it could not apply the 'benefit limitation' for couples occupying two-bed 'extra care' flats.

368. The Departments will continue dialogue with the Social Security Department regarding these and other options, in the knowledge that the Supplementary Benefit Scheme is already under review, and that consideration is already being given to removal of the 'benefit limitation' and the introduction of capped rent allowances for properties of different sizes.

Overall budgetary impact upon the Social Security Department

369. Overall, the financial impact on the Social Security Department of what is being proposed will be mitigated, as it already provides financial assistance, through Supplementary Benefit, to residents of Longue Rue House and Maison Maritaine, and to persons with a learning disability accommodated in HSSD's residential group homes. These existing payments will thus offset the potential additional expenditures for Social Security identified above.

370. On the other hand, if the measures outlined in paragraph 367 were to be implemented this would result in additional expenditure for the Social Security Department.

Redistribution of revenue budgets

371. **Bearing all the above in mind, it is recommended that the States directs that these - and all other funding issues that arise in conjunction with the development of 'extra care' housing at Longue Rue and Maison Maritaine - be addressed inter-departmentally between the Housing, Health and Social Services, Social Security and Treasury and Resources Departments, before the new 'extra care' schemes are first occupied.**

372. **Further, the States is asked to note that resolving the funding issues identified in this Section of the Report is likely to require a redistribution of monies in revenue budgets from one department to another.**

Subsidising the rents for two-bed flats during the transition phase

373. There is one further funding issue to outline.

374. As noted above, all of the existing residents of Longue Rue House or Maison Maritaine are single people; however, 19 of the flats planned for Phase are two-bed. This means that, initially, they will be under-occupied.

375. However, as the rents for the two-bed flats are, based on current modelling, some £60 per week higher than the one-bed flats, there may be some resistance to occupy them on financial grounds. On the other hand, the GHA will require the higher income from the two-bed flats to service its loan repayments.

376. **The only fair solution would thus appear to recommend that all the residents moving from Longue Rue House or Maison Maritaine into the 'extra care' accommodation be charged the rent for a one-bed flat, for so long they occupy the larger accommodation.**

377. **In a full year, this would mean subsiding the rental income across both 'extra care' schemes by a maximum of £59,000, which it is proposed be paid to the GHA from the CHP Fund.**

378. However, once a two-bed flat was vacated by its original occupant who had transferrred from Longue Rue House or Maison Maritaine, the full rent for a two-bed flat would be applied to the next tenant, thus reducing over time the annual rental subsidy payment to the GHA.

Rules of Procedure Rule 15(2)

379. At this stage, and without the detailed modelling having been undertaken, it is impossible to say whether the overall impact of the proposals in this Report will have a positive, negative or neutral effect on States' revenue expenditure. Indeed, to do this with any accuracy it would be necessary to have details of:

- the care and support needs of the first tenants; and
- their financial circumstances;, and
- the staffing numbers and mix;,

which is clearly impossible given that the 'extra care' schemes will not be ready for occupation until three years hence.

380. **To address this conundrum, and to comply with Rule 15(2) of the States Rules of Procedure, Treasury and Resources have agreed that when it comes to approve the actual grant sum required for these 'extra care' schemes on behalf of the States, it will require a detailed and robust business case outlining not only the building costs of the two schemes but also modelling of the revenue consequences for the States, based on various assumptions about the circumstances of the schemes' first occupants, and the staffing mix and numbers to care for them.**

Determining a long-term funding arrangement for 'extra care' housing

381. As if the funding issues identified above were not complicated enough, as part of the formulation of the Older People's Strategy there are currently discussions taking place (at staff level) between Housing, HSSD, Social Security and Treasury and Resources about the possibility of funding at least the care and support costs of 'extra care' housing as part of the Long-term Care Insurance Scheme[30]. (This would have implications for the contribution rate payable by individuals to provide funding for this Scheme.)

382. While there are some persuasive arguments as to why 'extra care' housing should be funded through the Long-term Care Insurance Scheme, this is a complex issue that goes beyond the scope of this Report; nonetheless, it is one that needs to be tackled with vigour as part of the States Report on the Older

[30] Under these proposals, these costs will be met by the Housing Department from General Revenue.

People's Strategy, which is intended to come to the States later this year. In the meantime, **the Departments are progressing these proposals on the basis that 'extra care' housing is <u>not</u> to be funded either in whole or in part from the Long-term Care Insurance Scheme.**

383. However, it is worth noting here that part of the reason for this discussion arises from the fact that whereas for the purposes of paying long-term care benefit under the Long-term Care Insurance Scheme the value of capital assets – whether savings or property – are totally disregarded, in seeking Supplementary Benefit assistance to live in 'extra care' housing the value of such capital assets will taken into account as part of the assessment process[31].

384. This means that a tenant of 'extra care' housing could be forced to sell their property to pay for their rent and household expenses[32], whereas a person moving into residential care would be unlikely to be in the same situation.

385. It also potentially discriminates against a person who is 'asset rich/cash poor', creating a perverse financial incentive for a person to choose – or be forced to choose - residential care over 'extra care' housing, when the whole thrust of the proposals in this Report is to demonstrate the benefits for the individual of receiving care and support in an 'extra care' flat rather than in a residential home.

11) CONSULTATION

386. The funding aspects of the proposals outlined in this Report have been discussed with the Treasury and Resources and Social Security Departments. All are agreed that, given the financial issues highlighted in this Report, there is an urgent need to develop a sustainable model of funding both the capital and revenue costs of 'extra care' housing, to enable the benefits espoused in this Report to be replicated in similar schemes on other sites in the future.

12) CONCLUSIONS AND RECOMMENDATIONS

387. The initiatives described in this States Report are about implementing a strategic direction towards greater choice and independence for all Islanders. Joint working between the Housing and HSSD, in partnership with the GHA, will enable this outcome for people currently institutionalised by both departments.

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[31] For completeness, it should be noted that where a person occupies a bed in a private residential home but cannot afford the co-payment from their own financial resources, they may receive Supplementary Benefit to enable them to do so. In assessing the level of Supplementary Benefit payable, regard <u>will</u> be had to the value of any capital assets they own.

[32] Alternatively, they could rent out their former home and use the income to cover the costs of 'extra care' housing.

388. The Departments have acknowledged that the provision of 'extra care' accommodation is a better way of providing for Islanders of all ages with care and support needs, to enable them to retain their independence.

389. This States Report has provided a snapshot of some elements of the Older People's and Supported Housing Strategies. Whilst the proposals outlined aim to address some of their many strategic objectives, the Departments do not wish to imply - in the absence of the wider Strategies being considered by the States - that these projects will provide a 'one size fits all' solution to meet the care and support needs of the Island's population. The Older People's Strategy, in particular, is far more comprehensive and wide ranging than it has been possible to convey in this Report.

390. Primarily, that Strategy will recommend ways to support people to remain in their own homes. However, where this is not possible, the Strategy will recommend 'extra care' housing as the next best solution to enable Islanders to retain as much of their independence as possible, whilst receiving the care and support they need in a home which they can call their own. This is at the very heart of the proposals outlined in this Report.

391. The States is, therefore, asked to support the proposals to redevelop the Longue Rue and Maison Maritaine sites to provide 'extra care' housing for Islanders with care and support needs of all ages.

392. Accordingly, the Housing Department and HSSD recommend the States:

(a) to approve the use of the Longue Rue House and Maison Maritaine sites, as delineated in Appendices 6 and 7, to provide 'extra care' housing to be developed and managed by the Guernsey Housing Association;

(b) to agree that the Corporate Housing Programme Fund be used to provide capital grant funding associated with the first phase of the redevelopment of the sites of Longue Rue House and Maison Maritaine (including the costs of demolishing both residential homes), such capital grant funding not to exceed £22 million for both schemes combined;

(c) to agree, in accordance with the existing procedures for general needs social housing, that the actual grant sum required for these 'extra care' schemes be approved, on behalf of the States, by the Treasury and Resources Department, upon production of a robust business case outlining the building costs of the two schemes plus modelling of the revenue consequences;

(d) to approve the use of the Corporate Housing Programme Fund to provide "one-off" expenditure not exceeding £900,000 for furniture and fittings for those persons transferring into the new 'extra care' housing from Longue Rue House and Maison Maritaine, and any residential home

managed by the Health and Social Services Department, the actual sum to be approved, on behalf of the States, by the Treasury and Resources Department;

(e) to agree that, for the reasons set out in paragraphs 361-365 of this Report, for so long as they occupy it, any resident of Longue Rue House or Maison Maritaine who moves into a two-bed 'extra care' flat will be charged the rent for a one-bed 'extra care' flat, the difference between the rental for a one- and two-bed flat in each case being annually reimbursed to the Guernsey Housing Association from the Corporate Housing Programme Fund;

(f) to direct that the revenue funding issues, identified in Section 10 of this Report, be addressed inter-departmentally between the Housing, Health and Social Services, Social Security and Treasury and Resources Departments as part of the preparation of the robust business case to be presented to the latter department;

(g) to note that, as identified in paragraphs 328-372 of this Report, in resolving these revenue funding issues there is likely to be a need for a redistribution of monies in revenue budgets from one department to another; and

(h) to note the likely proposals for the Phase 2 development of the Longue Rue House and Maison Maritaine sites and the associated funding consequences, as set out in paragraphs 260-274 of this Report.

Yours faithfully

D B Jones
Minister
Housing Department

A H Adam
Minister
Health and Social Services Department

APPENDIX 1

GLOSSARY OF TERMS

Carer	Someone who cares for a person who has a disability and who needs help with daily living activities.
Care services (Also known as personal care or domiciliary care)	Are generally used to describe services provided to help someone with daily living activities. (Care Services should not be confused with Support Services.)
Community care	Community care services provide *health care* to people in their own homes who have chronic medical conditions and who require regular nursing support; and *social care* to people in their own homes who require care services for assistance with daily living activities, and/or support services to help encourage independent living. Services are delivered by integrated teams including Home Helps (people who help with house cleaning), Senior Carers (people who provide assistance with daily living activities), Occupational Therapists, District Nurses and Nursing Auxiliaries.
Daily Living Activities	The things we normally do on a daily basis to look after ourselves such as feeding ourselves, bathing, dressing, grooming, using the toilet, transferring from a bed to a chair and back, maintaining continence, work and leisure activities.
Day centres and day services	Are provided for people who need help and support to continue living at independently. This may be support to retain or regain independence or short term care to give carers a break. The service would normally operate on a daily basis and cater from between 10 to 30 people. The planned programmes of care and support could include practical help such as learning or relearning daily living skills such as cookery, gentle exercise groups and help with mobility, as well as activities such as craft and hobbies, games,

	outings and entertainment which help to combat social isolation. The service would also normally include lunch and opportunities to use assisted bathing facilities, hairdressing services, etc. Day services can also be provided for people with specialist needs such as physical and learning disabilities, dementia, etc. or for people recovering from illness such as a stroke, where they can re-learn skills that may have become difficult.
Dependency	Describes how reliant a person is on someone else for help with daily living activities or for medical support – low dependency means not very reliant, high dependency means very reliant.
‘ Extra care’ housing	Independent housing units (flats generally) where an on-site care team provides 24/7 care services to assist with daily living activities as well as providing support services. ‘Extra care’ housing schemes may also provide outreach care or support services into the surrounding community and may be a base for community facilities such as restaurants, hairdressers, etc.
Health care	Health care is associated with people who have acute or chronic medical conditions and for whom a nursing service is required.
‘ In reach’ services	Re services <u>delivered into an extra care scheme</u> by an external health or social care professional or team. An example would be a specialist nurse coming into the scheme to run a falls clinic, or continence advice or a community nurse coming into the scheme to promote flu vaccinations or other health promotion programmes.
Nursing care	Similar built environment to residential care providing care for short-term rehabilitation and for people with long-term chronic ailments which require regular nursing assistance as well as help with daily living activities
‘Outreach’ services	Describe those services or facilities which <u>are based within an extra care scheme</u> for the benefit of both residents and

	people from the local community. An example might be a day centre which provides a day service for individuals from the community or for residents who may be referred by social workers. Out-reach services might also be a specialist care or support service located and managed within an extra care scheme for the benefit of both residents and the local community. An example of this kind of out-reach service might be an Assistive Technology response service where staff based at a scheme respond to community alarms triggered by people who live in the surrounding community.
Preventative services	These services are associated with preventing the onset of situations or conditions that could lead to acute service responses. Services are associated with the promotion of health and the prevention of disease. An example of a preventative health programme would be 'Walk Your Way to Health', a programme offered by the Guernsey Health Promotion Unit.
Residential care	Usually a communal living environment characterised by single rooms with an ensuite bathroom or shared bathroom and toilet facilities, and providing a meal service for people who do not have severe medical problems but who need help with daily living activities.
Sheltered housing	Independent housing units (flats, bungalows, houses) that are linked to a community alarm service and with a warden who can help people access support services which enable them to live independently for as long as possible.
Social care	Social care is associated with people who are disadvantaged by age, frailty, disability, social isolation, substance abuse, etc. and who require help with daily living activities or support services to engender independence.
Supported housing	Independent housing units (flats, bungalows, houses) that are designed to help people with a range of needs to live independently for as long as possible.

Support services	Support services include services which enable independent living, such as helping to arrange shopping; housekeeping; helping to complete benefit claims; providing links to other community or voluntary services like Age Concern, GVS, etc.; providing links to States' services where necessary; arranging social events; help with laundry, etc.

APPENDIX 2

PROVISIONAL DRAFT OBJECTIVES OF THE OLDER PEOPLE'S STRATEGY

Albeit that the Older People's Strategy is only at draft stage, it is envisaged that five key strategic objectives will be outlined, which will collectively aim to ensure the development of a range of integrated services which better respond to individual needs.

These provisional objectives, together with further information about how it is intended that each will contribute to the overall aim of the Strategy, are shown below:

1. Modernisation of States' provision of social services to provide better preventative services, enable earlier intervention, and deliver community services, which enable individuals to gain maximum control over their lives and to live independently in the community.

This will be achieved by:

- Transforming social services to acknowledge the important role of social care in promoting independence and choice;
- Focusing on preventative services to prevent deterioration which increases the take-up of expensive publicly funded services;
- Partnering with the Third Sector[1] and other community-based organisations jointly to deliver lower level preventative services in the community;
- Finding ways to create better joined up services within the States and with external agencies, to ensure older people receive responsive and seamless services;
- Developing ways to support informal and family carers through carer assessments, information programmes, respite breaks, support to return to the workforce, and other ways to support the caring role and demonstrate that the contribution informal carers make is valued;
- Developing community care services that are person-centred and responsive to individual need;

[1] The Third Sector refers to voluntary organisations, community groups, faith groups, tenant groups, housing associations, co-operatives, sports organisations, charities, private clubs, etc., which are non-governmental and non-party political in nature and which are socially motivated and invest financial surpluses in further social, cultural or environmental programmes and benefits.

- Developing opportunities for rehabilitation in residential environments to ensure there are chances to return home before being recommended for institutional care;

- Developing services to enable all people to remain at home for longer, including those with dementia, people with disabilities, and older carers of people with disabilities;

- Establishing clear quality standards for community care services to ensure consistency of delivery and to ensure services are responsive to individual need; and

- Ensuring that paperwork and process are reduced to a minimum by establishing a single assessment of need that is shared across service providers.

2. Development of appropriate housing and neighbourhoods which meet the changing needs of older people, enable 'ageing in place', and which reduce the need for moves into institutional care.

This will be achieved by ensuring that:

- There is a wider range of housing across all tenures – social, partial ownership and for outright sale – as an alternative to residential care;

- Partnerships are developed with housing associations and the private sector to meet the housing needs of all older people, whether renting or buying;

- Programmes are developed which enable older people to remain in their own homes through the provision of repairs and maintenance services, a more streamlined aids and adaptations service, and support services delivered by travelling wardens into individuals' houses across the Island;

- Information and advice is more readily available so older people can make informed choices about their housing needs;

- Development plans include the need to deliver 100 units of specialised housing for older people immediately, with a further 40-50 units being planned and delivered during the 5-year life of this Strategy; and

- Plans to introduce Lifetime Homes and Lifetime Neighbourhoods standards are introduced for all publicly-funded developments, with a recommendation that **all** housing, irrespective of the intended resident, should be 'future-proofed' by adopting Lifetime Homes' standards.

3. More frequent and positive engagement with older people to provide more 'voice' for older Islanders through the development of information programmes and engagement mechanisms.

This will be achieved by:

- Building the capacity of older people and community groups to engage with us through the development of an Older People's Alliance (membership to include Third Sector, community and faith groups) and an Older People's and Carers' Forum (membership to consist of individual older people and their carers). These two fora will have links into the Strategy Steering Group and will help contribute to the development of policy and services; and

- Developing information programmes which link agencies and provide a one-stop shop for information about housing, care services, benefits, support services, etc.

4. Provision of sustainable funding streams for long-term care, recognising the need to change funding methods to support the modernisation of services.

It is recommended that:

- The definition of 'long term care' as it is currently understood in the Long Term Care Insurance (LTCI) Scheme be expanded to include some community-based services;

- That specific services be included in the LTCI scheme, in particular:

  a. Community care services currently provided by the HSSD's senior carer and carer services, which could be provided by the Third Sector in the future;

  b. Community nursing services provided by the HSSD;

  c. Extra-care care services only (accommodation costs are covered by rent and service charges) which may be provided by Third Sector organizations.

- Contributions to the LTCI Scheme should rise to accommodate its wider coverage (by an amount yet to be agreed);

- Needs assessment tools and eligibility criteria for care should be reviewed;

- Service level agreements should be developed with private residential and nursing homes; and

- A review of the LTCI should be undertaken during the life of this Strategy to review its scope, and to ensure sustainability and fitness for purpose.

5. Address workforce issues by recommending programmes to achieve increased workforce participation of older people, and identify gaps in the workforce which will impact future health and social care provision.

Although this Strategy was not envisaged to provide a detailed plan to respond to workforce issues, it has identified that the following actions are required:

- To develop 'Age Positive' business initiatives to increase the retention of older and retired people in the workforce;
- To develop training and re-skilling opportunities for older workers to enhance the chances of their retention in the workforce;
- To develop initiatives to introduce retirement planning at a younger age;
- To consider the option of making occupational pensions obligatory to ensure retirement is adequately funded in the future;
- To examine whether incentives to postpone the take-up of the States' pension should be developed;
- To work in partnership with the Education Department to develop the capacity of the island's own indigenous workforce to enter the caring profession; and
- To acknowledge that recruitment and retention of care and support staff will not be met entirely by developing the Island's own capacity, and that population management policy should be informed by, and reflective of, the future workforce requirements in health and social care.

A full explanation of each of these objectives and recommendations will be presented to the States for approval later in 2011.

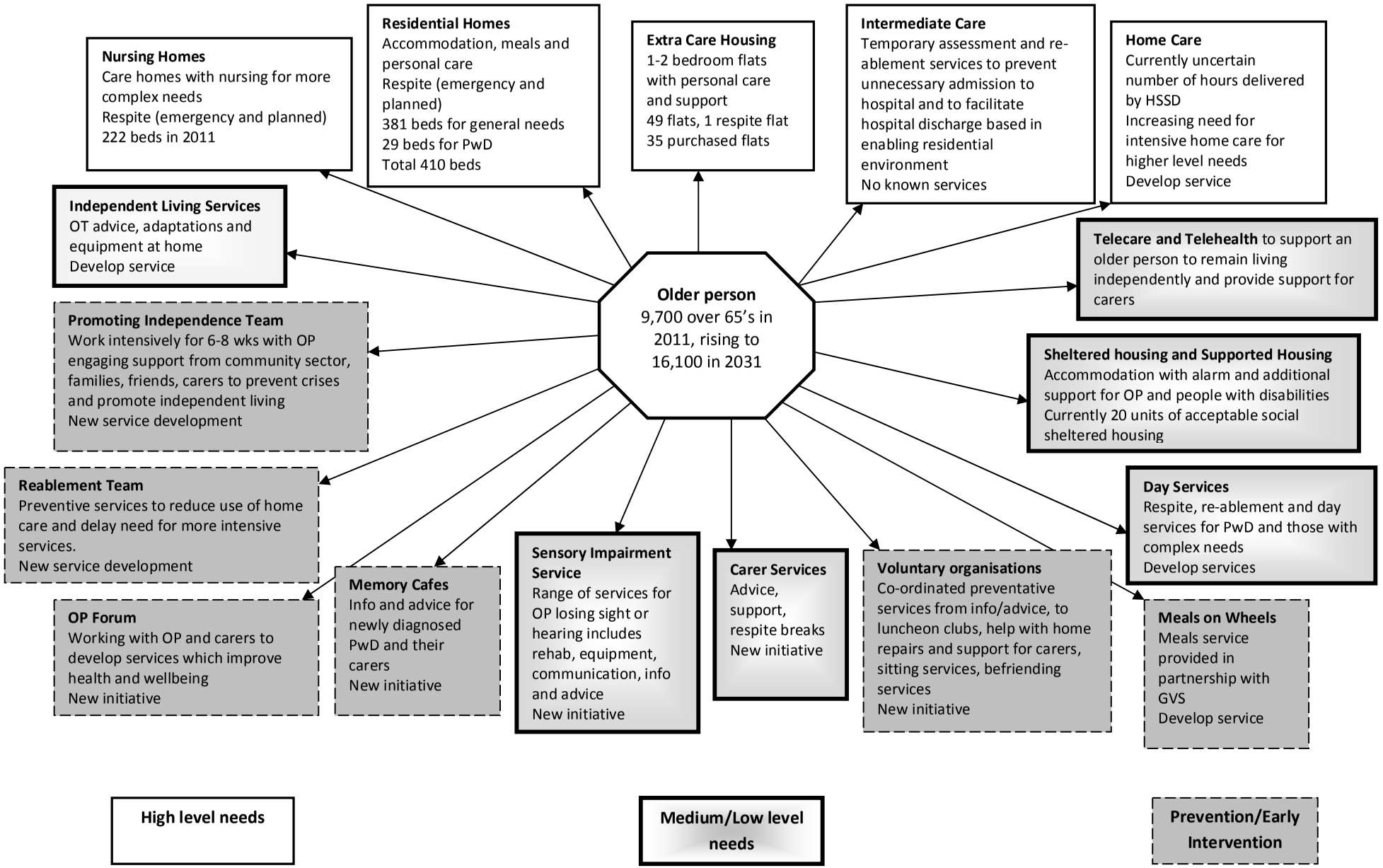
The overall aim of the Strategy will be:

> **'To improve the quality of life of older Islanders by promoting a positive view of ageing, and by supporting independence and choice.'**

The following diagram summarises the range of provision of services and housing options that are required to meet the needs of older Islanders in the future, as will be recommended in the Older People's Strategy.

Housing and Health and Social Services Departments
March 2011

Landscape provision of services for older people



APPENDIX 3

AN OVERVIEW OF HOUSING PROVISION FOR OLDER PEOPLE IN GUERNSEY

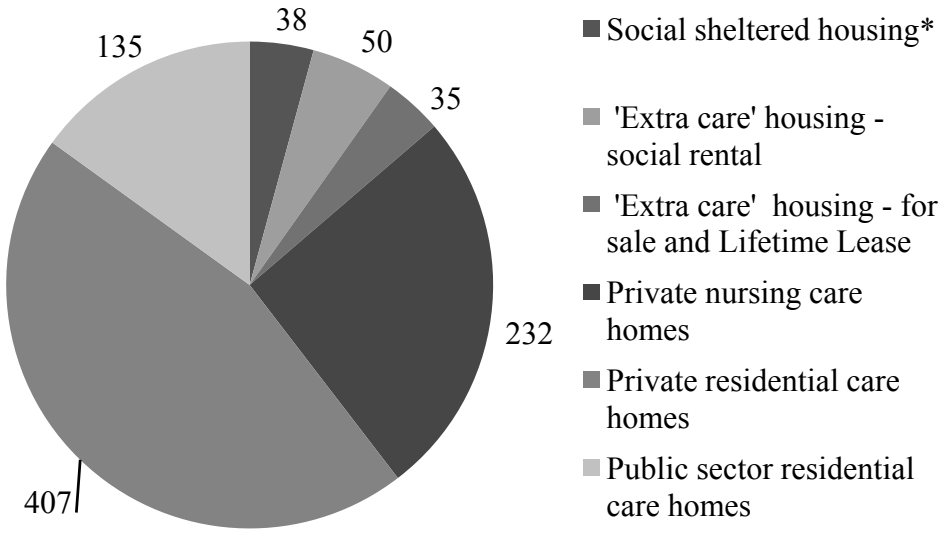
Section 2 of the States Report (paragraphs 74 to 87) highlights that there is a dearth of accommodation which has been designed to meet the specific needs of older Islanders in Guernsey.

The Island's existing housing stock is dominated by general needs accommodation and there is a shortage of 'specialised housing', as defined in the States Report, which has been designed to enable 'ageing in place'.

Figure 1 below summarises existing forms of accommodation – specialised housing and long-term care homes - which are available to older Islanders in Guernsey.

Figure 1: Housing provision for older Islanders in Guernsey

(Numbers indicate the number of places available)



** NB This includes Maison Le Clement which is proposed for demolition.*

The above shows that there are **897 places** for older Islanders who require some care and support.

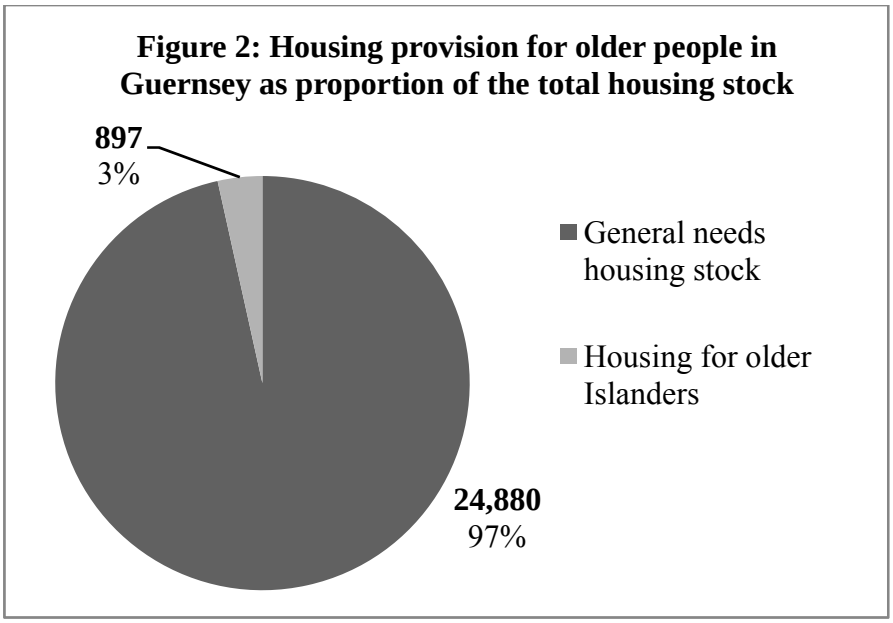
Hospital-based provision for frail elderly and people with dementia (117 ward beds) are excluded from the above, albeit that this type of provision, in the absence of alternative solutions, provides a permanent home for approximately one-third of these patients.

The above also excludes what is commonly referred to as 'retirement housing' as this does not generally include any design features to distinguish this type of accommodation from other general needs housing in Guernsey.

The Policy Council's Policy and Research Unit published the first annual housing stock bulletin in March 2011. Using information from the Corporate Address File, the housing stock bulletin identified that there were 25,777 domestic property units in Guernsey.

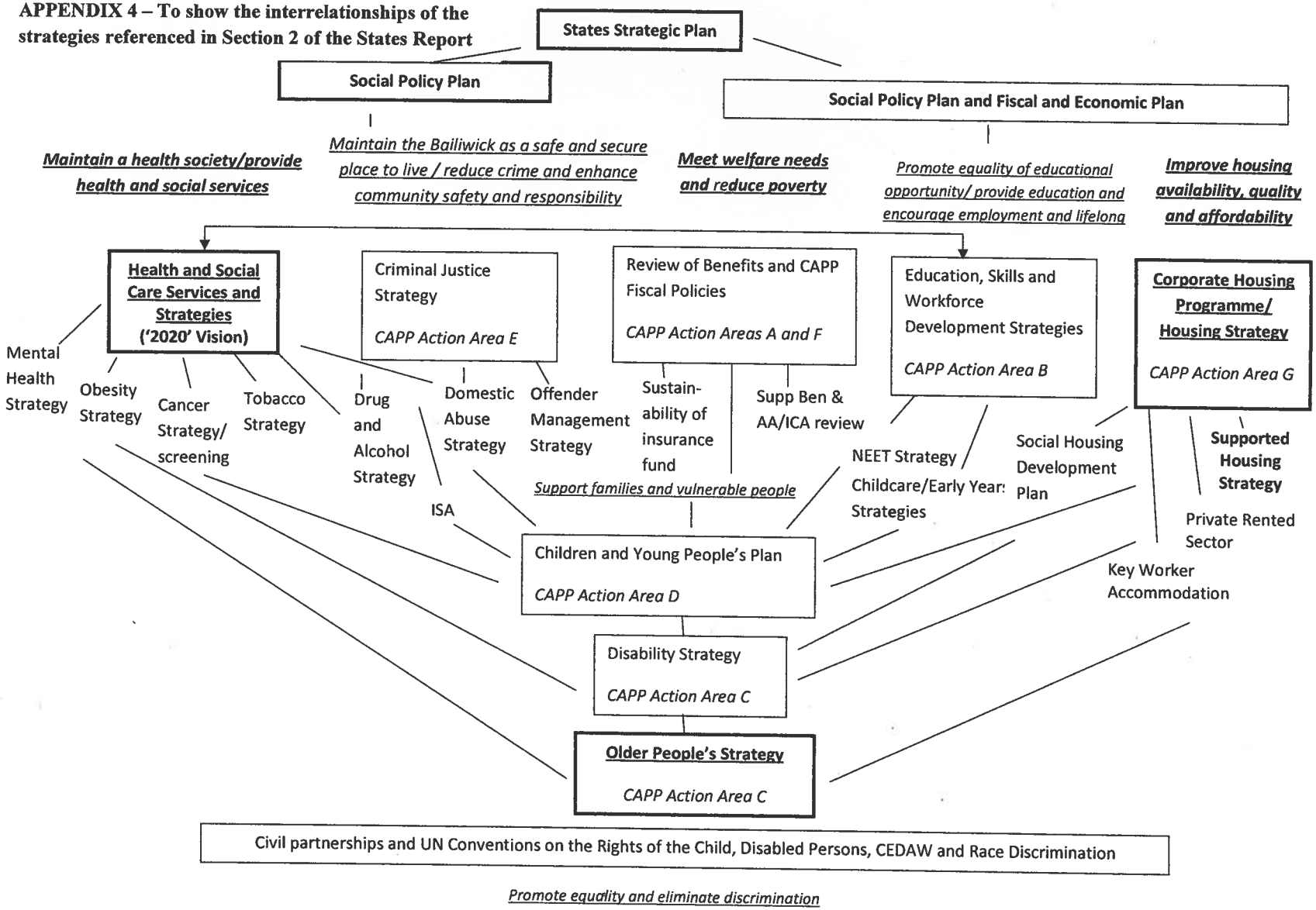
Figure 2 below shows the number of units of accommodation in the Island which are specifically aimed at older Islanders (897 units) compared to the net number of general needs property units in Guernsey (24,880 units).

Figure 2: Housing provision for older people in Guernsey as proportion of the total housing stock



It is interesting to note that Islanders aged over 60 years form 22% of the Island's population (2010 data: 13,928 people) but that housing provision for older people represents only 3% of the total housing stock.

APPENDIX 4 – To show the interrelationships of the strategies referenced in Section 2 of the States Report



APPENDIX 5

LESSONS LEARNT FROM GUERNSEY'S FIRST 'EXTRA CARE' HOUSING SCHEME AT ROSAIRE COURT AND GARDENS

Introduction

In May 2001, the States agreed that the site of the former Girls' Grammar School, at Rosaire Avenue, St Peter Port, should be developed to provide predominantly sheltered housing.[1]

The need for the Rosaire scheme arose out of a concern about the limited choices for older people and a dearth of such accommodation in the Island, leading to people with low and moderate care needs being admitted to more expensive residential homes.

Following a tendering exercise, it was agreed to redevelop the site as 'extra care' housing, to provide accommodation and on-site care and support for people, aged 55 and over, in a community housing scheme.

The result was Rosaire Court and Gardens - a mixed tenure development of 86 flats, consisting of:

- 50 flats for social rental (one of which is reserved as a respite flat by HSSD);
- 7 flats purchased on an affordable lifetime lease;
- 28 owner-occupied units;
- a manager's flat.

There are two main buildings on the site:

- Rosaire Court – comprising the communal facilities, the social rental flats, the lifetime lease flats, a limited number of owner-occupied flats and the manager's flat;
- Rosaire Gardens – comprising the majority of the owner-occupied flats.

The development of the scheme resulted from a partnership between Housing and HSSD, and a consortium of Housing 21 – a UK- based specialist housing association - and a Guernsey-based private development company, Rosaire Sheltered Housing Limited.

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[1] Housing Authority – *'Development of Sheltered Housing at Rosaire Avenue'* – Billet d'État VIII 2001.

Review by Public Accounts Committee

The development of the scheme was the subject of a review carried out by the National Audit Office on behalf of the Public Accounts Committee. As the results of that review are a matter of public record and were reported to the States, they are not repeated here[2].

However, at the time of that review, Rosaire Court and Gardens had only recently been opened and thus it was too early to assess the operation of the scheme. This is addressed by the paragraphs below, with the purpose of ensuring that the lessons learnt from Rosaire Court and Gardens are applied to the development of the new 'extra care' schemes proposed for the Longue Rue and Maison Maritaine sites.

Built Environment

At Rosaire Court, there some design features within the flats for rental that can be improved upon in the new 'extra care' schemes at Longue Rue and Maison Maritaine; namely:

- the configuration of the flats is not ideal, making the use of mobility aids and wheelchairs difficult and placing limitations on who can be accommodated there;

- the wet rooms, although accessible, were imported, ready-built, as 'pods'. The wall construction makes the installation of grab rails difficult and more expensive than adapting traditional construction;

- toilets and WCs are standard domestic models and are not suitable for people with mobility issues;

- the unit designs did not incorporate planning for hoist tracking or other equipment required to enable individuals to live independently for as long as possible;

- the interior design approach is not optimal to assist people with dementia or who find orientation challenging; and

- although spacious, corridors are relatively lengthy for people with mobility problems.

Service Model

As a new addition to the provision of social care in the Island, unsurprisingly it has taken some time to establish exactly what 'extra care' services are and who can benefit

[2] See Appendix to Public Accounts Committee – '*Housing Associations in Guernsey*' – Billet d'État II 2009.

from them. HSSD social care professionals have tended to perceive ‘extra care’ more as sheltered housing rather than as an alternative to residential care and, as a result those accommodated have principally had very low to no care needs. Steps have been taken to provide greater clarity and understanding of the service model and to ensure more appropriate referrals.

Conclusions

Despite these issues, Rosaire Court and Gardens continues to provide people who might otherwise have been referred to residential care with an alternative that promotes and maintains their ability to live independently. Residents of both the social rental and the owner-occupied flats are happy with the environment and the service.

Rosaire Court and Gardens has thus been a welcome addition to the landscape of housing and social care provision in Guernsey.

NOTES

DAT

ALL DIMENSIONS ARE STRUCTURAL, FIGURED DIMENSIONS TO BE USED IN PREFERENCE TO SCALED DIMENSIONS, CHECK ALL DIMENSIONS ON SITE. ANY DISCREPANCIES BETWEEN THIS DRAWING AND SITE CONDITIONS MUST BE REFERRED TO STATES PROPERTY SERVICES

APPENDIX 6

KEY:

- Longue Rue
- Courtil Jacques
- Les Caches Cottage

Notes:
Total site area (within dotted boundary lines:
13,000m2 or 140,000sq ft

590

A

REVISION DATE

States of Guernsey

HOUSING DEPARTMENT

CLIENT

PROJECT
Longue Rue Residential Home,
Rue Maze, St Martins.

TITLE
Location Plan

JOB NO
2010

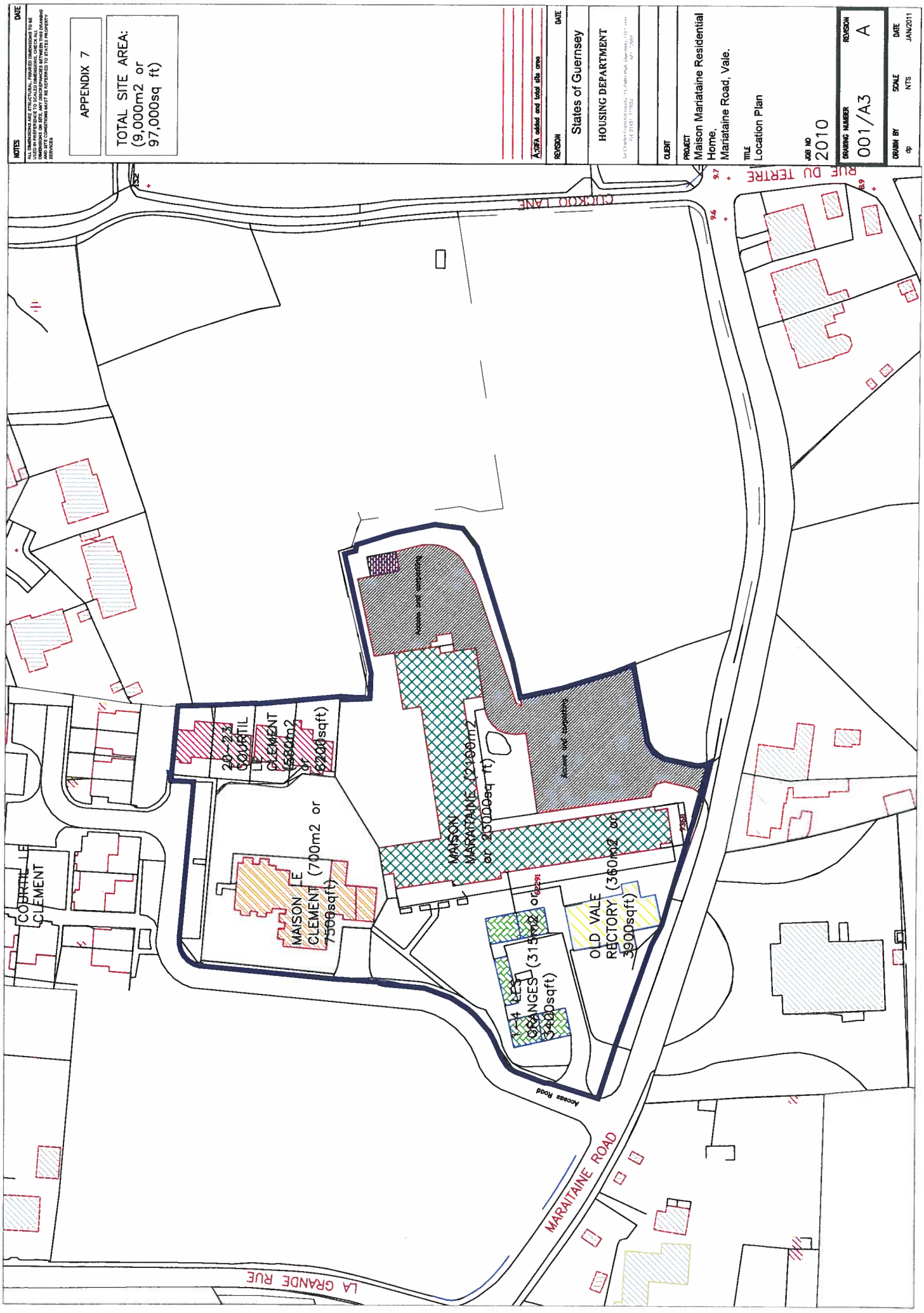
DRAWING NUMBER 001

REVISION

DRAWN BY dp

SCALE NTS

DATE 19/10/10


APPENDIX 7
TOTAL SITE AREA:
(9,000m2 or
97,000sq ft)
NOTES
DATE
REVISION
DATE
Access added and total site area
States of Guernsey
HOUSING DEPARTMENT
CLIENT
PROJECT
Maison Mariataine Residential
Home,
Mariataine Road, Vale.
TITLE
Location Plan
JOB NO
2010
DRAWING NUMBER
001/A3
REVISION
A
DRAWN BY
dp
SCALE
NTS
DATE
JAN/2011
CUCKOO LANE
RUE DU TERTRE
20-23
COURTIL
LE
CLEMENT
(560m2
or
6200sqft)
MAISON
LE
CLEMENT (700m2 or
7500sqft)
COURTIL LE
CLEMENT
MAISON
MARAITAINE (2100m2
or 23000sq ft)
Access and turning
Access and turning
OLD VALE
RECTORY (360m2 or
3900sqft)
LES
ORANGES (315m2
or
3400sqft)
Nobbs Road
MARAITAINE ROAD
LA GRANDE RUE

APPENDIX 8

PROVISIONAL SCHEDULE OF ACCOMMODATION AND COMMUNAL FACILITIES IN THE NEW 'EXTRA CARE' SCHEMES

The following may change during the detailed design process.

Longue Rue House

Total area of proposed scheme = 5,300sq.m

One-bed flats	58 sq.m x 51 units
Two-bed flats	70 sq.m x 10 units

Maison Maritaine

Total area of proposed scheme = 4,950sq.m

One-bed flats	58 sq.m x 44 units
Two-bed flats	70 sq.m x 9 units

Day Centre

Communal areas common to both schemes:

Corridors
Main communal lounge
Dining areas
Café kitchen
Tenants tea kitchen
Small lounges/hobby rooms
Communal WC's
Assisted bathrooms
Hairdressing/beauty therapy room
Informal seating spaces
A Housing Managers' office
A Care Managers' office
Photocopying room/area
Staff overnight room with en-suite
Staff rest room with kitchenette
Staff locker/change room & toilets
1 guest room with en-suite
Laundry

Sluice room
Cleaners storage
General storage
Buggy/Scooter store
Treatment room

In addition to the above, provision has also been made in the outline costs for both schemes for:

- Connecting walkways, which might be enclosed or just covered
- Landscaping, garden areas
- Infrastructure - parking, road, drains, paths
- Patio's, seating, external lighting, sensory areas
- Attractive elevational treatment
- Signage
- Door entry security, alarms, possible CCTV, swipe cards or code pads
- Fire systems
- Demolition of 1-4 Les Granges, 4 Courtil Le Clement bungalows, Maison Le Clement, the existing Care Home and renovation of the Old Vale Rectory building
- Eco-technologies - solar panels, v. high insulation, air tightness, Mechanical Heat Recovery System, Code Level 3 to 4 on energy efficiency, very good sound insulation
- Scheme designed to be fully wheelchair friendly
- Lifts (but costs will vary depending on number of lifts)

APPENDIX 9

‘LIFETIME HOMES STANDARDS’

The Strategy will recommend that all new specialised housing developments be built to a common design standard - to the principles of **‘Lifetime Homes’ -** to ensure that design maximises independence, quality of life and can accommodate increasing fragility.

The principles include:

- level access to doorways;
- wider internal doorways;
- larger circulation areas for wheelchair use;
- sockets and light switches at a convenient height for wheelchair users;
- a wheel chair accessible WC and shower room.
- incorporating wider car parking spaces; and
- minimising distances from car parking to the home.

Lifetime Homes Standards have been adopted in recent general needs social housing being provided by the GHA.

Many of the design principles, if incorporated at the time of construction, help to reduce the need for costly adaptations at a later date if an individual’s mobility changes, for example.

The Strategy will therefore encourage all new build specialised housing developments to be built to Lifetime Home Standards and to offer the possibility of both sheltered housing and extra care services.

APPENDIX 10

FUNDING ISSUES IN RESPECT OF PERSONS WITH A LEARNING DISABILITY CURRENTLY ACCOMMODATED BY HSSD

Introduction

1. Paragraphs 340-365 of this Report identified various funding issues for departments and individuals transferring from the Housing Department's residential homes to the new 'extra care 'accommodation planned for the Longue Rue and Maison Maritaine sites.

2. Similar issues apply in respect of existing residents of HSSD's residential homes for persons with a learning disability. These are summarised below.

Funding of care and support costs

3. The care and support costs of existing residents of HSSD's residential homes for persons with a learning disability are met in full via HSSD's General Revenue budget.

4. With the housing of 15 persons with a learning disability in the new 'extra care' housing, there is a *potential* reduction in General Revenue expenditure for HSSD, associated with the re-provision of services for its Learning Disability clients and the staffing thereof, as outlined in paragraphs 321-324.

5. However, this potential "saving" may be offset by any additional staff that may be required to staff 'The Oaks' as outlined in paragraph 172.

6. In addition, the Housing Department *may* need to be recompensed to reflect the fact that the care and support provided for people with a learning disability in the 'extra care' housing will be provided by staff employed by the Housing Department not HSSD (see paragraph 322).

Funding of property costs

7. Those persons with a learning disability who are currently accommodated by HSSD pay a rental charge to that department towards the cost of their accommodation. Whilst this varies considerably by property, generally speaking, rents are in line with social housing rents for equivalent accommodation. If residents are unable to meet these costs, they are able to seek assistance from Supplementary Benefit.

8. For up to 15 persons, their moves to 'extra care' housing *may* lead to a <u>reduction</u> in income for HSSD, depending upon whether the beds they release are taken up by new clients.

Payment of rent and service charges for 'extra care' housing

9. While, as noted above, it has not been decided what the rent and service charges will be for the new 'extra care' housing, based on current modelling some residents in a HSSD residential home *could* pay more rent for their 'extra care' flat than for their existing accommodation, others *could* pay less.

Meeting the costs of food and other household expenses

10. In addition to rent and service charges, the Departments also recognise that when they transfer to be 'extra care' tenants, some current learning disability residents of a HSSD residential home will be required to meet the costs of their food, heating, hot water and other household expenses, which currently are paid for from HSSD's General Revenue budget.

11. However, for those who currently pay £70 per week towards their living expenses, the move to an 'extra care' flat will have less, if any, financial impact; particularly, as many of these residents will already be supported to meet these costs from Supplementary Benefit.

12. Nonetheless, by building flats with high insulation levels, use of solar panels and other energy efficient technology, the GHA will be working on keeping tenants' heating, hot water and other costs to a minimum; however, these will still be a new and "additional" expense for those persons with a learning disability transferring to the new accommodation.

The budgetary impact upon the Social Security Department

13. In relation to all these personal expenses - rent and service charges, and other daily living expenses - where a tenant with a learning disability is unable to pay them in full, it is proposed they will be able to seek Supplementary Benefit assistance from the Social Security Department, as would any other low income householder in the Island.

14. The Departments acknowledge that this has the potential to have an adverse impact on the Social Security Department's Supplementary Benefit expenditure, which is funded by formula-led expenditure from General Revenue. However, the impact of these 15 learning disability clients is likely to be minimal, as most will already be receiving Supplementary Benefit support.

(NB The Policy Council applauds the joint and partnership working between the Housing Department, the Health and Social Services Department, the Social Security Department and the Guernsey Housing Association to increase opportunities for independent living. The Policy Council is aware that all Departments involved acknowledge that further research and discussions are necessary to investigate future funding for such housing care for the elderly schemes.)

(NB The Treasury and Resources Department has commented as follows.)

The Chief Minister
Policy Council
Sir Charles Frossard House
La Charroterie
St Peter Port

31st March 2011

Dear Deputy Trott

PROVISION OF 'EXTRA CARE' HOUSING AT MAISON MARITAINE AND LONGUE RUE

I refer to the above mentioned joint Report from the Housing and Health and Social Services Departments.

My Board accepts that the two homes are no longer fit for purpose and the cost of remedial work, together with the disruption this would involve, would not provide a value for money solution. It is also accepted that this particular project should be funded through the Corporate Housing Programme. While, in an ideal world, the wider strategic context for the replacement of these homes as extra care housing would already be in place, we are satisfied that there is an urgent and therefore overriding need to commence the planning and redevelopment of the extra care facilities at Maison Maritaine and Longue Rue House ahead of the States debating the Older People's Strategy.

In the light of these considerations, my Board supports the proposals contained in this States Report.

However, it is essential that the strategy for the future provision of care for the elderly and the accompanying complex funding issues, are addressed as soon as possible. It is clear that there will be an increasing need for facilities of this kind as the population ages, and my Board intends to ensure that a robust and sustainable funding model is put in place for these projects so that this aspect of care for the elderly is developed on a

sound financial footing going forward. It seems clear that the funding of this project contains three separate elements: the cost of the capital project, the cost of the extra care services (provided by the Housing and Health and Social Services Department) and the living expenses of the clients (where assistance from public funds is required). It would seem logical that these costs should, in future, be met through a funding model comprising the States Capital Programme, the Long Term Care Insurance Fund and the Supplementary Benefit Scheme respectively. My Board therefore wishes to continue working with the Housing, Social Security and Health and Social Services Departments to develop a sustainable funding model which addresses the needs of the clients.

My Board also believes that a review of the Corporate Housing Programme (CHP) should be undertaken to determine whether or not this separate funding mechanism, which is used to meet the capital and revenue expenditure on social housing, will continue to remain appropriate into the future. In particular, we consider that the continuation of an arrangement which enables the capital costs of social housing to be progressed outside of the States Capital Programme, should be reviewed in time to inform the next Capital Programme in 2014. For the record however, my Board cannot foresee circumstances in which any future States would fail to allocate adequate funds to facilitate the on-going provision and maintenance of social housing.

My Department looks forward to working with those other Departments with a key interest in all of the complex funding issues to ensure these are comprehensively and appropriately addressed.

Yours sincerely

C N K Parkinson
Minister

The States are asked to decide:-

V .- Whether, after consideration of the Report dated 15th March, 2011, of the Housing Department and the Health and Social Services Department, they are of the opinion:-

1. To approve the use of the Longue Rue House and Maison Maritaine sites, as delineated in Appendices 6 and 7, to provide ‘extra care’ housing to be developed and managed by the Guernsey Housing Association.

2. That the Corporate Housing Programme Fund be used to provide capital grant funding associated with the first phase of the redevelopment of the sites of Longue Rue House and Maison Maritaine (including the costs of demolishing both residential homes), such capital grant funding not to exceed £22 million for both schemes combined.

3. In accordance with the existing procedures for general needs social housing, that the actual grant sum required for these 'extra care' schemes be approved, on behalf of the States, by the Treasury and Resources Department, upon production of a robust business case outlining the building costs of the two schemes plus modelling of the revenue consequences.

4. To approve the use of the Corporate Housing Programme Fund to provide "one-off" expenditure not exceeding £900,000 for furniture and fittings for those persons transferring into the new 'extra care' housing from Longue Rue House and Maison Maritaine, and any residential home managed by the Health and Social Services Department, the actual sum to be approved, on behalf of the States, by the Treasury and Resources Department.

5. That, for the reasons set out in paragraphs 361-365 of that Report, for so long as they occupy it, any resident of Longue Rue House or Maison Maritaine who moves into a two-bed 'extra care' flat will be charged the rent for a one-bed 'extra care' flat, the difference between the rental for a one- and two-bed flat in each case being annually reimbursed to the Guernsey Housing Association from the Corporate Housing Programme Fund.

6. To direct that the revenue funding issues, identified in Section 10 of that Report, be addressed inter-departmentally between the Housing, Health and Social Services, Social Security and Treasury and Resources Departments as part of the preparation of the robust business case to be presented to the latter department;

7. To note that, as identified in paragraphs 328-372 of that Report, in resolving these revenue funding issues there is likely to be a need for a redistribution of monies in revenue budgets from one department to another.

8. To note the likely proposals for the Phase 2 development of the Longue Rue House and Maison Maritaine sites and the associated funding consequences, as set out in paragraphs 260-274 of that Report.

HEALTH AND SOCIAL SERVICES DEPARTMENT

FOOD HYGIENE, FOOD SAFETY AND OFFICIAL CONTROLS

The Chief Minister
Policy Council
Sir Charles Frossard House
La Charroterie
St Peter Port

28th February 2011

Dear Sir

EXECUTIVE SUMMARY

1. This report seeks approval for the drafting of a single piece of legislation to consolidate existing food legislation, to update terminology in line with modern business practices and to introduce specific controls for high risk foods i.e. foods of animal origin. This will provide for a consistent and proportionate system of regulation appropriate to the Guernsey context.

2. There are currently twenty pieces of food safety legislation in force in Guernsey, dating back to 1947, and this causes confusion and places an unnecessary burden on the food sector. It is intended that this proposed legislation will ease the burden on business and will not introduce any additional regulatory pressure.

INTRODUCTION

3. The food industry in Guernsey is thriving, with many businesses developing new products for local consumption and for export e.g. oysters, butter, cheese, eggs and meat. In addition, there are some 700 food businesses delivering food to the public by retail and catering.

4. At present there are different standards applied to businesses operating locally and those producing food for export.

5. The proposals contained in this report will bring about a fair and consistent system for all food operations in Guernsey and will facilitate trade with other jurisdictions.

6. This will bring food safety measures in line with customer expectations about the safety of food and the hygienic practices in premises.

BACKGROUND

7. Food law aims to secure a high level of protection of human life and life-long health. It takes account of cross-cutting issues associated with animal health and welfare, plant health and the environment, e.g. salmonella in eggs, E coli associated with meat production.

8. Within Europe, the science around food and health is changing. The 'farm to fork' ethos is moving towards the whole system approach from 'the beginning to end of the food cycle'. This incorporates all aspects of food safety, manufacturing, processing and distribution through to the health outcomes associated with consumption of food, nutrition and the health claims made about food.

9. The principles of risk assessment, risk management and risk communication are important facets of this regime and will ensure that a measured approach is taken and that appropriate actions are implemented to protect public health. The 'precautionary principle' is introduced as an option to food safety risk management when the scientific evidence base is unclear.

10. The European Food Safety Authority (EFSA) Food and Veterinary Office (FVO) has power to examine official controls applied by competent authorities and is at liberty to inspect food operations in non EU states where food is being produced for import into the EU and where the EC Regulations do not apply. This updated legislation in Guernsey will ensure appropriate local measures are implemented to satisfy these requirements.

11. The legislation will introduce the concept of 'official controls' to be applied by the 'competent authority' (i.e. the HSSD Board). This ensures that authorised officers are competent and trained to undertake their duties, and that their actions are verified as being fair and consistent, transparent and proportionate.

12. In the UK (and its devolved administrations), similar legislation was enacted in 2005 and 2006 which applied to all food business operations, including primary production, official controls and sanctions for non compliance.

SCOPE OF FOOD SAFTY REQUIREMENTS

13. The scope is summarised as follows:-

14. Food business operations: this covers the definition of food business operations and places the onus of producing safe food on the food business operator. In particular, 'food business' means any undertaking, whether for profit or not, and whether public or private, carrying out any of the activities related to any stage of production, processing and distribution of food. This would include seasonal and sporadic businesses. The expression 'stage of production, processing and distribution' covers all stages from and including primary production up to and including sale or supply to the final consumer.

15. Currently all food businesses in Guernsey are required to register with HSSD and are inspected at frequencies determined by the risk the operation poses to public health. At present there is no charge for the initial registration process. The registration of a food business requires a site visit to the proposed premises and bespoke business advice on food safety matters including the provision of a range of documentation to support the development of a hazard analysis critical control point (HACCP) system. It is proposed that a one-off charge of £100 will be introduced to meet this cost to the service for initial registration.

16. Official controls and the competent authority: i.e. the HSSD Board. The competent authority is responsible for ensuring that the food law function is undertaken and maintained. This includes the official control of ensuring the safety of food consumed by the public.

17. The traceability of food is an important factor so that the origin of the food can be determined as well as where it is going to be consumed. The rapid alert system is already in place and links HSSD to the UK Food Standards Agency and European Food Safety Authority so that contamination of the food chain can be alerted and food poisoning prevented.

18. To assist this process, crisis management and emergency procedures to protect the food chain need to be put in place. This also covers the controls placed on foods that are imported and also the safety of feeding stuffs for animals intended for human consumption.

19. The competent authority will be required to authorise suitably qualified and trained officials to undertake duties. This currently applies to the staff employed in the Environmental Health team and the Official Veterinarian, currently contracted to the Commerce and Employment Department, who performs meat hygiene inspections at the abattoir.

20. In addition, the competent authority will appoint suitable 'food examiners' engaged in laboratories which must meet accredited standards and use approved methodologies to test the microbiological quality of food and chemical composition of food.

21. The hygiene of foodstuffs: details the requirements for risk management in food business operations, known as food safety management systems based on the principles of HACCP. Most food businesses in Guernsey already comply with this requirement. Food hygiene is required in all premises which include moveable or temporary operations, transport of food, equipment, food waste, processes, personal hygiene and training of food handlers.

22. Foods of animal origin: specific hygiene rules for foods of animal origin are required as they pose the greatest risk to public health if not managed safely, e.g. meat, shellfish and fishery products, milk and dairy products, eggs etc.

23. Businesses involved in export to EU countries are required to be 'approved'. This approval process allows the use of the 'oval health mark', which is applied to the packaging and documentation of foods of animal origin and facilitates free passage through the borders of European countries.

24. Whilst this is currently granted by HSSD, there is no local legislation on which to base the procedure of approval or the removal of approval. The specific approval of production premises and procedures, risk-based food safety management systems and the necessary documentation to allow free flow of produce through the EU will be provided for in the legislation to ensure the continued free movement of goods.

25. The legislation will include the specific rules for the organisation of official controls on products of animal origin intended for human consumption. This includes the risk-based approach to controls implemented by the 'competent authority' to ensure food safety and the protection of public health, through inspection, audit and verification of the food itself, food processes and food premises.

26. Sanctions for non compliance: existing food safety legislation includes sanctions for food business operators who fail to comply with the requirements of the law. Sanctions include the service of improvement notices for minor non conformities, remedial action requirements through to emergency prohibition notices which require the closure of the operations due to the imminent risk to public health. Some serious cases may be referred to the Courts for prosecution.

27. Alderney: Food law extends to all food business operations in Alderney.

LEGAL REQUIREMENTS

28. The Law Officers have been consulted and have advised that the drafting of Ordinances and other legislation under the European Communities (Implementation) (Bailiwick of Guernsey) Law, 1994 will be able to provide for the issues detailed in this report.

RECOMMENDATION

29. The Health and Social Services Department recommends the States to approve the drafting of a single piece of legislation, within the terms of the European Communities (Implementation) (Bailiwick of Guernsey) Law, 1994, to consolidate existing food legislation and to implement the food safety and food hygiene provisions set out in this report.

Yours faithfully

A H Adam
Minister

ANNEXE[1]

DRAFTING OF LEGISLATION - PRIORITY RATING SCHEME

STATES REPORT ON FOOD SAFETY

Criteria	Score
Criteria 1 – Availability of funding This legislation does not have financial implications. The legislation will consolidate 20 pieces of old legislation and will modernise the terminology and systems consistent with the modern food industry and will aid exports. The score will be 'yes' as funded, albeit zero.	**Yes**
Criteria 2 – Urgent project This legislation is needed urgently to ensure compliance with approval of premises associated with exports of foods of animal origin e.g. fish, shell fish, meat, eggs, dairy products etc. The requirements are needed to allow continuation of exports and prevent impacts on the local food industry.	**Yes**
Criteria 3 – Fiscal and economic benefits As 2. The legislation supports the local food industry in ensuring free passage of goods throughout the EU. Evidence indicates that businesses holding EU approvals can receive better prices for their products. Recent problems with fish exports were aided by the approval process although this is not currently vested in local legislation. The support for trade is clearly embedded in the SSP.	**5**
Criteria 4 – Social benefits The improvement in food safety will improve public health by reducing food poising rates, thus improving community health and wellbeing. There will be a consistent and proportionate approach to all food business operations whilst maintaining the local culture.	**5**

[1] For the purpose of prioritising legislation, all future States Reports requiring new legislation will include a brief annexe containing information justifying the need for legislation; confirming how funding will be provided to carry out functions required by the new legislation; explaining the risks and benefits associated with enacting/not enacting the legislation; and the estimated drafting time required to draw it up.

The legislation will provide a single point of reference and will be easy to access. All linked to the SSP.	
Criteria 5 – Environmental benefits The legislation will provide specific requirements for food businesses involved with foods of animal origin and will provide for improvements in meat hygiene, food waste disposal and reduce risk of zoonoses (disease from animals to people).	**5**
Criteria 6 – Approved new service This is not a new service and does not require service development.	**5**
Criteria 7 – Time The current legislation is based on the Food and Drugs (Guernsey) Law 1970 and the Ice Cream Ordinance 1947. Much of this legislation is obsolete and needs to be updated urgently.	
Criteria 8 – International reputation pressures The EU Standing Committee of Food Chain Issues Food and Veterinary Inspectorate are at liberty to inspect any jurisdiction supplying food into the EU. The UK Food Standards Agency has repeatedly asked the department when the updated food safety standards will be implemented. There is an understanding that Guernsey will apply the same food safety standards as the UK (Protocol 3). Whilst staff do their best to do this in practice, there is no legal framework locally. Exports of FOAO are of a particular risk to the island's reputation.	**6**
Criteria 9 - Demand There is support within the industry for a compliant regulatory environment so that they can demonstrate this to their customers. The industry requires a consistent and proportionate system of official controls appropriate to the local culture.	**4**

This information was the outcome of consultation with traders. The community requires, and indeed deserves, the highest standards of food safety in shops, restaurants, hotels etc to prevent food poisoning, prevention of supply of contaminated food etc. Improved meat hygiene standards will allow an extension of the 'over thirty month' scheme so that meat is not incinerated at the animal carcase incinerator.	
Criteria 10 – Departmental Priority The department considers its food safety function to be of high priority for the protection and improvement of public health. The service relies on the legislation to provide the framework for the administration of its systems and interventions with the food industry sector. The current legislation poses business risks for the department as activities are undertaken to facilitate trade but are not substantiated in local legislation. These systems could be subject to audit by the EU FVO and would currently fail. This could result in a ban on some food exports.	**5**

(NB The Policy Council has no comment on the proposals.)

(NB The Treasury and Resources Department has no comment on the proposals.)

The States are asked to decide:-

VI.- Whether, after consideration of the Report dated 28th February, 2011, of the Health and Social Services Department, they are of the opinion:-

1. Within the terms of the European Communities (Implementation) (Bailiwick of Guernsey) Law, 1994, to consolidate existing food legislation and to implement the food safety and food hygiene provisions set out in that Report.

2. To direct the preparation of such legislation as may be necessary to give effect to their above decision.

HEALTH AND SOCIAL SERVICES DEPARTMENT

FOOD SUPPLEMENTS, NUTRITIONAL INFORMATION AND HEALTH CLAIMS

The Chief Minister
Policy Council
Sir Charles Frossard House
La Charroterie
St Peter Port

28th February 2011

Dear Sir

EXECUTIVE SUMMARY

1. This report seeks approval for the drafting of legislation to implement legislative provisions in respect of food supplements and provisions in respect of nutritional information and health claims. The statutory provisions will introduce controls on the labelling and composition of food supplements and introduces specific rules on vitamins and minerals in food supplements to ensure that these products are safe and appropriately labelled so that consumers can make informed choices. In addition, the legislation will introduce controls for nutritional labelling of all food and health claims made about all food through labelling and advertising (Appendix 1).

INTRODUCTION

2. There is a thriving food supplements industry in Guernsey supplying products locally through a large number of retail outlets and also for export into the European market. A number of suppliers have websites that advertise products and these companies act as fulfilment businesses. In some cases the products are advertised by locally based businesses but the products are not actually stored in or despatched from Guernsey.

3. Food supplements, e.g. vitamins and minerals etc, are eaten to enhance or enrich the diet and are, therefore, included within the definition of ‘food ‘in the Food and Drugs (Guernsey) Law, 1970. Food supplements are not ‘medicinal products’ unless they fall within the technical definition of 'medicinal products' in the Medicines (Human and Veterinary) (Bailiwick of Guernsey) Law, 2008. Traditional herbal medicines (or remedies) are medicinal products.

4. Advertising and labelling of food is a mechanism to provide information to the public to allow consumer choice. This includes the composition of food,

ingredients and nutritional information and includes terms used such as 'low fat, 'low salt', 'high energy', which are considered to make a health claim about the food.

BACKGROUND

5. Whilst the Food and Drugs (Guernsey) Law, 1970 contains powers to make Orders under sections 4, 5 and 7 in respect of composition of food, ingredients in food, provision of information concerning food, labelling and descriptions of food, current statutory instruments do not regulate food supplements, nutritional information or health claims.

6. The EU introduced standards for food supplements through Directive 2002/46/EC and member states, including the UK, have introduced legislation to implement these standards. Since 2002, additional regulations have been introduced which provide for nutritional information and controls over health claims being made about food. Due to the changes required to labelling and composition of food, the legislation has a phased approach to allow businesses time to comply.

7. The content of the Directive and subsequent regulations have not been implemented locally in Guernsey although large quantities of food goods are exported to EU Member States. The powers in the Food and Drugs (Guernsey) Law, 1970 do not allow Orders to be made to fully implement the Directive and subsequent regulations.

REASONS FOR SEEKING EU EQUIVALENCE

8. The current situation means that Guernsey is not applying detailed EU standards which arguably apply, insofar as they concern free movement of goods provisions under Protocol 3.

9. At present there are no restrictions on the claims that companies can make in respect of nutritional and health claims on the island, as a result there are no safeguards for local consumers as to the authenticity of claims made (except for 'medicinal claims', which are regulated by the Medicines Law, as noted above).

10. Action by the lobbyists in the UK, such as the Health Food Manufacturer's Association (HFMA), has resulted in various UK MPs raising Parliamentary Questions in Westminster and debates in the House of Commons. This has resulted in direct engagement with the Foods Standards Agency and the Ministry of Justice on this matter.

11. Companies trading from Guernsey and advertising products in the UK are subject to scrutiny by the UK Advertising Standards Authority (ASA). Adjudications made against any such company as a result of health claims made about food products they are advertising in magazines or on their websites are not subject to regulatory sanction on the Island by the ASA. The adoption of identical

advertising regulations will ensure that any company trading in Guernsey will have to meet EU standards in respect of nutritional or health claims and an appropriate domestic sanction can be imposed.

12. Various UK Trading Standards offices have contacted this department about concerns at the lack of up to date regulation on the labelling and composition of food supplements along with the daily intake information.

13. Food products, including food supplements, which do not meet the EU standards in respect of their composition, labelling or the advertisement of any nutritional or health claims may put consumers at risk of ill health effects and may arguably affect free movement of goods.

14. The sale of goods by companies that do not comply with EU Food Standards requirements and advertising legislation would bring with it significant reputational issues for the Island.

15. The overwhelming majority of companies trading from Guernsey with EU Member States voluntarily comply with these standards and the adoption of these standards will have minimal effect on those businesses.

IMPLEMENTATION OF LOCAL LEGISLATION

16. The Health and Social Services Department is aware of a number of business operations that do not comply with EU food safety standards in respect of food supplements, nutrition and health claims and a new statutory instrument will be essential to bring about improvements in products sold locally and for export.

17. The food supplements industry has been consulted through the Commerce and Employment Department's 'Guernsey Fulfilment and Mail Order Group' and through open and private consultation meetings with businesses. The industry is supportive of local legislation as this will assist the development of bonafide businesses, which will be able to demonstrate to their customers that they work within an appropriately regulated environment.

18. The Law Officers have been consulted about the drafting of the legislation and has advised that legislation may be drafted under the European Communities (Implementation) (Bailiwick of Guernsey) Law, 1994, to ensure that the relevant parts of the EU Directive and Regulations are implemented locally (where necessary). Local implementation will be undertaken in a manner that is appropriate to the industry in the Bailiwick of Guernsey.

19. The new legislation on food supplements will require some additional training of the food enforcement staff due to the complexity of the ingredients in food supplements, and will require the introduction of a food sampling programme to ensure compliance with the standards. This is likely to cost approximately £7,000 in the first year and around £5,000 per annum to maintain and will be met from the existing budget.

RECOMMENDATIONS

20. The Health and Social Services Department recommends the States to resolve:

i) to introduce food safety standards for food supplements, to implement relevant parts of Directive 2002/46/EC and any other necessarily related European Community Directives or Regulations throughout the Bailiwick;

ii) to introduce compositional and nutritional labelling and advertising of food, including health claims made about food, to implement EC Regulation 1924/2006 and any other necessarily related European Community Directives or Regulations throughout the Bailiwick;

iii) to acknowledge the adverse effect on the reputation of the States of Guernsey, so that high priority is given to the drafting of the legislation.

Yours faithfully

A H Adam
Minister

Appendix 1

FOOD SUPPLEMENTS

Food supplements are concentrated sources of nutrients or other substances with a nutritional or physiological effect, whose purpose is to supplement the normal diet. Food supplements are marketed 'in dose' form, for example as pills, tablets, capsules or liquids in measured doses etc. Supplements may be used to correct nutritional deficiencies or maintain an adequate intake of certain nutrients. However, in some cases excessive intake of vitamins and minerals may be harmful or cause unwanted side effects; therefore, maximum levels are necessary to ensure their safe use in food supplements.

The European Commission has established harmonised rules to help ensure that food supplements are safe and properly labelled. In the EU, food supplements are regulated as foods and the legislation focuses on vitamins and minerals used as ingredients of food supplements.

The main EU legislation is Directive 2002/46/EC related to food supplements containing vitamins and minerals.

The Directive sets out labelling requirements and requires that EU-wide maximum and minimum levels are set for each vitamin and mineral added to supplements. As excessive intake of vitamins and minerals may result in adverse effects, the Directive provides for the setting of maximum amounts of vitamins and minerals added to food supplements. This task has been delegated to the Commission and is currently ongoing.

In addition, its Annex II contains a list of permitted vitamin or mineral substances that may be added for specific nutritional purposes in food supplements. Annex II has been amended by Regulation 1170/2009 of 30 November 2009.

Vitamin and mineral substances may be considered for inclusion in the lists following the evaluation of an appropriate scientific dossier concerning the safety and bioavailability of the individual substance by EFSA. Companies wishing to market a substance not included in the permitted list need to submit an application to the European Commission.

NUTRITION AND HEALTH CLAIMS

A health claim is any statement used on labels, in marketing or in advertising that health benefits can result from consuming a given food or from one of its components such as vitamins and minerals, fibre, and ‘probiotic’ bacteria. There are different types of health claims. For instance, statements that a food can help reinforce the body’s natural defences or enhance learning ability are called “general function” claims. Examples also include claims on the reduction of disease risk and other substances that may improve or modify the normal functions of the body, e.g. “Plant sterol have shown to reduce cholesterol levels, a risk factor in the development of coronary heart disease” or

“Calcium may help improve bone density”.

A nutrition claim states or suggests that a food has particular beneficial nutritional properties. Examples include “low fat”, “source of omega-3 fatty acids” or “high in fibre”.

The Regulation on Nutrition and Health Claims on Foods requires that foods bearing nutrition and health claim must meet certain nutritional requirements or so-called “nutrient profiles.” Foods need to comply with these conditions in order to be eligible to make such claims. The profiles will help ensure that consumers who utilise claims to guide healthy diet choices, and who may perceive foods bearing claims as having a nutritional or health advantage, are not misled as to their overall nutritional value.

ANNEXE[*]

DRAFTING OF LEGISLATION - PRIORITY RATING SCHEME

STATES REPORT ON FOOD SUPPLEMENTS, NUTRITIONAL INFORMATION AND HEALTH CLAIMS

Criteria	**Score**
Criteria 1 – Availability of funding There are no financial implications with this legislation. Staff will need some training and a sampling programme will be introduced although this will be met from within the existing budget.	**Yes**
Criteria 2 – Urgent project This project is required urgently. This will provide a framework to ensure that the composition of food supplements can be regulated, nutritional information about food is provided and that health claims made about food are registered and not misleading to the consumer. The same requirements have been placed upon the States of Jersey, who have already drafted legislation. This has been shared with the Law Officers Chambers to speed up the process.	**Yes**
Criteria 3 – Fiscal and economic benefits Consultation with local business has indicated support for the legislation so that they can demonstrate their compliance with an appropriate regulatory environment to their customers. The food supplements business is significant with over 40 businesses being involved in export. This legislation will support business and therefore meets a number of objectives in the SSP.	**5**

[*] For the purpose of prioritising legislation, all future States Reports requiring new legislation will include a brief annexe containing information justifying the need for legislation; confirming how funding will be provided to carry out functions required by the new legislation; explaining the risks and benefits associated with enacting/not enacting the legislation; and the estimated drafting time required to draw it up.

Criteria 4 – Social benefits Standards for food supplements, nutritional information and issues associated with health claims are vitally important to protect public health, provide information to consumers to allow informed choices about the food they eat and to ensure that advertising is accurate and not misleading.	**5**
Criteria 5 – Environmental benefits There are no environmental implications associated with this legislation.	**0**
Criteria 6 – Approved new service This is not a new service.	**3**
Criteria 7 – Time This legislation has been in discussion for the last 3 years, although not at States level. However the issues has been raised by the Channel Islands Minister during the last three visits to Guernsey.	**3**
Criteria 8 – International reputation pressures. The States of Guernsey has been under scrutiny by the UK Parliament, with a number of PQs being raised about the food supplements industry and lack of local legislation to regulate the industry. A number of local companies have had adverse advertising adjudications imposed by the UK Advertising Standards Authority. Food supplements standards need to be applied to ensure the continuation of exports into the EU.	**6**
Criteria 9 - Demand There is demand amongst the industry to implement local legislation to allow them to operate in an appropriate regulatory environment and for this to be demonstrated to customers in other jurisdictions. There has been a consultation with the sector and their views have been taken into account.	**4**
Criteria 10 – Departmental Priority The safe sale of food supplements is a high priority for the department to ensure public health protection. The department's policy on food, nutrition and on obesity requires good	**5**

consumer information to be provided so that consumers can make informed choices about the food they eat. The border line issues with the Medicines (Human and Veterinary) (Bailiwick of Guernsey) Law, 2008 need to be effectively delineated to protect the public.	

(NB The Policy Council has no comment on the proposals.)

(NB The Treasury and Resources Department has no comment on the proposals.)

The States are asked to decide:-

VII.- Whether, after consideration of the Report dated 28th February, 2011, of the Health and Social Services Department, they are of the opinion:-

1. To introduce food safety standards for food supplements, to implement relevant parts of Directive 2002/46/EC and any other necessarily related European Community Directives or Regulations throughout the Bailiwick.

2. To introduce compositional and nutritional labelling and advertising of food, including health claims made about food, to implement EC Regulation 1924/2006 and any other necessarily related European Community Directives or Regulations throughout the Bailiwick.

3. To acknowledge the adverse effect on the reputation of the States of Guernsey, so that high priority is given to the drafting of the legislation.

4. To direct the preparation of such legislation as may be necessary to give effect to their above decisions.