Committee for Health, Social Services & Public Safety

Review of supported living for older people in the context of Transforming Your Care

Committee powers and membership

Powers

The Committee for Health, Social Services and Public Safety is a Statutory Departmental Committee established in accordance with paragraphs 8 and 9 of the Belfast Agreement, section 29 of the Northern Ireland Act 1998 and under Standing Order 46. The Committee has power to:

- Consider and advise on Departmental budgets and annual plans in the context of the overall budget allocation;
- Consider relevant secondary legislation and take the Committee stage of primary legislation;
- Call for persons and papers;
- Initiate inquiries and make reports; and
- Consider and advise on any matters brought to the Committee by the Minister for Health, Social Services and Public Safety.

Membership

The Committee has 11 members including a Chairperson and Deputy Chairperson and a quorum of 5. The current membership of the Committee is as follows:

Ms Maeve McLaughlin (Chairperson)

Mr Jim Wells MLA (Deputy Chairperson)

Mr Roy Beggs MLA

Mr Mickey Brady MLA

Ms Pam Cameron MLA

Mrs Joanne Dobson MLA

Mr Gordon Dunne MLA

Mr Kieran McCarthy MLA

Ms David McIlveen MLA

Mr Fearghal McKinney MLA

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Background to the Review

1. In October 2013, the Committee for Health, Social Services and Public Safety agreed that scrutiny of the implementation of Transforming Your Care (TYC) would be one of its strategic priorities for the 2013/2014 Assembly session. It began this work by focusing on one particular programme of care – learning disability – and produced a report in January 2014. The Committee then selected older people as the next programme of care within Transforming Your Care on which to focus its attention.

2. The TYC Strategic Implementation Plan states that for older people, one of the significant changes and benefits of TYC which will be realised over the next 3 to 5 years is:
"Community-based alternatives to residential care are increasing all the time, and there is a need to ensure that the availability and functioning of these is more widely known so that people can see the different styles of ***independent living*** *that it is now possible to offer to older people, where the traditional response would have been to offer a residential placements. Due to improved availability of these types of* ***community-based alternatives****, it is expected that the demand for statutory residential homes will decline further" (Section 4.3.2 of the TYC Strategic Implementation Plan).*

3. The Committee observed that the "shift left" outlined in TYC, whereby more services will be provided in people's own homes or in community settings rather than in institutional settings, is also envisioned in terms of living options for older people. However, the Committee also noted that within the TYC Strategic Implementation Plan itself, there was an acknowledgement that alternative models to residential care, where the emphasis is on more independent living, are not widely known about by the public. Given this context, the Committee believed it would be useful to carry out a review into supported living options for older people. Furthermore, the Committee noted that the TYC Strategic Implementation Plan links greater availability of "community based alternatives", such as supported living, to a reduced

demand for statutory residential home places. Given that the future of statutory residential homes is a live issue and subject to ongoing public consultation, the Committee believed that supported living was a timely and relevant important subject to explore.

Terms of Reference

4. The Committee agreed the following terms of reference:
    - Consider the structure and availability of supported living options for older people in Northern Ireland;
    - Assess the capacity of supported living options to meet the policy objective of Transforming Your Care in terms of reducing the need for residential home places; and
    - Identify examples of best practice in relation to supported living options in other countries/regions which could be applied in Northern Ireland.

Committee Consideration

5. The Committee held seven evidence sessions from February 2014 to June 2014. The Committee heard from:
    - The Department of Health, Social Services and Public Safety (DHSSPS)
    - The Department of Social Development (DSD)
    - The Northern Ireland Housing Executive
    - The Health and Social Care (HSC) Board
    - Five Health and Social Care (HSC) Trusts
    - The Commissioner for Older People in Northern Ireland
    - Age NI
    - The Northern Ireland Federation of Housing Associations (NIFHA)
    - Professor Anthea Tinker, King's College London.

6. The minutes of evidence of these sessions are at Appendix 1, and the presentations and notes provided by witnesses are at Appendix 2.

7. The Committee also wrote to DHSSPS and DSD throughout the course of the review to seek additional information when required. The written correspondence from both Departments is at Appendix 3.

8. The Committee considered two papers from Assembly Research and Information Service entitled “Caring for an ageing population: TYC proposals” and “Specialised grouped housing for older people: introductory briefing”. These can be found at Appendix 4.

9. The Committee visited Cedar Court in Downpatrick on 7 May 2014, which is a supported living facility in the South Eastern Trust area. On 4 June 2014, the Committee visited the Pavillions in Lisburn where it viewed a proposed model of housing combined with care for older people. Details of both these facilities can be found at Appendix 6.

10. All references in the report to “the Department” refer to the Department of Health, Social Services and Public Safety, unless otherwise specified.

List of Recommendations

11. **In relation to establishing a new definition for supported living, the Committee recommends that the Department consults with older people's representatives, including but not limited to, the Older People's Commissioner for Northern Ireland. The Department should also consult with NIFHA and other relevant stakeholders. The Committee recommends that the Department should <u>not</u> re-label supported living facilities as "frail elderly" schemes, given that the purpose of facilities is to promote older people's independence and support them with what they can do, rather than focusing on that which they cannot.**

12. **The Committee recommends that the HSC Board requires each of the five HSC Trusts to produce an action plan setting out their proposals for raising awareness of the concept of supported living for older people as a model of care, as well as proposals for better promoting the facilities within their area.**

13. **The Committee recommends that the Department does not proceed with its proposal to create a supported living champion, given the costs involved. The Committee believes promotion should be carried out by government departments and/or their relevant arms-length bodies, as part of their existing responsibilities in relation to supported living for older people.**

14. **The Committee recommends that the potential of the Trusts to take on an element of risk sharing with the housing associations should be further explored. Risk sharing may in fact act as an added incentive for the Trusts to better promote their supported living facilities. The Committee also recommends that there is more joint planning between the Trusts and housing associations before decisions are made to commission new facilities.**

15. **The Committee recommends that the Departments should <u>not</u> commission researchers or consultants to evaluate and review Gnangara and Hemsworth Court, but rather this piece of work should be carried out by officials from the Departments and/or their arms-length bodies as part of their existing roles.**

16. **The Committee recommend that the HSC Board reviews the criteria which the Trusts are using in terms of suggesting supported living as an option for an older person in the context of their needs assessment.**

17. **The Committee recommends that the Department should begin forecasting the need and demand for supported living places over a 10 year period. These indicative forecasts should be kept under review, and reassessed when decisions are being taken to build new facilities.**

18. **The Committee recommends that the Department should begin collecting data on the number of older people supported in their own home through domiciliary care who would be suitable for supported living, in order to provide a fuller understanding of need and demand.**

19. **The Committee recommends that the Department reviews the current indicator of performance for older people living in supported living facilities for the Indicators of Performance Direction for 2015. The Committee recommends that a revised indicator should be produced with an associated target, which provides as assessment of the Trusts' performances in terms of their approach to supported living.**

20. **The Committee recommends that the Department clarifies its strategic position on the links between the availability of supported living places for older people and the availability of places within statutory residential homes.**

21. **The Committee recommends that in terms of implementing Transforming Your Care, DHSSPS and DSD work closely in terms of developing housing options for older people which will have the best health outcomes for older people, based on the evidence available.**

Discussion of Key Issues

Definition of supported living

What is supported living?

22. The Committee has ascertained that there is a significant level of confusion around what is meant by the term "supported living" and other terminology used in relation to housing options for older people.

23. This issue first came to the Committee's attention through an Assembly research paper which pointed out that the terminology has changed with the various iterations of Transforming Your Care (Appendix 4). In the initial publication of 2011, Transforming Your Care stated that it wanted to help older people to live independently *"at home or in supported accommodation."* However, in the Transforming Your Care Strategic Implementation Plan (October 2013) the wording had changed somewhat, to older living independently *"at home or in assisted housing".* The Commissioner for Older People in Northern Ireland had also picked up on this issue and advised the Committee:
"*Small differences between the editions of Transforming Your Care cause some confusion over the nature of the objectives for supported living. The initial publication set out an aim for people to be supported to live independently at home or in supported accommodation, and the implementation document talked about people living at home or in assisted housing, so the confusion about exactly what the definitions are goes back as far as that" (Appendix 1).*

24. The Department initially advised the Committee at an evidence session on 26 February 2014 that there were 414 supported living facilities for older people, comprising around 9,000 tenancies. Departmental officials advised:

"The paper we provided sets out the number of supported living facilities and tenancies for older people: 414 facilities covering some 9,081 tenancies. Those represent just over 14% of the overall Supporting People budget and just under 60% of supported living units. Obviously, other groups that utilise supported living include those with learning disabilities, people with mental health needs and those with physical disabilities" (Appendix 1).

25. However, when the five HSC Trusts attended Committee on 12 March 2014, they stated that there were currently 18 supported living facilities across the five Trust areas. The Belfast Trust advised the Committee:
"The trusts are here today to speak specifically about supported housing, which is a partnership model between health and social care trusts, particularly the social care dimensions to trusts, and housing associations, whereby they pool their expertise in housing and care to provide a model of support that allows people to have their individual home and front door while receiving, as an option, 24-hour support, instead of, for example, domiciliary care, residential care or even nursing care" (Appendix 1).

26. The Committee queried the Trusts on their figure of 18 supported living facilities, as opposed to the figure of 414 referred to by the Department. The Belfast Trust offered this explanation:
"I think that the distinction is between supported housing and sheltered dwellings. We do not see sheltered dwellings as supported housing. Sheltered dwellings are a housing option for people with low or no needs who choose to go into that" (Appendix 1).

27. The Committee also took evidence from the Northern Ireland Federation of Housing Associations (NIFHA) regarding the definition of supported living. Like the Trusts, they made a distinction between supported living and sheltered housing, and were very clear that these are two different models. NIFHA stated:
"Sheltered housing is the lowest level. Most people in sheltered housing will not have a care aspect to their accommodation. They may

have domiciliary care, but, generally speaking, they are much more independent. Supported living is the next step up. It has the added advantage of 24-hour security and safety. It is usually for people who need an element of support to maintain their tenancy and an element of care. It is the next step up from sheltered housing.

28. We see sheltered accommodation as near enough to independent living, with a little bit of help, such as someone being there to point you in the right direction. The scheme coordinator will be there, 9.00 am to 5.00 pm, Monday to Friday, with a luncheon club once a week and other activities.

29. Supported living is geared towards people with more complex needs, such as people with early onset dementia. As I mentioned, it also supports carers. We are very clear about the definition" (Appendix 1).

30. NIFHA also asserted that different definitions are currently being used across government and other agencies, and that more clarity is required. NIFHA stated:
"This inquiry has demonstrated that different terminology is used, including by different parts of government. I hope that one of the outcomes of the inquiry will be that we clarify, at a government level, the various definitions and that those definitions will be used across government, so that we have clarity about what is being provided where" (Appendix 1).

31. The Committee also raised the issue of definitions with Age NI. When Age NI was asked during the evidence session is they had a clear definition of what supported living was, the reply was:
"No, is the straight answer to that. We do not have a very clear definition" (Appendix 1).

32. Given the conflicting definitions and the discrepancies in terms of figures quoted by the Department and the Trusts in relation to the number of

supported living facilities, the Committee wrote to the Department for clarification on the issue. The Department advised that the facilities referred to by the Trusts were all commissioned under the Supporting People programme, whereby tenants receive personal care support from the HSC. The 414 facilities referred to by the Department include the Supporting People facilities, but in addition include sheltered and FOLD housing, developed primarily as social housing, where tenants may not require any support from the HSC (Letter dated 3 April 2014, Appendix 3). A separate letter from the Department, also dated 3 April 2014, advised that it was currently using the Northern Ireland Housing Executive's definition of supported living facilities which is – *"Supporting People funds a range of housing related support services for vulnerable older people to improve their quality of life and attain independence. These services can be provided in their own homes, or in hostels, sheltered accommodation or other specialised housing support"* (Letter dated 3 April 2014, Appendix 3).

33. However, the Committee then received a further letter from the Department which advised that the current definition quoted above was now being reviewed in an effort to better reflect supported living within the context of Transforming Your Care (Letter dated 28 April 2014, Appendix 3).

34. The Committee raised this issue with the Department when it came to give evidence to the Committee for a second time on 11 June 2014. Notwithstanding the fact that the definition of supported living is currently being reviewed, the Department stated:
". . . we consider "supported living" to encompass a range of health and care provision, health-related adaptations, housing accommodation and housing support services that are designed to help vulnerable people to retain their independence in their community" (Appendix 1).

35. The Department reiterated its previous position that supported living is a wide-ranging term which includes supported housing, and that there are 414 supported housing facilities in Northern Ireland. The Department described the 18 schemes referred to by the Trusts and NIFHA as "supported living" as "frail

elderly schemes" and included them within the 414 supported housing facilities.

36. When the evidence was put to the Department that there was a lack of clarity around the definition of supported living, it did not appear to accept this. For example, when the Committee advised the Department that NIFHA regarded supported living as the facilities provided under the Supporting People programme and not sheltered housing, the Department replied:
"What you have given is a definition that they believe clearly describes it. I would not question that. I think that there are other elements that you could include or exclude from that definition, and that is what the current discussions are around: what is a good, working definition that everyone could commonly agree on? (Appendix 1)".

37. The Department for Social Development then provided this view:
"In the housing strategy, 'Facing the Future', the definition that we have given you is the definition that we use. "Supported living" is an umbrella term for a range of services aimed at supporting people to live independent lives. One element is supported housing, but there are others . . . such as adaptations and so on, which support people to remain in their own home. I do not think that the definition that we have given is at odds with the definition that the Federation of Housing Associations has given or the trusts . . . Different terms are sometimes used, but we are all talking about the same thing, and we have a common understanding across our Departments and organisations (Appendix 1)".

38. However, the Committee did not accept the arguments put forward by the two Departments that their wide-ranging definition of supported living did not conflict with the definition put forward by the Trusts and NIFHA. The Committee is of the view that there is a clear discrepancy in terms of how the various organisations are defining supported living, with the Departments including sheltered housing in the definition, and the Trusts and NIFHA excluding it.

Impact of definitions on service users

39. The Committee took the view that the definition of supported living is important for a number of reasons. Firstly, how supported living is defined and whether that definition is commonly shared and understood by stakeholders has a direct impact on tenants, potential tenants and their families, However, the Department did not seem to recognise this as an issue. It stated:
"The work under way is to see whether we can make sure that we can reach an accepted definition that everyone finds useful, but I do not think that there is any significant evidence that the absence of a fixed definition is causing any difficulties (Appendix 1)".
40. However, the Committee presented officials with anecdotal evidence of the Larne Housing Executive office interpreting a query from a member of the public about the availability of "supported living" in that area as referring only to facilities built under the Supporting People programme. The advice was given that there was no availability, when in fact sheltered housing was available in that area. In other words, the Housing Executive was using the definition of supported living being used by the Trusts and NIFHA (i.e. the 18 facilities built under the Supporting People programme), and not the wider definition used by the DHSSPS and DSD.

41. Faced with this evidence, the Department did admit that the lack of an agreed definition could result in these sorts of misunderstandings:
"We have not actually arrived at a new definition. As reflected by the difficulty that you found when you contacted the Larne Housing Executive, we are trying to work up a definition that everyone would agree on and understand" (Appendix 1).

42. The Committee is of the view that if local Housing Executive officers are defining supported living in a different way from the way in which DHSSPS and DSD define it, this can result in real difficulty for people trying to access services at a local level.

43. The Committee noted that during the evidence session on 11 June 2014, the two Departments described the 18 facilities built under the Supporting People programme and referred to by the Trusts and NIFHA as “supported living”, as “frail elderly schemes”. This term had not been used by the DHSSPS at all during the evidence session on 26 February, and yet on 11 June there were nine references to it during the session.

44. The Committee challenged the DHSSPS on whether it was attempting to re-label facilities which would have previously been referred to as “supported living” as “frail elderly” instead. The Department replied:

“We would consider "frail elderly" schemes to be one possible expression – for supported living” (Appendix 1).

45. The Committee then questioned the Department on how suitable the term “frail elderly” would be in terms of encouraging older people to move into facilities that were labelled in that way. DSD officials replied:
“It is an unfortunate term. It is common parlance in the housing world among housing professionals, but I take your point. We thought that Professor Tinker's definition of extra care housing was quite useful. We are talking about the same thing, but the terminology is probably unfortunate.”

46. The Committee observed that it appears that little real thought has yet been given to the appropriateness or otherwise of any definitions or terminology in relation to supported living. The Committee was surprised that both Departments would not have recognised that the term “frail elderly” was not particularly compatible with schemes intended to promote older people’s ability to live independently. Given the fact that there are significant voids in a small number of supported living facilities, and that the Trusts have advised that they are working hard to promote these facilities among the local communities, it seemed strange that the Departments were contemplating re-labelling these facilities as “frail elderly”. In the Committee’s view, such terminology is not likely to attract or encourage older people to avail of them. The Departments

did not seem to grasp that language and definitions are important in terms of the messages they communicate and impressions they convey.

Indicator of performance

47. Clarification on the definition of supported living is also important in relation to the "HSC (Indicators of Performance) Direction (NI) 2014" which sets out the key performance indicators which the HSC Board is required to measure during 2014/2015. A new indicator was produced for 2014/2015 which is: *"Number of older persons living in supported living facilities".*

48. The Department advised that an associated target has not yet been developed for this indicator, however full reporting on the indicator by the Trusts will be required by March 2015. Correspondence from the Department indicated that the definition of "supported living facilities" in relation to this indicator of performance was:
"Supporting People funds a range of housing related support services for vulnerable older people to improve their quality of life and attain independence. These services can be provided in their own homes, or in hostels, sheltered accommodation or other specialised housing support"
(Letter dated 3 April 2014, Appendix 3).

49. This would suggest that the indicator of performance covers older people living in a range of accommodation, and not just the 18 facilities built under the Supporting People programme. The Committee asked the HSC Board if it was clear what it was asking the Trusts to measure in terms of this indicator of performance. The HSC Board advised that the Trusts were only measuring the number of people in the 18 facilities:
"So, from our purposes when we are counting, and I know that it is just about how we count things, there is a clear difference in how we provide the care that leads us to separate out the 18 supported living arrangements under the performance indicator that we have from the Department from any domiciliary

care service that we might provide into sheltered accommodation. That is covered in our overall domiciliary care figures (Appendix 1)".

50. Therefore, it was clear to the Committee that what the Trusts were measuring as supported living places was not the same as the definition being used by the Department. While the HSC Board claimed that it was just technical issue in terms of how things are counted, the Committee concluded that the Department had agreed a performance indicator without firstly establishing that the HSC Board and the Trusts were clear on what was included within the term "supported living facilities". As it stands, the HSC Board is collecting information from the Trusts which is not in line with the Department's current definition of supported living facilities.

Findings and recommendations

51. The Committee concluded that it is very concerned about the lack of clarity around the definition of supported living. Furthermore, it appeared to the Committee that while the Department has committed to reviewing the definition, it did not fully acknowledge that different organisations are currently using different definitions and that this has an impact on service users.

52. The Committee noted that the Department intends to review the current definition to better reflect supported living in the context of Transforming Your Care. The Committee observed that perhaps this indicates that the role of supported living in terms of delivering better health outcomes for older people, as envisioned in Transforming Your Care, has not been fully thought through. This may explain why the Department was originally using a definition of supported living employed by the Northern Ireland Housing Executive.

53. **In relation to establishing a new definition for supported living, the Committee recommends that the Department consults with older people's representatives, including but not limited to, the Older People's Commissioner for Northern Ireland. The Department should also consult**

with NIFHA and other relevant stakeholders. The Committee recommends that the Department should <u>not</u> re-label supported living facilities as "frail elderly" schemes, given that the purpose of facilities is to promote older people's independence and support them with what they can do, rather than focusing on that which they cannot.

Awareness and promotion of supported living

54. As the Transforming Your Care Strategic Implementation Plan indicates, there is not a great deal of public awareness of supported living as a model of care for older people. The Plan states:
*"Community-based alternatives to residential care are increasing all the time, and there is **a need to ensure that the availability and functioning of these is more widely known so that people can see the different styles of independent living that it is now possible to offer to older people,** where the traditional response would have been to offer a residential placements" (Section 4.3.2 of the TYC Strategic Implementation Plan).*

55. The evidence obtained by the Committee supported the view that there is currently not a great deal of awareness of the concept of supported living among older people. Age NI stated:
"Very clearly, I think there is a greater awareness of fold and sheltered accommodation, but of the more specialist housing models, housing-with-care models, there is probably not huge awareness among older people" (Appendix 1).

56. The Commissioner for Older People in Northern Ireland conveyed a similar message:
"From listening mostly to older people, I know that they do not know what supported living is; that is my general sense. It is not just the Committee that is confused about the definitions. Older people are largely unaware of what the choices might be for supported living. Yet,

when I have gone to supported facilities and met the residents there, they very much welcome them. They like where they are living and enjoy the independence and freedom as well as the support and care. So, there is a lot of confidence that, when people live in supported living facilities, they are suitable. There is a lack of knowledge about them from the outside, and there is a paucity of comprehensive modelling about what level we should have" (Appendix 1).

57. The Northern Ireland Federation of Housing Associations (NIFHA) argued that more needed to be done to promote the concept of supported living both among older people and professionals. NIFHA suggested that a "supported living champion" was needed:
"We have to do much more collectively to educate professionals and the public about supported living and the other housing care and support options for older people. It is true that good efforts have been made to promote individual schemes, but I do not think that we have done enough collectively to promote the whole range of options available. To help to rectify that, we suggest the creation of a supported living champion and have included the outline proposal for that in our written submission to the Committee" (Appendix 1).

58. When the Department initially gave evidence to the Committee on 26 February 2014, it stated that older people became aware of supported living once they came into the "system" – either via the Housing Executive for those people already living in social housing, or via a social worker for those people who were having their health needs assessed. When the Committee suggested that a more pro-active approach was required to raising awareness of the option of supported living, an official from the HSC Board replied:
"Information about the availability of resources in any given area is on a trust website, for example. People can access that through the Housing Executive website. That type of information is available, but it does not mean that it is promoted on a daily basis" (Appendix 1).

59. A departmental official elaborated on this point:

"It is not about having a public awareness campaign on which we would spend tens of thousands of pounds on television advertising or something like that. It is about the relationship with the social worker, working with individuals and their family to assess need, establish circumstances and present some of the available options" (Appendix 1).

60. When the five HSC Trusts gave evidence to the Committee, they advised that they were putting substantial effort into promoting their supported living facilities. The South Eastern Trust stated:

"We have done a lot of publicising of Cedar Court, which is our new facility in Downpatrick. We have developed a DVD, which is being used widely in publicising the facility and what it can offer. That is on our trust website. The needs assessment that the professional undertakes with an individual is a one-to-one engagement, but, as well as that, we are doing all that we can to ensure that the wider public has an understanding of that as an option" (Appendix 1).

61. Similarly, the Belfast Trust stated:

"In Belfast, we have just opened Hemsworth Court on the Shankill Road, and it is in the process of becoming occupied. Belfast Trust has done a significant amount of work with our partner, Helm Housing, which has driven that. We have also produced a DVD and have done a lot of work with local community groups, local GPs, local older people's groups and local newspapers to try to get it out through word of mouth, because that is most effective" (Appendix 1).

62. Likewise, the Western Trust stated:

"For some of our areas where uptake has perhaps not been as good as we had anticipated, we have had open days, placed advertisements in the press and worked with the housing association to try to promote the use of the provision . . ."(Appendix 1).

63. The Committee noted the comments made by the HSC Board and the Trusts above, in which they suggested that they were actively promoting their supported living facilities, including displaying material on their websites. On 30 June 2014, the Committee examined the information available on the five Trusts' websites. It was disappointed to discover a number of gaps in the information provided. For example, the Belfast Trust had listed Hemsworth Court under the section for residential homes, rather than under the section for supported living. The South Eastern Trust had provided ample information on Cedar Court, but no information on the supported living facility in Lisburn. The Western and Southern Trusts had no information at all on their websites regarding their supported living facilities for older people. The Northern Trust was the only Trust which had supplied clear information on its two facilities. The Committee wrote to the Trusts, with the exception of the Northern Trust, to challenge them on the lack of information on their websites, and how this aligned with their assertion that they were actively promoting supported living. The responses are at Appendix 5.

64. When the Department gave evidence to the Committee for a second time on 11 June 2014, it had changed its position regarding the need to promote supported living for older people. Officials advised that they were attempting to secure funding for a project to pilot a supported living champion:
"I am aware of the federation's proposal for a champion for supported living, and, as I said in my opening statement, we have taken that into account, along with comments from our last appearance at the Committee, and we have now identified that as a proposal for which we are seeking funding. We are in the process of trying to negotiate funding across the range of projects that I outlined, one of which is to establish a champion for supported living who could take on that

broader role of publicising the option and benefits of supported living, both to the community and to other stakeholders" (Appendix 1).

65. The Department advised that the creation of a supported living champion was one of three projects which would cost around £500,000 in total to cover a 2-3 year period. The funding is expected to come from an independent trust and government departments.

Findings and recommendations

66. The Committee believes that more needs to be done to promote the concept of supported living for older people, both before and at the time people get to a point in their life when they may benefit from this model of care. If people do not have a prior awareness of the concept of supported living, they may be less likely to choose it as an option when their health begins to deteriorate.

67. The Committee is of the view that effective promotion is only possible when there is a clear definition of what exactly is being promoted. This points to the importance of establishing a clear and shared definition of supported living for older people.

68. The Committee welcomes the fact that during the course of the review the Department appeared to accept that more needs to be done in terms of promotion. However, the Committee is not convinced that the creation of a supported living champion is the best method of doing this. During the evidence session on 26 February 2014 departmental officials argued that promotion was not about spending "tens of thousands of pounds on television advertising or something like that". Yet by the 11 June 2014, departmental officials were proposing to spend £500,000 on a project, which will include the creation of a supported living champion as a pilot for two years. While obviously the

creation of a supported living champion would not cost £500,000, there is likely to be significant expenditure incurred, running into tens of thousands of pounds.

69. The Committee is of the view that the creation of a new role such as a "supported living" champion is not a good use of public money. The Committee believes that the HSC Trusts have a key role in terms of promoting supported living. It is not convinced that Trusts are approaching this task as effectively as they could be. The paucity of information available at a basic level on some of the Trusts' websites suggests that there is not enough focus on promoting supported living at a strategic level. Given the HSC Board's role in terms of performance managing the Trusts, the Committee believes that it should also have a greater focus on this issue.

70. **The Committee recommends that the HSC Board requires each of the five HSC Trusts to produce an action plan setting out their proposals for raising awareness of the concept of supported living for older people as a model of care, as well as proposals for better promoting the facilities within their area.**

71. **The Committee recommends that the Department does not proceed with its proposal to create a supported living champion, given the costs involved. The Committee believes promotion should be carried out by government departments and/or their relevant arms-length bodies, as part of their existing responsibilities in relation to supported living for older people.**

The existence of voids in supported living facilities

72. The Committee learned that while there are waiting lists for some supported living facilities, a number are currently carrying vacancies, which are commonly referred to as voids. The Northern Trust advised: *"There are three voids in the Brook, which is a very big complex that has a mixture of bungalows and other supported living. There are no voids at all in Barn Halt, and, in fact, there are six people on its waiting list" (Appendix 1).*

73. The South Eastern Trust stated:
". . . St Paul's Court is fully occupied. There is a waiting list of three for that facility. In Cedar Court in Downpatrick, which, as I mentioned, is a relatively new scheme, we have eight voids. However, there have been 24 admissions to the unit since it opened, so one reason for the voids relates to turnover . . . there will inevitably be some tenants who come into these facilities and then need to move on to a more dependent model, depending on their needs" (Appendix 1).

74. The Southern Trust advised:
"The capacity across the three schemes is for only 41 older people, and it is fairly limited. The schemes have a fairly low turnover, and, normally, we have waiting lists. At the minute, we are by default in a lucky position, because there are four spaces in the 41 units in the Southern Trust area" (Appendix 1).

75. Belfast Trust has four supported living facilities but did not provide information at the evidence session on the level of vacancies or waiting lists. Rather, it stated:
"In Belfast, we have just opened Hemsworth Court on the Shankill Road, and it is in the process of becoming occupied" (Appendix 1).

76. The Western Trust simply stated:
"We have found that we have had voids in some areas because the location is not sufficiently local for people" (Appendix 1).

77. The Trusts did not suggest to the Committee that the issue of voids was a source of particularly anxiety for them. However, when the Northern Ireland Federation of Housing Associations (NIFHA) gave evidence to the Committee, it painted a much bleaker picture in terms of the impact of voids. NIFHA advised that a number of facilities were carrying significant voids, and this in turn was having a serious financial impact on the housing associations who run those facilities. NIFHA referred to the Gnangara facility in the Western Trust where the voids have resulted in Fold Housing Association losing £1 million in revenue. NIFHA explained:
"There are probably pretty good rates of occupancy overall, but most schemes have at least one or two vacancies. A particular issue is that it often seems to take longer to fill the schemes than a housing association and its respective trust expected. That means that very good schemes, which everyone agrees are the right model, can take twice or three times as long to get up to their viable level. That means that housing associations are incurring very big losses from the outset, and those losses are not sustainable . . . The respective trusts in almost all the schemes are confident of achieving full occupancy eventually. However, in the 12, 18 or 24 months that it could take to achieve that, housing associations incur unbudgeted and unsustainable losses" (Appendix 1).

78. NIFHA stated that these financial losses act as a serious dis-incentive for housing associations to invest in further facilities, and a representative from Fold Housing Association advised that it had taken the following decision:

"We are not seeking to develop any further newbuilds for supported living at present because we have lost £1 million to one of our schemes in Enniskillen, which has challenged our board" (Appendix 1).

79. NIFHA suggested that these financial losses have had a wider impact on the sector:
"The experience of Fold — I think that Helm and Trinity have had similar issues in their supported living schemes for older people — means that housing association boards now have to be mindful of that as they consider whether they can take forward new schemes" (Appendix 1).

80. NIFHA suggested that some sort of risk-sharing arrangement was required in relation to the financial impact of voids:
"As these services really are delivered in a true partnership, there needs to be a fair sharing of risk for that partnership to be meaningful. Some flagship supported living schemes for older people are incurring major losses for housing associations, particularly because they have taken longer to populate than expected. Some assurances on revenue funding and voids are vital to enable that fair sharing of risk" (Appendix 1).

81. When the Committee took evidence from DHSSPS and DSD on 11 June 2014, both Departments acknowledged that the issue of voids was a serious one. The Departments advised that there are two out of the 18 schemes where voids are an issue – Gnangara in the Western Trust and Hemsworth Court in the Belfast Trust.

82. They advised that their respective Ministers had asked officials to explore the possibility of risk-sharing with the housing associations. DSD officials stated:

"There is a loss being sustained by housing associations in the period during which full occupancy is being achieved . . . Some associations are continuing to develop schemes, but more are becoming more cautious, because there is considerable risk involved. There needs to be some element of risk-sharing, and that is something that we are looking at" (Appendix 1).

83. However, officials from the DHSSPS introduced a note of caution to the idea of risk sharing:
"It is currently under discussion, but if we were to pay for those voids, that would be money that would otherwise be paying for the care of older people. We are keen to make sure that, when we spend money on the care of older people, it is delivering care for older people, as opposed to paying for a void" (Appendix 1).

84. The Departments advised that one of the elements of the research which they wish to undertake at a cost of £500,000 over a 2-3 year period is to review the two facilities which have experienced significant voids. DSD officials explained:
"One of the things we want to look at it in the piece of research . . . is to look specifically at Gnangara and Hemsworth Court to see what went well, what did not go well and what we can do to fix what did not go well. We are very aware of the problems" (Appendix 1).

Findings and recommendations

85. The Committee observed that the Western Trust and the Belfast Trust did not fully communicate to it the problems they were experiencing with voids in relation to Gnangara and Hemsworth Court. It was disappointed to learn through its own research that the Western Trust has no reference to the existence of Gnangara on its website, and that the Belfast Trust lists Hemsworth Court as a residential home on its website, rather than as a supported living facility. The Committee believes this is further evidence to

support its recommendation that the five HSC Trusts should be required to produce an action plan setting out their proposals for raising awareness of the concept of supported living for older people as model of care, as well as proposals for better promoting the facilities within their area.

86. The Committee welcomes the fact that DHSSPS and DSD are now holding discussions around the issue of risk sharing with the housing associations. It is of concern that housing associations may not invest in new builds and thereby limit the development of supported living as an option for older people. The Transforming Your Care Strategic Implementation Plan has a working assumption that the number of facilities will increase, and it is important that this vision is not jeopardised:
"Community-based alternatives to residential care are increasing all the time, and there is a need to ensure that the availability and functioning of these is more widely known so that people can see the different styles of independent living that it is now possible to offer to older people, where the traditional response would have been to offer a residential placements. ***Due to improved availability*** *of these types of community-based alternatives, it is expected that the demand for statutory residential homes will decline further" (Section 4.3.2 of the TYC Strategic Implementation Plan).*

87. **The Committee recommends that the potential of the Trusts to take on an element of risk sharing with the housing associations should be further explored. Risk sharing may in fact act as an added incentive for the Trusts to better promote their supported living facilities. The Committee also recommends that there is more joint planning between the Trusts and housing associations before decisions are made to commission new facilities.**

88. The Committee was surprised to learn that the Departments are planning to commission a bespoke piece of research in order to evaluate the two facilities which experienced significant voids. The Committee is of the view that this sort of work is normal government business and should be built into the post-project evaluation process. **The Committee recommends that the**

Departments should <u>not</u> commission researchers or consultants to evaluate and review Gnangara and Hemsworth Court, but rather this piece of work should be carried out by officials from the Departments and/or their arms-length bodies as part of their existing roles.

Target population for supported living

89. The Committee observed that different organisations appear to have different understandings as to what kinds of older people are suitable for supported living.

90. An Assembly research paper commissioned by the Committee referred to the consultation document published by DHSSPS and DSD in 2012 called – "Who Cares? The future of adult care and support in NI". It refers to supported housing as something which *"provides people with that little bit extra help and security, while at the same time enabling people to remain in a domestic environment as long as possible" (Appendix 1).*

91. The Northern Ireland Federation of Housing Associations described supported living as being an option for a *"significant proportion of our ageing population" (Appendix 1).*

92. The HSC Board provided the following picture of the types of older people suitable for supported living:
"In a nutshell, the people who are suitable are those who need care and support. Some of that is housing-based support to allow them to be able to live in their own accommodation, and some of it is care. I do not think that we have ever made any secret of the fact that the easiest correlation are those who would previously have gone into residential care . . . It is that cohort of people who cannot live, or chose not to live,

on their own for any longer and need a level of care and support. They do not need medical or nursing care (Appendix 1)".

93. However, the Trusts painted a different picture in terms of who supported living was aimed at. Belfast Trust stated that it was suitable for a very small percentage of older people, and referenced the fact that it was an expensive model of care:
"This model of care is very specialised. It is very expensive on the capital and revenue side, and it needs to be targeted at people who most need, and could most benefit from, the model. That is not something that would be open to every older person who wants to live in a community-type environment. So, from the Department's and the trusts' point of view, it is very targeted at those who would most benefit from it, because it is expensive for the state . . ." (Appendix 1).

94. When the Committee raised this issue with the Department on 11 June 2014, it stated that the Trusts were correct in asserting that supported living was suitable for a minority of older people. The Department stated:
"The majority of older people are fit, well, independent and active, and a significant number of older people are able to manage what limitations they have because of their health or through disabilities with minimal support. The people whom we consider to be suitable for the 18 schemes are not those people; they are people with significant care needs. That is a very small group of the overall over-65 population (Appendix 1)".

95. However, the Committee is of the view that there are differences in NIFHA, the HSC Board, the Trusts, and the Department's understanding of what kinds of older people are suitable for supported living. For example, the Department used the language of people with "significant care needs", whereas the HSC Board referred to older people who need "housing-based support" and a "level of care", but not "medical or nursing care".

Findings and recommendations

96. The Committee is concerned that there appears to be a lack of shared understanding between the housing associations, the HSC Board, the Department and the Trusts in terms of the types of older people suitable for supported living.

97. **The Committee recommends that the HSC Board reviews the criteria which the Trusts are using in terms of suggesting supported living as an option for an older person in the context of their needs assessment.**

Planning and projections for supported living facilities

98. One of the key issues which the Committee wished to explore within its review was the long-term projections for the need for supported living facilities, and the proposals to meet these needs. This was one of the subjects which the Committee initially discussed with the Department during the evidence session on 26 February 2014. The Committee was somewhat surprised when the Department did not have long-term projections, and did not seem to see a need for such projections. Officials advised:
"It is not a case of us having an exact view and saying that there must be x number of facilities. The important thing is that there is a choice, and supported living should form part of that choice . . . If you were to roll the clock back to 15 years ago, we could have given you a projection as to how many residential nursing home beds were going to be in place and how many people would be in them, because that was the only choice available. It is not as exact as that anymore . . . Particularly with the provision of domiciliary care and reablement services, a lot of people are choosing to carry on living in their own

home in circumstances that, 10 years ago, were not available to them. So, an increase in population does not clearly equate to a demand for certain types of provision . . . So, an increase in the population cannot simply be worked up into a ratio for increases of all these different types of care" (Appendix 1).

99. The Older People's Commissioner for Northern Ireland expressed concern that there did not seem to be any publically available departmental planning or modelling data for supported living. She argued that planning was essential in terms of appropriate provision of services for older people:
"I have not been able to access a comprehensive modelling of future need and demand with service delivery set against it, including workforce planning, allied services and buildings . . . Whether it is supported living, nursing care, domiciliary care, residential care, sheltered housing, supported living or assisted technology, the planning will fall out of the modelling of demand and need much more clearly. The exact detail of whether it is supported housing or sheltered housing is, in some regards, less significant than whether you are confident that you have in place the modelling that lets you know what our population looks like now and going forward: what does it want, and what does it need, based on what we know now; what do other international jurisdictions tell us is the likely pattern of demand . . .It is imperative that that is based on accurate projections of the need and the likely preferences and choices of today's and tomorrow's older people. Those should be transparent and publicly available" (Appendix 1).

100. The Older People's Commissioner also made the point that the planning that does exist appears to be short-term in nature:
"To date, I have not seen a comprehensive plan that outlines the need and future demand for supported living, particularly one outlining a variety of models, for a number of years ahead. Much of the planning

still seems to be quite short-term within the current short-term envelopes of money . . .” (Appendix 1).

101. The Northern Ireland Federation of Housing Associations similarly contended that there needed to be more long-term planning around supported living, beyond the 3-5 year cycle of budgets aligned to the Supporting People programme. NIFHA advised:
“In planning for the future, there is a pretty good working relationship between the Housing Executive, which administers Supporting People on the capital and revenue side, and the trusts in planning individual schemes. We are less good at working at a more strategic level, looking overall at the level, scale and type of housing care and support that will be required over the next five to 10 years and ensuring that we align our work at a more strategic policy and funding level” (Appendix 1).

102. The Committee raised the issue of long-term planning with the Department at the second evidence session on 11 June 2014. At this session, the Department appeared to have shifted its position slightly from 26 February, when their primary argument was that long-term modelling was not possible because of the range of choices now available to older people. On 11 June, the Department argued that long-term modelling was not desirable because there was too much risk in terms of creating over-capacity and potential voids.

103. The Department reasoned that the current planning structure used in the context of the Supporting People programme, whereby plans are made to build specific facilities in specific locations over a 3-5 year period, is sufficient.

104. The Department contended that the current approach was working well, given that there are not significant voids or waiting lists for the majority of facilities – in effect this was evidence that supply was matching demand.

105. In terms of need, the Department advised that under the Supporting People programme, seven more facilities to cater for 155 tenants will be built, to be opened within the next 3-5 years. However, the Committee challenged the Department as to whether the seven facilities with the 155 places in the pipeline represent what will be provided, as opposed to what is required based on need. The Committee also made the point that given that the majority of current facilities are at full occupancy, the creation of only seven new facilities may not really offer all older people a choice of moving into one. The Department advised that they need to plan for full or nearly full occupancy of facilities in order to make them financially viable, and added that people may have to wait a short time for a place to become available:
"You will sustain people in their own homes and plan for them to move into one of those dwellings or settings" (Appendix 1).

106. However, the Department could not provide figures on how many people were in this position and agreed to investigate this issue further. The Department subsequently wrote to the Committee to advise:
"The Department collects information on domiciliary care through an annual weekly survey. This survey provides key indicators including number of hours provided, the number of people supported by domiciliary care and the balance of provision between the statutory and independent sectors. However, the information collected by the survey does not enable the identification of specific individuals receiving domiciliary care in their own homes who could also be supported in supported living accommodation. The HSC Board has also confirmed that it does not hold this information" (Letter dated 25 June 2014, Appendix 3).

107. The Department's indicator of performance relating to supported living facilities for older people is also of relevance to the matter of planning and projections. The "HSC (Indicators of Performance) Direction (NI) 2014" sets out the key performance indicators which the HSC Board is required to measure during 2014/2015. A new indicator was produced for 2014/2015 which is:

"Number of older persons living in supported living facilities".

108. The Department advised that an associated target has not yet been developed for this indicator, however full reporting on the indicator by the Trusts will be required by March 2015. Officials provided the following rationale for the creation of an indicator without a corresponding target:
"The indicator that has been developed will give us a better idea of the number of places available and the number of people who are using supported living, and that would give us an indication, if we felt we needed a target, to create a sufficient marketplace of choice. Currently, we do not have a target . . . The issue for us with the indicator of performance is whether a central target established by the Department might be necessary to drive further expansion. That is something that we will consider when the indicator of performance starts reporting back to us with data" (Appendix 1).

109. The Committee was concerned with the Department's approach to the indicator of performance, and the lack of associated target. The Committee was not clear on how the Department would be able to differentiate between a "good" number of older people living in supported living facilities, as opposed to a "bad" number, and how these numbers would indicate either a "good" or "bad" performance by a Trust.

Findings and recommendations

110. The Committee is not convinced of the Department's logic in stating that long-term modelling of the number of older people who may require a place in a supported living facility is not required. The Department's argument that it is not possible to come up with such figures because older people have a greater choice of housing and care options does not stand up to scrutiny. The Committee believes that given the known projections around the ageing population, that it should be possible to work up projections around the

percentage of older people who could potentially choose or be suitable for supported living.

111. The Committee does not believe that the current approach of planning for individual facilities over a 3-5 year period is sufficient. It is of the view that a more long-term approach is required.

112. **The Committee recommends that the Department should begin forecasting the need and demand for supported living places over a 10 year period. These indicative forecasts should be kept under review, and reassessed when decisions are being taken to build new facilities.**

113. **The Committee recommends that the Department should begin collecting data on the number of older people supported in their own home through domiciliary care who would be suitable for supported living, in order to provide a fuller understanding of need and demand.**

114. **The Committee recommends that the Department reviews the current indicator of performance for older people living in supported living facilities for the Indicators of Performance Direction for 2015. The Committee recommends that a revised indicator should be produced with an associated target, which provides as assessment of the Trusts' performances in terms of their approach to supported living.**

Link between supported living places and statutory residential home places

115. The Transforming Your Care Strategic Implementation Plan states:

"Community-based alternatives to residential care are increasing all the time, and there is a need to ensure that the availability and functioning of these is more widely known so that people can see the different styles of independent living that it is now possible to offer to older

people, where the traditional response would have been to offer a residential placements. Due to improved availability of these types of community-based alternatives, it is expected that the ***demand for statutory residential homes will decline further****" (Section 4.3.2 of the TYC Strategic Implementation Plan).*

116. This statement suggested to the Committee that the Department's policy intention is to offer a place in a supported living facility, rather than a place in a residential home, to a greater number of older people going forward. The Department's reasoning appears to be that this would reduce the number of people moving into residential homes (statutory and independent sector), and this reduction would allow the Trusts to close more of their statutory residential homes.

117. The Committee questioned the Trusts about the links between supported living places and residential home places. Specifically, the Trusts were asked how many people they expected to place in a supported living facility over the next 3 years, who previously would have been placed in a residential home. However, none of the Trusts could provide even an indicative figure. The Belfast Trust elaborated further on the links between supported living and residential homes:
"The provision of supported housing is a relatively new phenomenon in the system, and I think that it would benefit from formal evaluation and some strategic thinking about what is needed in the future and how much it would replace high-end accommodation and care, that is, nursing and residential care. However, that is, I think, an unknown to most of us at the moment" (Appendix 1).

118. This suggested to the Committee that the Trusts were of the view that the strategic thinking on whether or how supported living could replace residential care has not yet been undertaken. The Committee were concerned to learn this, given the policy direction set out in the Transforming Your Care Strategic Implementation Plan.

119. When the Committee raised this issue with the Older People's Commissioner, she was of the view that the availability of supported living will not necessarily reduce the need for residential places because the overall population of older people is increasing:
"Supported living options, and whatever their future developments, will not necessarily reduce the need for domiciliary, residential or nursing care because the overall population rise and the overall demand for Health and Social Care support will be significant as our population ages" (Appendix 1).

120. During the evidence session with the Department and the HSC Board on 11 June 2014, the HSC Board stated that TYC was not making an explicit link between the need for supported living facilities and the need for statutory residential homes. The Board stated that the reference to "community based alternatives to residential care" was much broader than supported living facilities:
"I suppose that what we are talking about in TYC is not just supported living, but a range of ways in which people can be supported in the future. We know that we have had a 5% decrease in demand for residential care across all sectors, whether statutory or independent . . . Seán referenced our ability through intermediate care and intensive domiciliary support to maintain people at home for a lot longer; so, in itself, it is not supported living that is making that shift, it is a range of things that has meant that the demand for residential care overall has gone down" (Appendix 1).

121. While the Committee noted the HSC Board's explanation, it took the view that to describe domiciliary care as a "different style of independent living" was not a convincing argument.

Findings and recommendations

122. The Committee is not convinced that the Transforming Your Care Strategic Implementation Plan sets out a coherent or clear policy direction in terms of the relationship between supported living facilities and statutory residential homes.

123. **The Committee recommends that the Department clarifies its strategic position on the links between the availability of supported living places for older people and the availability of places within statutory residential homes.**

Models of best practice from other countries/regions

124. The Committee obtained information on a range of housing models aimed at supporting older people to retain their independence by means of two Assembly research papers (Appendix 4). It also took evidence from Professor Tinker from king's College London who briefed the Committee on a range of international research (Appendix 1).

125. The Committee also visited the Pavillions in Lisburn, where there is a proposal by a private sector developer to pilot a model which will incorporate housing and care (Appendix 6).

126. The Older People's Commissioner advised the Committee that in terms of planning for supported living provision, it is important to examine models operated in other places:
"Any planning and modelling must involve older people, but not only today's older people; it must involve looking at what some younger people think that they will want in the future. It also has to look at evidence in this jurisdiction and internationally on the trends. It must look critically at why something did not work as well as what did work: why what seemed like a really good idea at the time did not work that well" (Appendix 1).

127. During the evidence session with DHSSPS and DSD on 11 June 2014, DSD officials advised that they had commissioned a range of research looking at international experiences of supported living. Part of that research examined best practice in terms of design standards and the use of assistive technology. DSD officials informed the Committee that the Northern Ireland Housing Executive has also done research on the concept of retirement villages, and that there have been recent discussions with private developers and voluntary organisations regarding a proposal for a retirement village in Northern Ireland.

128. However, the Committee noted that neither Department volunteered any research or benchmarking which has been done in terms of the health outcomes associated with supported living models. The Committee's research papers had flagged up the links between health and housing, and this was an issue which Age NI raised with the Committee:
"In order to live at home, and for home to be the hub of care, people need a decent suitable home in which to live. We believe this aspect receives little or scant attention in public policy. . . May of the chronic conditions experienced by older people have a causal link to, or are exacerbated by, particular housing conditions . . . The interface between housing and health is one of the areas that we have to see coming through in policy planning and service planning" (Appendix 1).

Findings and recommendations

129. The Committee observed that in terms of learning from other countries and regions, the focus to date appears to be around design and the use of assistive technology. While this work is welcome, the Committee is of the view that more emphasis should be placed on how supported living models can keep older people healthy and well.

130. **The Committee recommends that in terms of implementing Transforming Your Care, DHSSPS and DSD work closely in terms of**

developing housing options for older people which will have the best health outcomes for older people, based on the evidence available.

Appendix 1

Minutes of Evidence

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	Mr Kevin Keenan	**HSC Board**	
	Ms Pamela McCreedy	**HSC Board**	
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	Mrs Melanie McClements	**Southern HSC Trust**	
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	Mr Michael Sweeney	**DHSSPS**	
	Mrs Fionnuala McAndrew	**HSC Board**	
	Mr Brian O'Kane	**NIHE**	

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Transforming Your Care and Older People: DHSSPS and Health and Social Care Board

26 February 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Transforming Your Care and Older People: DHSSPS and Health and Social Care Board

26 February 2014

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Mr Seán Holland	Department of Health, Social Services and Public Safety
Mr Dean Looney	Department of Health, Social Services and Public Safety
Mr Kevin Keenan	Health and Social Care Board
Ms Pamela McCreedy	Health and Social Care Board

The Chairperson: You are all very welcome. We have Seán Holland, deputy secretary of the Department's social services policy group; Mr Dean Looney, from the community care directive at the Department; Pamela McCreedy, director of Transforming Your Care (TYC) at the Health and Social Care Board (HSCB); and Kevin Keenan, assistant director of social services, older people and adults at the Health and Social Care Board.

This is the Committee's first evidence session on the review of supported living, which is obviously specifically for older people, in the wider context of Transforming Your Care. Our purpose today is to gather the facts and figures around the Department's approach to supported living. I ask you to keep your answers concise and to try to keep on the topic of supported living, because we do not want to engage in a general discussion around this today. We will have an opportunity to come back to this. We are keen to get to the facts and figures. As you know well, it is a 10-minute presentation, and then it will be opened up to members. I assume that you are leading, Seán.

Mr Seán Holland (Department of Health, Social Services and Public Safety): Absolutely, Chair. I will try to take those comments on board and whizz through an opening statement. First, thanks, as always, to the Committee for giving us this opportunity to speak to you regarding older people in supported living.

You mentioned facts, so I will start with a few facts. Older people in Northern Ireland receive care and support from a broad range of social care services, including residential care, nursing home care and

domiciliary care. Since 2008, the number of residential care home packages for older people has decreased by 5%; the number of nursing home packages has increased by 7%; and the number of people receiving domiciliary care has increased by 10%. That obviously has to be viewed in the context of the changes in demographics. Northern Ireland, like the rest of the UK, has an ageing population. People are living longer. A point that the Committee has previously made about that is that it is of course something to be celebrated, but it is significant in respect of planning.

By 2022, we estimate that the population will rise by 11%, and that, within that, the number of people aged over 65 will increase by approximately 26%. That represents 344,000 people. The most significant figure in the demographic is probably those whom we call the "old old" — those over 85. That is anticipated to increase by 50%. Obviously, as I said, that is something to be celebrated. I will not dwell on it, but I think that it is important that we set the context that having an older population is something that enriches our community and adds to life in many ways, but it presents challenges in providing services.

Rates of ill health and disability increase dramatically the older we get. The rate of disability amongst those over 85 is 67%, compared with only 5% amongst young adults. Dementia, of course, is one of the most significant issues with an older population growing. It is projected that 60,000 people will be suffering from the condition by 2051. In addition, the profile of older people requiring recurring care is becoming more complex, with many people now living with chronic conditions.

Within that context, 'Transforming Your Care: Vision to Action' sets out a number of service changes that are proposed. They are aimed at promoting independence and reducing reliance on traditional institutional care. They include the likes of fall-prevention programmes, reablement programmes, which promote rehabilitation in independence — I know the Committee has heard about that — and the use of telehealth and telecare programmes for remote monitoring.

As set out in the paper that we provided, supported living provides an environment for people who cannot live independently in their own home but who may not yet require the additional support of residential nursing home care. The Supporting People programme helps fund supported living in Northern Ireland. DSD, the Housing Executive and Health and Social Care all play an important role in the provision of supported living for older people.

The Supporting People commissioning body is chaired by the Housing Executive but includes representation from the board, the Regulation and Quality Improvement Authority (RQIA) and two Departments: DSD and DHSSPS. The commissioning body assesses and prioritises proposals for supported living developments. Those proposals are generated by five area Supporting People partnerships: northern; southern; western; Belfast; and south eastern. All of those include representation from the relevant trusts.

Once a commissioning body approves the scheme, a housing association is selected to take forward the development. While DSD commits capital funding for development and revenue funding for housing with support services, such as befriending services or help with security, Health and Social Care provides the funding for personal care and support to tenants on the basis of their assessed needs.

The paper we provided sets out the number of supported living facilities and tenancies for older people: 414 facilities covering some 9,081 tenancies. Those represent just over 14% of the overall Supporting People budget and just under 60% of supported living units. Obviously, other groups that utilise supported living include those with learning disabilities, people with mental health needs and those with physical disabilities.

At this point, the Department has not established a specific target for supported living for older people. However, an indicator of performance to measure the number of older people living in supported living facilities has been established for the first time within the set of performance indicators that HSC uses. Primarily, our objective is to offer choice to older people. Choice means a range of different options, and supported living needs to be one of those options.

Supported living is provided in the context of a range of other services. I will briefly cover some of them. Domiciliary care, which I mentioned, was provided to over 25,000 over the course of a survey week in September 2013. The regional social care procurement group has initiated a project that will undertake a regional audit of domiciliary care.

Reablement services, which I also mentioned, aim to maximise a person's capacity for independent living by supporting and enabling people to do things independently rather than simply doing things for people and fostering long-term reliance on care and support. Reablement has been rolled out in three of the five trusts, and plans are in place for a full roll-out across the region.

Self-directed support aims to give service users even greater choice and control over how their needs are met. As a first step, it is intended that, by March 2015, 100% of those who are eligible for an adult social care service will be made aware of the amount of money that has been set aside to meet their needs.

Assistive technology also plays a role, and Northern Ireland has been recognised by the European innovation partnership as one of the leading regions in Europe for addressing the health and social care needs of the older population through innovation. For example, the telemonitoring service referred to in the briefing paper provided over 274,000 telehealth-monitored patient days and 432,000 telecare-monitored patient days in the first eight months of this financial year.

Housing adaptations are also significant, and DHSSPS and DSD have worked collaboratively on the issue for many years. They produced a review report, which was consulted on from February to May last year. The review report's recommendations, which include closer working and more creative approaches to adaptation, have been welcomed in the consultation, and officials are drafting a final report and an associated action plan to take forward the recommendations.

Members will be aware that the strategic implementation plan for TYC indicates that the effect of this broad range of community-based alternatives to residential care will most likely lead to a decline in the demand for places in residential care. To that end, the HSC Board has published a programme initiation document on improving services for older people, which involves a new process for consulting, engaging and implementing change. That was published on 21 August.

The first of two public consultations is under way. It relates to the HSC Board's consultation document 'Making Choices: Meeting the current and future accommodation needs of older people'. It recognises that, in some circumstances, it may be better to develop a new supported living facility rather than making piecemeal changes to statutory residential homes. That consultation document sets out four criteria that are proposed will be used to assess the future role and viability of individual statutory residential homes. The Committee is well aware of the detail of that, so I will not go through each of them. The consultation runs until 7 March 2014. At the end of the consultation, it is hoped to agree final criteria that may be used in future exercises to determine the viability of individual specific homes.

In closing, it is fair to say that supported living has a role to play in enabling the implementation of service reform proposals. It is an important alternative service to residential care for some people while, for others, different community-based alternatives such as reablement may be more appropriate. However, it is important to stress that assessed need and service-user choice have to remain the key determinants of how and where care supports are met.

The Chairperson: Thank you, Seán. As I said, we want to focus specifically on the supported living issue. If I picked you up right, you said that there are now performance indicators in the Health and Social Care Board.

Mr Holland: They are being developed, yes.

The Chairperson: You said that there was no target yet for supported housing. Why is that?

Mr Holland: The first thing to say is that we do not believe that older people should necessarily live in any one particular setting. The important thing is that people have choice, and that, combined with an assessed need, should determine where they live. It is not a case of us having an exact view and saying that there must be x number of facilities. The important thing is that there is choice, and supported living should form part of that choice. The indicator that has been developed will give us a better idea of the number of places available and the number of people who are using supported living, and that would give us an indication, if we felt that we needed a target, to create a sufficient marketplace of choice. Currently, we do not have a target.

The Chairperson: I do not think that anybody would have any difficulty with choice, or should not have any difficulty with choice. However, we know the demographics, and we know that there is an ageing population. You have given us the figures for up to 2020 and the percentage of the population

that will be over 80 at that stage. So, we know the projected forecast. Why, therefore, are we not setting targets that address the need?

Mr Holland: It is difficult to set a target for choices that people will make in the future because you do not know what choices people will make, which is one issue. It may well be that we will set targets if the current exercise indicates that there is not sufficient provision. Equally, you do not want to have overcapacity. These facilities are increasingly bespoke and designed to meet particular needs. You certainly do not want to have a target that is driving you to build facilities that people may not choose to live in.

I will offer this to my colleagues to see whether they have anything more to add about the process.

Mr Kevin Keenan (Health and Social Care Board): Supported housing is only one of the options that we need to develop to meet the needs of older people in the future. It is not the only option available to us. With regard to numbers and targets, we work very closely with the DSD on the three-year funding cycle. We had many meetings with it at the beginning of the current cycle, and it asked us what we wanted to develop across a range of programmes of care. We jointly made the submission to the Department for the funding. The current target that the DSD side of the house is working to is somewhere in the region of 850 units, but that covers a range of programmes and geographies. We are on target to achieve probably 650 to 700 of those.

The Chairperson: First, I think there is an issue about how many of those are for older people. Do you have a figure for that?

Mr Keenan: Most of the proposals that we put forward in the funding cycle that I am talking about were linked to existing residential provision. Most of the projects on which we have worked closely with DSD and the Housing Executive have concerned re-providing statutory residential facilities around the country. I think that 10 homes have closed over the past five years. To date, the majority of those have been re-provided for by supported housing facilities.

The Chairperson: We are not honestly saying that, of the 414 facilities with, I think, 10,000 tenancies, what we have across the North is anywhere near addressing the need. I go back to Seán's point about choice. Of course there should be choice; that is a must. However, there is clearly an identified need here. What ratio is being applied to forecasting the elderly population? There does not seem to be one.

Mr Holland: I am not sure that those numbers necessarily indicate that we have a current deficit in provision. I am not aware of significant numbers of people wanting to live in supported living arrangements and not being able to avail themselves of them because of a lack of capacity.

The Chairperson: I am sorry, Seán, but my point is that you do not need to be a statistician to work it out. With such an increase in our ageing population over the coming years, and we have 414 facilities, surely that is not —

Mr Holland: Not necessarily. I will ask colleagues to come in in a moment, but I think that older people's expectations of where and how they lead their life are changing fairly significantly. Particularly with the provision of domiciliary care and reablement services, a lot of people are choosing to carry on living in their own home in circumstances that, 10 years ago, were not available to them. So, an increase in population does not clearly equate to a demand for certain types of provision. Pamela, would you like to come in?

Ms Pamela McCreedy (Health and Social Care Board): That is exactly the point that I was going to make. There has been a significant increase of investment in domiciliary care. I am sure that you find that, when you are out in public, that is what they voice. In the main, they want to stay at home. It takes you into different fields of supported living, whereby people have individual needs that it helps them meet in a more robust way than would be the case in their own home. As we know, it is a continuum. That is where the residential care/nursing home care element comes in. However, there has been significant change in investment in domiciliary care over the past couple of years. So —

The Chairperson: With respect, I think that is a separate issue. There is a big issue there around investment in domiciliary care and adopting a regional approach to how some of the domiciliary care packages are agreed. We need to park that. We are talking specifically about the facts and figures

around supported living. To come at this slightly differently: the implementation plan for Transforming Your Care talked about improved availability of supported living places. In his opening comments, Seán said that the demand for residential care places will decrease. Can you quantify that expected shift?

Mr Holland: I referred to the most recent decline in demand for residential places. It is important to realise that, although I mentioned a range of services, it does not equate to a journey that one individual older person will make through those services. So, for example, one older person may choose to stay at home until they go into a nursing home, whereas another older person in similar circumstances will make the choice to bridge those journeys by going into supported living. Or, indeed, it may not be a bridge and they may end their days in supported living. So, an increase in the population cannot simply be worked up into a ratio for increases of all these different types of care. The important point is that we have a range available and people are able to make choices. If we discover that people are not able to make a particular choice because of a shortage of provision, a target, at that point, comes into play and you stimulate the market in one way or another to make sure that that gap is filled. At the moment, though, that is certainly not the situation; demand for supported living is not outstripping supply.

The Chairperson: Seán, I am trying to ascertain here what seems to me to be a presumption around the notion that a decrease in demand for residential care is a view. I am not hearing anything scientific. The TYC implementation plan said:

> *"Due to improved availability of community-based alternatives, it is expected that demand for statutory residential homes will further decline."*

Can you quantify that expected shift?

Mr Keenan: We work very closely with the Housing Executive under the auspices of the Supporting People programme. We have a planned programme of developments across all of the programmes of care on a rolling three-year basis. As things stand, there are six proposals in the pipeline for older-people developments, amounting to 155 placements. Those are based on submissions that come to the commissioning body from the trusts. They are based on business plans, and those business plans are interrogated by us to make sure that they are based on assessed need.

The Chairperson: I appreciate that, because we are getting facts and figures. You said 150 —

Mr Keenan: The six concrete proposals that we have been considering at the commissioning body amount to about 155 places. There are a couple of other slightly more tentative proposals that have not quite reached business case yet or have not been approved.

The Chairperson: I appreciate that. Page 18 of your document talked about the number of intended developments. Where are the intended developments? What stage are they at? Where will they be located? How will they be funded? Is that the 155?

Mr Keenan: Yes.

The Chairperson: So, they are at various stages of business planning.

Mr Keenan: They are at various stages, yes.

The Chairperson: I assume that they are site specific?

Mr Keenan: Yes.

The Chairperson: Therefore, some ratio is being applied around the needs of the increasing elderly population.

Mr Dean Looney (Department of Health, Social Services and Public Safety): At this point in the process, the demand is considered at a local level through the area Supporting People partnerships. The issue for us with the indicator of performance is whether a central target established by the

Department might be necessary to drive further expansion. That is something that we will consider when the indicator of performance starts reporting back to us with data.

The Chairperson: Finally — I know that a number of members have indicated that they have questions — as this develops, it would be very useful to have the specifics around those 155 places. We are accepting that they are at various stages of their business cases and planning. However, the Committee would seek to be informed as that process develops.

Mr Holland: We can get that information from the commissioning body and supply it to you.

Mr Brady: Thank you for the presentation. Seán, you said that the fact that people are living longer is to be celebrated, and that is certainly true for older people. However, that goes hand in hand with a quality of life and an expectation that people will have an enhanced quality of life rather than having to go into residential care. Our research people have told us that the Supporting People budget was £8·9 million for 2012-13. Could you give us some idea of what it was in 2013-14 through to 2016? It would not seem unreasonable to assume that, if you are going to put in place a situation where people want to remain at home, the budget should increase. That does not seem unreasonable in the circumstances.

I sit on the Social Development Committee, so I am aware that there is not as close a working relationship as you have pointed out. For instance, it is not that long since the Minister for Social Development stood up in the Assembly and admitted that he had failed to reach his Supporting People housing targets. To date, and we are not even at the end of the financial year, almost £70 million has been handed back. That includes maintenance etc. You could build a lot of supported housing and a lot of social housing for £70 million. There seems to be a disconnect there. I am not sure how close the interdepartmental relationship is. Sitting on both Committees, it seems to me that it is not obvious, and that is my point.

With regard to the budget, it would be useful to find that out. DSD is very heavily involved — I will qualify that by saying that it should be very heavily involved — in building houses. You mentioned choices and said that people would make the choice to stay at home; but, if a lot of older people knew what was in store for them with the infrastructure that is provided, they may well make other choices. In my experience — I deal with it daily, and I am sure that we all do at a constituency level — the infrastructure and the support is simply not there. I have been dealing with people for a long time. We have been through Customer First and all of that, and the bottom line is that it is all about money. That needs to be addressed, the systems need to be addressed, and proper procedures and proper infrastructure need to be put in place.

To me, it is a great principle that people should remain at home, and most people want to do that, but they can only do that if there is a proper and supportive infrastructure to ensure not only that they can stay at home but that their quality of life in doing that is enhanced as they grow older. It has been admitted on many occasions that people are living longer, because of modern medicines and all of that, but not necessarily more healthily. People need to be treated as people and not as commodities. Unfortunately, we have moved away from treating people as human beings and to treating them as commodities, because you can now make money out of them if they live in residential care in the private sector. That is just a personal observation over many years, and I think that that is something that needs to be addressed. However, it would be helpful if we could get the budgets through, because £8·9 million is not really that much in the scheme of things.

Mr Holland: Specifically, what budget figures are you looking for, Mickey, because we can supply you with —

Mr Brady: The Supporting People budget for older people. That spend was £8·9 million —

Mr Holland: That is the Housing Executive's Supporting People budget.

Mr Brady: That is the figure that we got from our research people, and that is for 2012-13, so I am looking for figures for 2013-14, 2014-15 and 2015-16, if that is possible. I am sure that it is.

Mr Holland: It is a Housing Executive budget, but we can certainly get that information for you.

Mr Brady: Again, with this close working relationship, it should not be any problem.

The Chairperson: I want to come in to clarify on that. The briefing paper that we have states that, in 2012-13, the trust spent £3·7 million on providing support in supported living settings. Was that all older people in supported living?

Mr Looney: Yes, it is.

The Chairperson: So, is that £3·7 million out of the overall £8·9 million?

Mr Looney: No, that is in addition. The £8·9 million is separate; it is the Housing Executive's funding that goes into supported living. The £3·7 million is from health and social care trusts.

The Chairperson: I am sorry, Mickey, thank you for letting me come in on this. I think that it is important. The trusts spent £3·7 million in 2012-13 on older people in supported living. Is that accurate?

Mr Looney: They did, yes.

The Chairperson: OK. Do we have an expected spend for 2013-14?

Mr Looney: I do not have those figures to hand, but I can check them with finance colleagues when we return to the Department. I should also say that the expenditure on supported living for older people is not reported in the same way by each trust, so £3·7 million represents the expenditure of some trusts. Some trusts report the expenditure on supported living through their domiciliary care budget, and that is why, I think, your research paper also refers to expenditure on domiciliary care for older people, which is around £160 million.

The Chairperson: With respect, I find it difficult that we cannot get access to the budget and projected budget when we are having an evidence session on supported living.

Mr Looney: As I said, we can check that for you with finance colleagues when we return.

The Chairperson: Seán, is that not something that the Department should bring to us?

Mr Holland: I apologise if you feel that we have not brought you information that you required. We have given you the budget that we have spent. It is, as my colleague said, a budget that is made up of different components. There is the personal social care component, which the HSC provides. There is also the Housing Executive budget, which itself has different components. There is both a capital and a housing support component. If you want us to supply projected figures, we can certainly go back and bring those to you.

The Chairperson: We need to get clarity on the £3·7 million, because we are now hearing that it goes through different trusts differently and it might be part of the domiciliary care package. We are talking specifically about supported living here, so I think that we need to get a breakdown of that and clarification on whether that is all for older people in supported living. As Mickey Brady has asked, how much do we expect to spend this year and next on supported living? If we can get that information, it would be very useful.

Mr Brady: Is the figure of £8·9 million, which we got from our research people, just for supported housing?

Mr Looney: That is my understanding of it, yes.

Mr Brady: Yet we have been told by the Minister for Social Development that the targets have not been reached. Is that something that there is a discussion about?

Mr Holland: Yes.

Mr Brady: Can we be assured that targets will be reached next year or the year after? This is supported housing, which is, obviously, separate from social housing, which is a huge issue in its own right. Again, targets are failing to be met there. I assume that the £8·9 million was not used, or that only part of it was used, if they failed to reach the supported housing targets.

Mr Keenan: As you have suggested, the development of this model of care depends on different funding streams coming from two Departments: DSD and DHSSPS. Both of those Departments are very clear about what they have currently invested in supported housing. Our contribution at this point in time is £3·7 million. If the projects that I have told you about come to fruition, we have business cases and projected costs in there. If and when those facilities are built and funded from the housing side of the house, the trust will be providing the resources and the money to make sure that the care costs are met.

Mr McKinney: What are your projections?

Mr Keenan: We do not know exactly when all of these facilities are going to open.

Mr McKinney: But you should have a ceiling projection vis-à-vis the concept of them, surely.

Mr Keenan: Yes, we will.

Mr McKinney: What is it?

Mr Keenan: I do not have the figures from the composite business cases here.

Mr McKinney: In broad generality, is it a 10% figure? Is it a 20% figure? What is it?

Mr Keenan: Sorry, a 10% —

Mr McKinney: Increase.

Mr Keenan: Increase on the £3·7 million?

Mr McKinney: Yes, generally. Give us a ballpark even.

Mr Keenan: I think that there could be a couple of facilities open in the next 12 months. That is what we have got in front of us. I am not going to give you a percentage or a figure today on what that might add to the Health and Social Care budget, because I would not be confident about standing over it. We can go and find out for you, but I am not able to give you a figure here today.

Mr Holland: I reiterate my apology to the Chair that we do not have information that you were hoping to have today. We will endeavour to get that to you as quickly as possible in written response.

The Chairperson: Go ahead, Fearghal.

Mr McKinney: No, I will leave it until I see how the rest of the evidence proceeds.

Mr Beggs: Earlier, the point was made about choices. My experience is that supported living accommodation, where there is a mixture of Health Department and DSD support, is full. There are vacancies in sheltered housing, but what is commonly known as supported housing, where there is a bit more supervision, is full. As they are full, how is there choice? Furthermore, there is the proposed closure of the limited supported housing that there is in certain areas, such as Lisgarel in Larne. It is proposed that that be closed, without any proposal for replacement, so there will be no choice. How do you say that there is a choice?

Mr Holland: There are vacancies in some supported living facilities, and they are available to be filled. With regard to the planning for any local area, I go back, again, to the process that Kevin described. There is a commissioning process in each of the health and social care trust areas, and it identifies the need and commissions and develops schemes accordingly.

Mr Keenan: Two new schemes have opened in the past, I think, 12 months. There is one in Belfast and one in the South Eastern Trust. They are state-of-the-art facilities. They are taking a little bit of time to fill up, but you do not move 30 people into a new facility in one day. There is a planning and transition process, and the trusts are very confident that they will fill those facilities in due course.

As regards your geography — I know that you are preoccupied with Larne and the needs of the good people of Larne — we have been down to Lisgarel to talk to the people, their carers and their relatives. There are no plans currently in place for any supported housing developments in the Larne council area.

Mr Beggs: Are there other areas in which there is, similarly, no choice for supported living?

Mr Keenan: I have told you that there are six proposals in the pipeline and that there are four tentative proposals. Those are all significant developments. There are somewhere in the region of 28 to 30 places. It takes time. There is a lot of planning involved, and it is an extraordinarily complex process. We are not developing homes in every council area at the one time. This has to be a planned process over a period. It is a rolling programme.

Of the last two that opened, as I said, one is in Belfast and the other in the South Eastern Trust. We would like to think that the next geography that may benefit from a good supported housing development could possibly be the Northern Trust. However, we cannot move on all fronts at the same time.

Mr McCarthy: You will be glad to know that I am after more figures and facts. If the Committee is to do its job right, it needs to have precise figures. Those are what we are hoping that you will be able to provide. Indeed, we need to see evidence that the Department has concrete projections for how many tenancies are needed in the future.

Your paper refers to 414 facilities for older people and nearly 10,000 tenancies. I think, you said a few minutes ago, Seán, that there are unoccupied places at your facilities. If so, how many? Would you know?

Mr Holland: No, I do not have the exact figures for the voids.

Mr Looney: We are aware that housing associations have concerns about voids in their portfolio of properties. The housing associations' view would be that they are not sitting at 100% occupancy.

Mr McCarthy: You did say, Seán, that there are unoccupied places.

Mr Holland: There are some, yes.

Mr McCarthy: Can you get those figures for the Committee?

Mr Holland: We can approach the Housing Executive. It is important to realise that these are not Health and Social Care facilities. They are owned by housing associations and their building was funded by the Housing Executive. We can certainly request the information, but these are not things that we directly run.

Mr McCarthy: What is the rate of turnover of places in supported living facilities? Can you give us a figure there?

Mr Looney: That is something that we would also have to check with the Housing Executive.

Mr McCarthy: How many tenancies does the Department intend to create for older people over the next three years? I think that you disappointed us by saying that you had no target.

Mr Holland: I think that Kevin has already addressed that.

Mr Keenan: But that is not to say that that figure cannot be added to as more business cases come through the system or as need is identified at local level. This is not a static programme. This is not the last figure that we could offer up.

Mr McCarthy: In 10 years' time, how many older people would the Department wish to see housed in supported living?

Mr Holland: I would have to come back to my starting point: that depends on how many people want to live in supported living. It is not for us to tell people where they are going to live.

Mr McCarthy: Is that why you said in your introduction that you did not have targets for that?

Mr Holland: Yes.

Mr McCarthy: You do not have targets because you do not know what the choice will be at that time. Is there no way that that can be looked at? That is something that the Committee really needs to find out.

Mr Holland: That is why we are looking at the indicator to get a baseline as to how many people are making that choice, but, ultimately, it is an individual choice. If you were to roll the clock back to 15 years ago, we could have given you a projection as to how many residential nursing home beds were going to be in place and how many people would be in them, because that was the only choice available. It is not as exact as that any more.

Mr Beggs: In your paper, you mention the 414 facilities for older people and nearly 10,000 tenancies. How many facilities is the Department of Health involved in, and how many tenancies are you involved in? There is sheltered housing that is just the Housing Executive, but how many involve the Department of Health in supporting people?

Mr Holland: The indicator that we propose will assist us in giving you that exact answer. We do not have the exact answer at the moment. That is one of the reasons for the development of the new indicator.

Mr Beggs: I am astonished that the Department of Health does not know how many supported living accommodations it is contributing towards and the number of tenancies.

The Chairperson: I share that view. The Department was very quick to make calculations on residential care, for example, and to target the closure of 50% of residential care facilities. Thankfully, that is not now a reality and a proper consultation is taking place. However, if that had been a reality, where would those people be expected to go if you are saying that you do not have targets? How do you calculate 155 places as fitting a need, if we are serious about enabling people to stay at home or to live in supported housing? I find it irregular that the Department cannot give us those statistics.

Mr Holland: In relation to the closure of statutory residential care homes, it was not a target; it was thought that possibly up to 50% of statutory homes may close. Each home has to be considered on its own merits. The criteria that are currently being developed to assess whether any individual home will or will not close include the availability of alternative provision in the area. So, at a local level, it is proposed to be done on a planned basis. Currently, not a single home has closed or will close.

The Chairperson: I do not want to open the debate on residential care, but, with respect, Seán, 50% was in black and white.

Mr Holland: What was in black and white was "up to 50%".

The Chairperson: I think that the rest of the world, looking on, would say that that is a target. It was not just something that somebody decided to put on paper for no reason. Let us park that, because there are a number of members who want to speak.

Mr Beggs: With the mix of provision in the Supporting People programme, there could be a variety of providers, including statutory housing associations and, indeed, the voluntary sector. Which sector does the Department see as having the most potential to provide increased capacity in the near future?

Mr Holland: On future developments, again, I look to Kevin, who is involved in the commissioning. He can identify the people who have been identified to bring forward proposals.

Mr Keenan: Most of the facilities for older people in Northern Ireland are developed collaboratively, as I said earlier. It is usually the housing association that provides the bricks and mortar, and, in most of

the older people's developments, the trust provides the staffing, although the new Moylinney development in east Antrim may involve a voluntary sector provider.

Mr Beggs: What are the advantages and disadvantages of each different mix? If you are always going for the housing associations, what advantage do you see them having over others? What other options have you considered for staffing?

Mr Keenan: The Supporting People model, as I said earlier, is based on collaboration between two major Departments and the alignment of funding. We benefit from the fact that the money is provided for the bricks and mortar to provide state-of-the-art, modern facilities into which people can be appropriately placed, following assessment. It is then our obligation to make sure that they are provided with the appropriate support and care so that they can live there securely. When it works well, it is a very good alliance, in terms of both funding and methodology of support.

Mr Beggs: I am aware of Barn Halt in my constituency, and there are many other developments like that. Have you detected a high level of satisfaction with that model elsewhere in Northern Ireland?

Mr Keenan: I am not sure if it was contained in the papers that you received, but a piece of work has been done in relation to Barn Halt specifically. It is a follow-up piece of work in the form of a user satisfaction study, which was very thorough, and the message was very positive indeed. There are other facilities around the country, such as Mullan Mews in the east, Sydenham Court and Seven Oaks up in the west. We are getting reports of a high level of resident satisfaction with that model of care.

Mr Beggs: Are they all housing association-led developments for bricks and mortar, with provision of support by the trust?

Mr Keenan: Yes, they are. I would like to emphasise that. It is a model that, when it works well, is very highly regarded by the residents.

The Chairperson: I do not think that anybody is disputing that. Gordon is next.

Mr Dunne: Thanks very much for coming in this afternoon. What evidence is there that the private sector is keen to get involved in the provision of, say, retirement villages for folk who can manage to buy or, perhaps, to rent in the village? What sort of engagement do you have with the private sector on that?

Mr Keenan: I talked to Housing Executive colleagues a few days ago, and there is currently nowhere in Northern Ireland that could be described as a retirement village per se. However, we and the Housing Executive have been approached by private developers who were thinking of building this model of care in Northern Ireland. Nobody has yet put their money where their mouth is and developed retirement villages.

The model in the rest of the UK tends to be in the south-east of England, but it is not a model that has been widely promoted and progressed across the whole of the UK; it tends to be in certain pockets, and, I have to say, generally affluent pockets.

Mr Holland: That is also the experience internationally. That kind of model tends to thrive in areas with high personal net wealth.

Mr Dunne: Are we doing anything to encourage and incentivise private developers to come on board?

Mr Keenan: No. Although I do not want to digress, with investment from the private sector, and as part of the wider residential care debate, we have significant over-capacity of residential and nursing home care in certain parts of Northern Ireland. That is because private individuals have invested, at risk, and built facilities. At this time, we have an over-provision.

Mr Dunne: I was thinking more about what you said about retirement villages and the opportunity to rent or, in many cases, purchase in a quality development, where there would be space, and people would have amenities rather than living in confined areas. Such villages would have standards similar to what people are used to. Surely that needs to be encouraged and developed.

Mr Keenan: As I said, a number of people have thought about introducing and promoting such a model here. I am quite sure that those people have also done some marketing intelligence. At this point, the indicators may be that Northern Ireland is not ready for this model of provision just yet or that, in the current housing market, people are not prepared to take the risk to develop such a model of care to that scale, as you probably appreciate.

Mr Dunne: I am aware of some recent newbuilds for dementia care homes. Have you been engaged with any of those providers, or are you doing anything further to provide for those with dementia? It is certainly a big issue. We have just come from an Alzheimer's Society presentation, which was attended by number of MLAs. It made us very much aware of the problem, which needs to be addressed and funded. Will the Department provide any incentive to the private sector to engage and to provide quality developments, as I have certainly seen in north Down, in response to what is sadly a growing need? I feel that there is a role for the private sector. What is being done to encourage that?

Mr Keenan: We are working on two fronts. You are absolutely right: some private sector providers are looking at the market and the need. They have, quite rightly, identified that dementia is a huge challenge for us to which we have to rise. In some cases, they have reconfigured their services to point them in the direction of dementia care. In north Down, there have been a number of quite significant new developments. My understanding is that the trust is working closely with those developers because it sees the need for that type of care. Some of the more recent supported housing projects that have gone into the system under the umbrella of what we are talking about have also been targeted to meet the needs of people with dementia. Cedar Court, in the South Eastern Trust —

Mr Dunne: Sorry, where is that?

Mr Keenan: It is in Comber. There is also a new facility, Hemsworth Court, in the lower Shankill. The people who developed that have tried to ensure that it can rise to meet the needs of people with dementia as well. New facilities that are being planned take the dementia factor into account.

Mr Dunne: They do?

Mr Keenan: Yes.

Mr Dunne: These are joint ventures that the trust runs.

Mr Keenan: Yes. People with dementia will test this model severely, because it is premised on the tenancy model and a reasonable level of independence. This is the next tier down from residential nursing home care, in which people are very dependent. People with dementia will test the model to destruction; it will be very challenging.

Mr McKinney: This goes back to your point about choice. Transforming Your Care states that there is a need to ensure that the availability of supported living is more widely known about and promoted. How is that being done, and what is the budget?

Ms McCreedy: That touches on a few of our earlier points. Without digressing from supported living and supported housing per se, I have noted that part of the statutory residential review is to look at the needs in each area by geography. A significant amount of work has already been developed and been done.

I go back to the Chairperson's point. What provision do we have for people at home in domiciliary care? Do we have a clearer articulation of who is in supported living, who is in residential care and who is in elderly mentally infirm (EMI) care, and so on, across the spectrum? We need to layer growth on that and the age of the population and build in assumptions around anticipated choices that people may make. It goes back to Seán's point that people will have choice, and you can but best anticipate where that will take you. That will start to tell us about any potential gaps and where they are.

It is known in part, and that will be part of the outworking of the consultation on the statutory residential review of what is currently available, but it is more about making sure that, as we move and change the model, we have the building blocks in place to make sure that people can avail themselves of that choice.

Mr McKinney: Specifically, how is the supported living aspect being promoted?

Ms McCreedy: We have been discussing people's awareness of it — the Committee has touched on that — how older people understand where it is, what it is like and how they can see, feel and touch it to know that it would be an option for them. At the moment, not everyone would rise up to understand that.

Mr McKinney: What evidence can you point to that it is being promoted? Can you tell me about the promotion campaigns and the types of budgets that are attached to that?

Mr Keenan: I would come at it from a different direction. As people get to a stage at which they need or want to move into a different model or configuration of care, they come into the system that we are talking about in two ways. They can come in from the housing side: they want to move, but they are not quite sure about the options, so they may get advice about what is available. Our Housing Executive colleagues promote that very strongly. Under the supported housing umbrella, there is a spectrum of accommodation models. On our side, if someone became more frail, more dependent or experienced disability and had to move, he or she might talk to his or her social worker, who would know about the availability of different models of care in that locality.

Mr McKinney: In that latter category, it is a crisis that introduces them —

Mr Keenan: Sometimes it can be as a result of advance planning. If someone is in the early stages of dementia —

Mr McKinney: Can you tell me about the promotion campaigns and the information flows? Where are the information flows for what people need to know? Are they available in advance or at the time?

Mr Keenan: It is usually on the basis of the assessment.

Mr McKinney: Are they available at that time and not prior to that?

Mr Keenan: Yes.

Mr McKinney: So there is no promotion campaign.

Mr Keenan: Information about the availability of resources in any given area is on a trust website, for example. People can access that through the Housing Executive website. That type of information is available, but it does not mean that it is promoted on a daily basis.

Mr McKinney: Yes, but Seán was talking about informed choices. What are you doing to inform the choices?

Mr Holland: At the point when people are having their needs assessed, they sit down with a social worker or a care manager, who will take them through the range of available options. In the past, those options may have been restricted to residential homes or nursing homes. Now, when a person is taken through the options, they include domiciliary care, reablement, supported living, residential care and nursing home care. It is not about having a public awareness campaign on which we would spend tens of thousands of pounds on television advertising or something like that. It is about the relationship with the social worker, working with individuals and their family to assess need, establish circumstances and present some of the available options. That is how the choice is being promoted on an individual basis.

Mr McKinney: For the record, I am not talking about expensive advertising campaigns. I am talking about information through the Pensioners Parliament and other mechanisms such as Age NI. What is being done in advance to prepare people for the choices that they will inevitably have to make, and not just at that time?

Mr Holland: With supported living, individual housing associations undertake campaigns in which they try to raise awareness about the range of services that they offer, including supported living.

Mr McKinney: Are you not doing that?

Mr Holland: We do it through individual assessments and by making sure that individuals are made aware of the available options and are supported in making a choice.

Mr McKinney: You referred to social work issues, but in other areas, how are people assessed as being suitable for a place in a supported living context? Are only social workers involved?

Mr Holland: It will be part of an assessment whereby an elderly or community care team will respond either to a request from an individual or a family member. Frequently, a GP initiates the process. Kevin, you previously managed that area of service. Is that a fair description?

Mr Keenan: It goes back to what I said earlier: people come into the system in two ways. They may come in through the housing route. They may be living in a Housing Executive house that is too big for them and may say to a housing officer, "This place is too big for me" or "I have a disability and can no longer use upstairs. What other options are there?" If people are in that situation, the housing side will work very closely with a social worker to do what Seán is talking about — namely, assess their needs and make sure that, wherever they end up, the service there is appropriately tailored for their needs, both in care support from a trust and the physical fabric of a building.

Mr McKinney: This can often be a traumatic period for people who find themselves moving from one side to another. What we have been talking about is people moving out of home. What information is provided on exiting when it comes to financial advice on renting or selling a home? Is there anything being done about easing the journey on the exit as opposed to just the entry?

Mr Keenan: Those are two sides of the same coin. If people reach a stage, either individually or with their family, whereby they feel the need to move, I would expect the housing side and the health and social care side to offer assistance. It is not just about their physical needs, and that is very important given what Seán said. Any move of this sort will have a financial dimension, so you would sit down with people and assess their financial means, because, in some cases, people do not have to pay a penny, but, in others, people have to contribute to their care. So there are physical, emotional and financial aspects.

Mr Holland: I can illustrate that with personal experience. We went through this process with my mother, who has passed away. We were visited by a social worker, who as well as undertaking an assessment, which involved the GP and an occupational therapist (OT), talked us through various issues. She said, for example, "You need to tell us about your money so that we can do a financial assessment", and she told us how much my mother was allowed to retain without having to make a contribution. The legal implications of that were talked through with us. That was my experience of the process.

Mr McKinney: I do not want to drill down into personal experiences, because I have my own, and they were not good.

What are the usual triggers that result in someone moving into supported living?

Mr Keenan: People could get an early diagnosis of dementia and would not be as able to live on their own, or, if they are living with somebody who goes out to work, that person is afraid to leave them there.

Another trigger could be the onset of physical disability. Somebody could become wheelchair-bound and be living in a home in which the doorways are not wide enough and that does not have an appropriate bathroom. In some cases, an OT might come to the house and do an assessment, and the property might have an adaptation. However, if the person feels the needs to move out, it could be the disability that triggers that.

Mr McKinney: Can people self-refer?

Mr Keenan: Yes, they can.

Mr McKinney: How many people self-refer?

Mr Keenan: We do not have that figure with us. I will go back to a point that Seán made earlier about the numbers that we are talking about this afternoon. The health and social care system does not

have unique responsibility for or total oversight of all entrants to that system. In fact, most facilities are the responsibility of the Housing Executive.

Mr McKinney: I am sorry to interrupt. Given the generality of our discussion, is that a failure?

Mr Holland: Do you mean a failure because we cannot identify the number of self-referrals?

Mr McKinney: It is not only the number of self-referrals. You have been unable to bring a lot of other information to the table, and that concerns me. Kevin spoke about self-referrals, but he also mentioned not having oversight. Is that a systemic failing as to how we move forward?

Mr Looney: It is recognised that the system can work better and that the two Departments can work more closely together. At the beginning of the year, both Ministers asked officials to have conversations with each other and to have a series of meetings to identify issues in the planning and implementation process and to consider a way forward that would address those. The exchange of information between the two Departments is one of those issues. We had a meeting last week that included representatives from the housing associations, and there was a helpful discussion from the perspective of the health and social care trusts, the Federation of Housing Associations, the Housing Executive and DSD. The forum that has been established will be the means through which we can address many of the issues and many of the improvements that can be made.

DSD made a commitment to review the Supporting People programme by March 2015. That mechanism also exists, and we will look at how the programme works and where improvements can be made.

Mr McKinney: Can we ask for that to be shared?

The Chairperson: Yes, absolutely.

Mr Holland: With any complex social issue, there is always a dilemma over whether you try to bring it all within the remit of one Department or group or whether you try to approach it on a partnership basis. You could end up with one massive Department doing everything.

Mr McKinney: I was struck by the graphic at the very start of the TYC document, on which all this is predicated, which is about a growing older population and increased pressures. With respect, we are not hearing enough evidence or information that you are putting in enough resource or that you are considering the issue in the context of its importance.

Are there waiting lists for supported living facilities?

Mr Holland: I am not aware of —

Mr Keenan: I do not have the numbers.

Mr McKinney: With respect, I am holding my hands up because there is an awful lot of information that we are not getting today. I will not make any assumptions about it, Chair. We are simply not getting the information. The homework has not been done. Maybe we should revisit the issue, Chair.

The Chairperson: Members have raised a number of issues that have not been answered. It is irregular that we are holding an evidence session specifically on this issue and that we do not have the detail. However, I know that Jim has been waiting. Have you finished, Fearghal?

Mr McKinney: I had one more question, but I will pass. I am not sure that I will get the information.

Mr Wells: This has been interesting. The session has covered some of the points that I wished to raise, but I am trying to tease out the commitment of the trusts, using that awful Americanism "going forward". I cannot think of any other phrase, so I will use it anyway. You gave us some idea about 2013-14. What is the commitment to funding, through the trusts, for the next few years for sheltered accommodation?

Mr Holland: It is impossible for me to give a detailed breakdown beyond the comprehensive spending review programme. The commitment from the trusts will be to respond to demand as it presents itself on the basis of assessed need. Kevin referenced the schemes that are coming on line, which reflect a commitment from the trusts to fund those schemes. That is the process through which I see that commitment being taken forward over the next few years.

Mr Keenan: Dean said that we are coming to the end of a cycle, and Mickey talked about the money that has not been spent in the current cycle. Hopefully, we will address some of the issues that you raised about the alignment of information, but we are moving into a new phase in which we will have to develop a new joint bid, look up the road and try to estimate the types of needs and the number of developments that we need to put into the system for the next three years. As for the horizon that we are working towards, we are not looking much further forward than 2015-16.

Mr Wells: I must say that, listening to these answers to questions on such a crucial issue, which, frankly, almost derailed Transforming Your Care because of the whole controversy, my impression is that there does not seem to be much concrete thinking. I would have expected a definitive plan as to where we were going and what we wanted to achieve, rather than reacting to proposals by some private entrepreneurs and housing associations. I am not content that you have grasped just how difficult an issue this will be. Unless the public are reassured that there will definitely be proper provision, the residential home issue will, unfortunately, come back to bite us. I am just wondering why the answers are not more definitive.

Mr Keenan: Most of the action proposals in the programme are aligned with the re-provision of statutory residential care in the relevant geographies. So it is not a random choice. Most of the proposals are about the straightforward re-provision of residential care facilities. There are plans in the pipeline for Greenisland, for example, where the home closed last year. This is a proposal to re-provide and put in place supported housing. We have concrete plans in the system for Moylinney Care Home, which also closed last year. Most of the proposals on the schedule relate to current statutory homes and the re-provision thereof.

Mr Wells: I wonder whether you sold that well enough. What disappointed me about all the controversy that erupted was that, when you dug a bit deeper, there were often concrete proposals for alternative provision. In Limavady, for instance, there was great controversy over Thackeray Place, but I learned that there was a proposal for a bigger, more modern unit to be built in Limavady a few miles away. However, that did not seem to be known by the residents, staff or local politicians. Have you been doing enough to make it clear to residents that there are attractive options out there?

Mr Keenan: I had two sessions yesterday with elected members of Ballymena Borough Council and the northern group of councils. I reiterated John Compton's acknowledgement that communication at the front end of this process could have been significantly better. However, we have worked hard at trying to get the broad message back on track. There was quite a bit of acknowledgement yesterday, at both sessions that I attended, that we have worked hard and are communicating the message a little bit better than previously. People are starting to learn that, behind all the headlines, some reasonably well-thought-through plans are in train and in the process of development in different parts of Northern Ireland that will soak up and address the needs to which you refer.

Mr Wells: Were the residents of the existing residential homes and their carers aware of that? I listened, obviously with a mixture of horror and shock, to all the media coverage and certain irresponsible BBC journalists, who remain utterly nameless, going around residential homes and interviewing very vulnerable old folk. Nowhere in that conversation did they show the slightest indication that they knew that there were realistic alternatives to their homes.

Mr Keenan: I will use two examples to give the story behind the headlines. I use the example of Greenisland, because it is in my geography. Plans for Greenisland were well advanced, residents were on board, had been kept in the loop and were well briefed. When the media firestorm broke, the people of Greenisland kept their heads down and worked with the trust to ensure that the home moved towards closure and people were able to move. The same applies to Rathmoyle Residential Care Home in Ballycastle. The people in Ballycastle want to keep on working with the Northern Trust to make the changes that have been proposed. So there were proposals in the pipeline, and there were good examples of people working with the trust. Unfortunately, as I said, the firestorm erupted in April and May last year and was not helpful. It caused a serious amount of distress.

Mr Wells: Let us take another example. Roy slipped in a constituency issue of his own, and one of mine is in Kilkeel, where there is a good residential home and a planning application has been submitted for sheltered accommodation that would more than replace what Slieve Roe House presently provides. However, that application is stuck in the planning system and there are objections from local residents, and so on. A commitment that there would be no change to that residential home, or any other residential home, until the replacement was built, would have allayed a lot of fears. There was a concern that a lot of people felt that the residential home would be closed, and the alternative would not be there. ·Is that a way forward to try to allay the public's concerns?

Mr Holland: That is exactly the work that Fionnuala McAndrew has been doing. She has been consulting on the criteria that will be used. Availability and accessibility of alternative services is one of the criteria that she has been consulting on, so that will now be a criteria. Unless that can be satisfied, suitable availability and accessibility of alternative services —

Mr Keenan: Kilkeel is a good example of what I was speaking about. A business case was done, and the proposal went through the appropriate local mechanisms in the Southern Trust area. I believe that all the parties bought into that concept. This has been held up by a very technical issue — the surrounding land, ownership and access — over which we in health and social care have no control.

Mr Wells: Slieve Roe was offered up by the Southern Trust, with all its residential homes, for closure, and it had not even put in the planning application for the alternative. That is what caused a lot of concern.

Mr Keenan: I do not want to broaden out this debate, but, as part of the revisiting of the residential care issue, we have said to the trusts that perhaps a more considered look is required at the possible sequencing and the choices that need to be made in each locality. We have moved away completely from the idea of a total closure programme. We are not consulting on that at present.

Mr Holland: The Minister made it very clear, Jim, that he was not happy with how some of the issues were handled at trust level. That is why this new process has been commenced.

The Chairperson: Thank you for that. I think that we will want to return to the issue. Certainly, from my perspective, which I think is shared, we did not get any sense today that there is a strategic approach that is based on the needs of the population. It is frustrating, Seán, that we could not be told today how many of the 414 facilities, for example, are actually funded by the Department of Health. Equally, we could not be told today of the breakdown of the £3·2 million budget and how much of that is directed towards supported living. Neither have we been told how 155 places will meet demand, or even how those calculations are made. The Committee, obviously, takes these issues very seriously. I suggest to you that it is a key component of Transforming Your Care that requires, at the very least, accurate data and statistics and, equally, a strategic plan on how it is taken forward. We did not hear that today.

I have no doubt that we will be writing to you with a number of questions and queries. We will await the answers to those, but I expect that we will have further engagement.

Mr Holland: Thank you, Chair. Chair, you know that I appear before the Committee not infrequently, and although it is often a robust exchange, I always endeavour to have available the information that I anticipate that the Committee will require. Occasionally, we have to say that we will come back to you with a written response. Today, the number of issues on which we have had to do that is, obviously, greater than I am happy with and, clearly, what you are happy with. However, it probably reflects the complexity of the issue in that this is not solely the preserve of the Health Department, the HSCB or the trusts. The issue involves several partners: different Departments, housing associations, and what have you. However, we will certainly do our utmost to respond to your requests for information.

The Chairperson: I accept that, Seán, but the Department of Health has a key role in Transforming Your Care. Therefore, at a very basic level, you should be in a position to come to a Committee with a budget. I will leave it at that and not reopen the discussion. We look forward to getting the information from you and continuing the conversation. Thank you for your time today.

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Transforming Your Care and Older People: Health and Social Care Trusts

12 March 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Transforming Your Care and Older People: Health and Social Care Trusts

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:

Ms Marie Heaney	Belfast Health and Social Care Trust
Mrs Una Cunning	Northern Health and Social Care Trust
Ms Nicki Patterson	South Eastern Health and Social Care Trust
Mrs Melanie McClements	Southern Health and Social Care Trust
Mr Alan Corry Finn	Western Health and Social Care Trust

The Chairperson: You are very welcome. Hopefully, I will get your names and titles correct. We have Mrs Melanie McClements, the assistant director of older people at the Southern Health and Social Care Trust; Ms Marie Heaney, a co-director of older people's services at the Belfast Health and Social Care Trust; Mrs Una Cunning, director of primary and community services for older people at the Northern Health and Social Care Trust; Mr Alan Corry Finn, director of primary care and older people's services and the executive director of nursing at the Western Health and Social Care Trust; and Ms Nicki Patterson, director of primary care and older people and the executive director of nursing at the South Eastern Health and Social Care Trust.

The Committee has read the briefing papers and wants to explore further a number of issues. We will move directly to questions from Committee members. The Committee's purpose today is to gather the facts and figures around the trusts' approach to supported living. I therefore ask for your indulgence and that you keep your answers to that topic. Some of you provided information in your briefing papers about other issues. That is useful information, but it is about reablement and domiciliary care, and we are not here today to engage in that general discussion. I want to keep us very focused, so we will stick to the topic of supported living. Given that there will be many questions, I ask each trust to keep its answers short and to the point. I ask people to work as best they can to get the proper outcome that we require.

I will start. Having worked through the issue in evidence sessions over the past number of weeks — we had the Department with us very recently to discuss supported living — I am specifically interested in the trusts' views on and understanding of the Department's policy on supported living accommodation for older people. I am not sure which one of you wants to lead on that.

Ms Marie Heaney (Belfast Health and Social Care Trust): I think that our interpretation of the Department's view on supported housing is that it is part of Transforming Your Care (TYC), and it is an option that should be developed in trusts for a very small part of the older population who would like to opt for that choice.

The Chairperson: I do not want to interrupt you, but is supported living not very different from supported housing? Is that accurate?

Ms Heaney: No. I think that there are issues with the definitions. The term "assisted living" originated in, I think, America. Locally, it became known as "housing with care" and then morphed into "supported housing". The trusts are here today to speak specifically about supported housing, which is a partnership model between health and social care trusts, particularly the social care dimensions to trusts, and housing associations, whereby they pool their expertise in housing and care to provide a model of support that allows people to have their individual home and front door while receiving, as an option, 24-hour support, instead of, for example, domiciliary care, residential care or even nursing care. Therefore, we interpret it as an option that we like to provide for people who would benefit from that model of care, but it is for only a small number of people.

The Chairperson: Leading on from that, in Transforming Your Care, there is a specific reference to supported living. From the trusts' perspective, does the Department have a clear policy that is articulated to the trusts?

Mrs Una Cunning (Northern Health and Social Care Trust): My understanding is that supported living is broader than just the accommodation-based issue. For example, we have things such as floating support and peripatetic services that are provided either to people in their own home or to those in, say, sheltered housing in order to allow them to keep the tenancy. Therefore, supported living is the broader option, but our understanding of today's discussion is that it is about the accommodation or housing part of that.

The Chairperson: OK. I may come back to that.

Mr Gardiner: This question is for the Southern Trust. What is your understanding of the trust's role in the future provision for supported living accommodation for senior citizens? It says here "older people", but I say "senior citizens".

Mrs Melanie McClements (Southern Health and Social Care Trust): At the minute, we have quite limited provision in the Southern Trust area. We have three supported housing schemes, one of which was developed in partnership with the trust and two of which are run independently by Abbeyfield UK. The capacity across the three schemes is for only 41 older people, and it is fairly limited. The schemes have a fairly low turnover, and, normally, we have waiting lists. At the minute, we are by default in a lucky position, because there are four spaces in the 41 units in the Southern Trust area. However, it is our intent to increase capacity by over 100%. Our applications for 48 new tenancies across three newbuilds are at different stages of planning. One is, hopefully, going for planning appeal on 19 March, and the other two have had their outline business case approved in the capital year 2014-15.

Mr Wells: I need to declare an interest because I am representing residents opposed to that application. I did not realise that you were going to mention it specifically. I will steer clear of any comment on it.

Mr Gardiner: I thought that you were one of the residents looking for accommodation.

Mr Wells: No, I am not that age yet. *[Laughter.]*

Mr Gardiner: What areas are you locating those in?

Mrs McClements: The one that Jim refers to is in Kilkeel.

Mr Gardiner: That will be for him.

Mrs McClements: It is a 12-unit frail elderly newbuild on the old Mourne hospital site. Definite sites have not been identified for the other two newbuilds. However, the areas that have been identified for them are somewhere across the Craigavon and Banbridge council areas and somewhere across the Armagh and Dungannon council areas. Coming up with those two areas was informed by needs assessment, demography, rurality issues and a range of planning assumptions. They are both 18-bed accommodation builds for frail elderly and people with low- to medium-level dementia.

Mr Gardiner: You talk about 18-bed builds and things like that. Is this where they will spend the twilight years of their lives?

Mrs McClements: Some may well do. Some may need a further transition into either residential or nursing care. Some may spend their later years in supported living and end their days there. Some may have further needs and need ongoing 24/7 options in residential or nursing facilities.

Mr Gardiner: I wish you well.

Mrs McClements: Thank you.

The Chairperson: I will ask the other trusts for their perspective on their role in the future provision of supported housing.

Mr Alan Corry Finn (Western Health and Social Care Trust): The Western Trust works in conjunction with the Housing Executive. The Housing Executive does the main assessment of need for the area, but we highlight specific areas of need and encourage the independent sector to develop facilities. We are pretty well provided for across the trust locality, with the exception of the Strabane area. We are in the middle of an assessment of need of that area.

Mrs Cunning: The Northern Trust has two supported living schemes. The Brook in Coleraine has capacity for 55 tenancies, mainly for people with dementia, but there are some older people there as well. We have another facility in Barn Halt in Carrickfergus, which has 26 tenancies. There is a planned supported living scheme for Newtownabbey, with 24 places for people with dementia. In Greenisland, there are plans in place for 36 places for frail elderly. In Ballycastle, there are plans in place for 28 places for frail elderly. On the broader aspect of supported living, we also have some peripatetic, floating schemes in Newtownabbey, Coleraine, Magherafelt and Cookstown. We have plans for Antrim, Ballymena and Moyle in the incoming year.

Ms Nicki Patterson (South Eastern Health and Social Care Trust): The South Eastern Trust's intention is to have an accommodation-based scheme in each of our four localities. We have an accommodation-based scheme in the Lisburn locality, with 23 places in St Paul's Court. We also have an accommodation-based scheme in Cedar Court in Downpatrick, which opened in August 2012 and has 24 places. We have Cuan Court in Newtownards, which is due to open again with 24 places at the end of this month or the beginning of April. A further scheme is planned for the Bangor area, and it will have 24 places.

Ms Heaney: The Belfast Trust has four supported housing schemes providing 130 tenancies. A fifth is in planning, and that will bring us up to 160 places. We have one or two for each area — north, south, east and west — and that is based on an assessment of need based on demography and projections. All our schemes are designed primarily for people with dementia and to provide them with an apartment and 24-hour support.

Mr McCarthy: Thank you very much. I am sorry that I missed your presentation. Last week, the Department advised the Committee that there are 414 supported living facilities for older people across the five trusts. However, your briefing paper refers to the trusts providing between two and five such facilities. Can each of the trusts clarify the reasons for the discrepancy between the figures provided by the Department and your figures?

Ms Heaney: I think that the distinction is between supported housing and sheltered dwellings. We do not see sheltered dwellings as supported housing. Sheltered dwellings are a housing option for people with low or no needs who choose to go into that. Supported housing is a very targeted —

Mr McCarthy: I hear what you are saying, but should that not have been set out clearly in the information that was provided? It said clearly, for instance, that there are 137 supported living facilities for older people in the Belfast Trust area. However, the briefing states that the Belfast Trust has three or four. That is an awful difference, and it is very misleading.

Ms Heaney: It is certainly confusing. I think that it is to do with definitions of supported housing.

Mr McCarthy: It applies to all the trusts. The Southern Trust was said to have 44, but the briefing states that it has three or four.

Mrs McClements: The Southern Trust submission for this week defined that as three full supported living schemes, as we see it, with the other 41 being sheltered accommodation. I reinforce Marie's interpretation that the Department's submission probably referred to both options.

Mrs Cunning: I agree with that. In the Northern Trust, we have 84 sheltered housing schemes.

Mr McCarthy: Chair, I think that it would be better and more sensible if we had those figures.

The Chairperson: It is a fair point. We will seek clarification from the Department. It is certainly quite misleading and confusing when we are talking about two different themes and figures that do not add up. I appreciate your raising that, Kieran.

Mrs Cunning: The most up-to-date information is held by the Department for Social Development (DSD). That Department provides sheltered housing and funds supported living.

Mr Beggs: We have heard about one of the locations where you have a small number of vacancies. Are there many, or any, vacancies in your supported housing schemes?

Mrs Cunning: There are three voids in the Brook, which is a very big complex that has a mixture of bungalows and other supported living. There are no voids at all in Barn Halt, and, in fact, there are six people on its waiting list.

Ms Patterson: From a South Eastern Trust perspective, St Paul's Court is fully occupied. There is a waiting list of three for that facility. In Cedar Court in Downpatrick, which, as I mentioned, is a relatively new scheme, we have eight voids. However, there have been 24 admissions to the unit since it opened, so one reason for the voids relates to turnover. As Marie mentioned, there will inevitably be some tenants who come into these facilities and then need to move on to a more dependent model, depending on their needs.

Mr Beggs: What is your projection of future needs, particularly given the proposed changes to statutory residential homes? What do you see as being the forthcoming demand that you will have to cater for in, say, the next three years?

Mrs Cunning: The plans for future schemes that we mentioned are up to 2015-16. However, I understand that discussions and negotiations are taking place between the Department of Health and DSD on what funding will be available for schemes beyond 2015-16. It is important to note that each trust will outline its own plans when the funding is made known to us. Planning is based on issues such as needs assessment in an area, capital funding, revenue funding, site availability and identification of a housing association. You then get into design, planning permission and build. Until a lot of that is clearer, we will just have the schemes up until 2015-16.

Mr Beggs: Are all the planned schemes on the Housing Executive's capital build scheme? You can make whatever plans you want but, obviously, unless capital is set aside for them, nothing will result.

Mrs Cunning: Yes; that is the point.

Mr Beggs: Are all the schemes in planning that you talked about on the capital builds scheme?

Mrs Cunning: Yes, all the ones up to 2015-16 that we referred to are.

Mr Beggs: Maybe you can come to us back and tell us the number of new units and tenancies that will be available when all the plans are developed.

I have a final point about supported living. If the elderly or vulnerable population need a higher level of support, do you agree that there are efficiencies in having them located close together to avoid travel time for carers?

Ms Heaney: Yes. There are certainly economies of scale to be had from grouping tenancies in one area, particularly for people who have a high level of need, require several overnight calls or constant supervision.

Mr Corry Finn: Let me say that the challenge is really in rural areas. In a big urban area, it is easier to have a larger facility and for local people to live there. We have found that we have had voids in some areas because the location is not sufficiently local for people. People really want to live as close as possible to their homes. Ideally, if it is possible, they want to live in their own homes with support. If they cannot do that, they want to live in their own village or town. The challenge for us is that that sort of care, support and facilities are more expensive because we are talking about much smaller facilities with higher overheads. It is a real challenge to provide that in rural areas.

Mr Brady: Thank you for your presentation. I have a couple of questions. How are people assessed for a place in a supported living facility?

Mrs Cunning: There is a combination of factors. We start with a general assessment of a person's needs. We have integrated teams, mainly of social workers, who will carry out an assessment. They will look at what type of care is suitable to meet that person's needs. There is a wide range. As Alan said, the best type of care for them could be at home or in some other facility. We start with that point of view. The difficulty with supported living is that we are planning for people's needs far ahead into the future. We carry out an assessment of need at a particular time, but, by the time we have been through all the things that we talked about — the capital, and so on — time will have elapsed when we get to the business case and get those units in place. We do an assessment of needs at a particular time, but that might change as we go through the process.

When people are deemed suitable, decisions are made. Usually, an admissions panel is set up to look at people's requirements and make decisions. Health, housing, housing associations, and so on, are represented on those panels.

Mr Brady: Are there any particular triggers that point towards assessment for supported living accommodation?

Mrs Cunning: Marie referred to that. This is the very high end of the market. It is hard to talk about older people as being a part of the market, but it is people with complex needs. We are talking about small numbers of people who are very suitable for that kind of care. The triggers may be issues such as dementia or that kind of thing, which means that people have complex needs.

Mr Brady: Are there facilities for self-referral, or do cases have to go through a GP or social work teams?

Ms Heaney: Supported housing schemes are targeted at people who are starting to develop dementia or another frailty. When a family or an individual are forward planning, they anticipate a time when they would require more support and make a positive choice to live in a supported housing option where they can live well with dementia. In supported housing schemes, the trick is to identify people early in their journey, when they or their families have an insight, and they can choose to live in an apartment or accommodation that uses assistive technology and has well-trained staff who can provide an enabling model of care that is not institutional. Increasingly, people want to choose that model of care rather than the traditional residential or nursing home model.

Mr Brady: Obviously, two Departments are involved: the DHSSPS and DSD. I sit on the Health Committee and the Social Development Committee. You provide the infrastructure for the housing, but DSD or the housing associations have to provide the houses. The Minister for Social

Development has already admitted that it has failed to reach its targets, so that will be an ongoing problem that you will have to deal with. If you do not have the accommodation, you cannot provide the infrastructure for that accommodation. Obviously, you are aware of that. How will you cope? Statistically, the elderly population is increasing but is not necessarily becoming healthier. People are living longer, but it is modern medicine that keeps them alive longer. That will be an increasing problem unless it is dealt with. I am sure that you are aware that DSD is involved in the special needs management allowance (SNMA). Has that been an issue? The Social Development Committee has had presentations from the Regulation and Quality Improvement Authority (RQIA) and the housing associations, which are completely at odds. Have you encountered that?

Ms Heaney: SNMA is a different issue. It is a historical funding stream to housing that is provided for housing associations' residential accommodation. It is not open to other residential providers and is certainly not a feature of current and modern supported housing schemes.

Mr Brady: The point is that we are moving away from that. Getting away from that type of institutionalised set-up is part of the Transforming Your Care ethos.

Mrs Cunning: Madam Chair, I know that we are not here to talk about that today, but we need to keep in mind that these people have very complex needs. For the vast majority of older people that you are talking about in relation to demographic changes, the trusts are developing a wider range of services to deal with that, including assisted living and domiciliary care, which you have heard about.

The Chairperson: Maybe I did not pick it up, but can people self-refer?

Mrs McClements: They can self-refer, but they will still go through the same panel process. They may not have been in direct receipt of health and social care services. They may be coping independently with quite progressed conditions such as dementia in some instances, and they have not yet come into our loop. Some people self-refer, but they will then come into our process, where they will get professional assessment and go through the same panel process.

Mr Wells: The Department told the Committee last week that, in 2012-13, the trusts had spent £3·7 million in providing supported living. Can each trust give a breakdown as to how much it spent?

Mrs McClements: The Southern Trust spent £200,000.

Mr Wells: Any advance on £200,000?

Ms Heaney: The Belfast Trust spends between £500 million and £650,000. Each scheme costs around £500,000.

Mr Wells: Did you say £500 million?

Ms Heaney: I am sorry. I meant to say £500,000. Each scheme costs in the region of £500,000 to £600,000, and we have four schemes.

Mr Wells: So you spend around £2 million?

Ms Heaney: Yes.

Ms Patterson: The South Eastern Trust has two accommodation-based schemes. For one of them, the costs for 2013-14 were £272,000; for the other, the costs were £231,000.

Mr Corry Finn: I do not have the exact figures for those schemes in front of me. However, as Una mentioned, we have a range of other facilities and services for which I have figures, but I am not sure whether that will be of any assistance to you.

Mr Wells: By a process of deduction —

Mrs Cunning: It must be £1 million.

Mr Wells: Yes. If you add the figures for the other four together, that leaves the Western Trust with £1 million.

Mrs Cunning: We can confirm that. We will send that information in.

Mr Wells: Under TYC, we expect expenditure to increase. Have you any idea what is in the budget for the next two years? What are you bidding for? That is perhaps a better question. What is happening? Clearly, TYC indicates that this is a growth area and that we need to have better provision for people to prevent them from ending up in more expensive care. Are you planning to expand this? I am a bit worried that you do not seem to know, as yet, what you are getting.

Mrs Cunning: You are asking about the position beyond 2015-16, so we do not know what we are getting then. However, with plans for future schemes, the trusts will have set money aside because they fund the personal care element. Housing is funded through DSD. So we are aware of what we are spending.

Mr Wells: You are not told by DSD what it is spending but are then expected to provide the care element.

Mrs McClements: We have forward-planned for the projected cost based on all things being equal. In the Southern Trust area, for example, the three schemes will deliver. In the next financial year, there will not be an impact because, even if we or Trinity Housing are successful with planning permission, it will not be live in the next financial year but in the year after that, and we have approximate projected costs for that.

Mr Wells: How much contact is there between housing associations, DSD and the trusts about the future, or do you leave that entirely to them to dictate?

Ms Heaney: There are processes. At board level, there is a joint commissioning group with representatives from all trusts and the Housing Executive. That is the forum at which assessment of need is discussed and plans made. There has to be a joint assessment of need for a local area. Trusts then bring forward business cases based on that need.

Mr Wells: I am not detecting a dramatic change in gear to provide a lot more of these schemes.

Ms Heaney: At this time, certainly from the Belfast perspective, when we get our fifth scheme in place, we will have 160 tenancies for this group. That is in the context of a range of other services that people choose. We believe that we are meeting current and future demand for at least the next two or three years. It is also important to point out that we would want to carry out some evaluation of the totality of the model across the city, and probably across Northern Ireland. This is not a choice for a high percentage of the older population. It is a choice for a very small percentage of the population.

Mr Wells: As you know, the plans for residential care — I do not know what is going to happen now — envisaged a significant drop in that provision, and presumably a lot would have been soaked up by the type of care that you provide. You could not have done that had it gone ahead because the sort of numbers we are talking about would never have met that need.

Mr Corry Finn: The Western Trust has 57 facilities covering almost 1,300 individual units, from sheltered dwellings up to the most dependent people. Around 300 of those are jointly commissioned. I know that we are not here to talk about other subjects, so please stop me if you want to, but, with domiciliary care, people are choosing to stay in their homes.

To elect to go into supported housing is a life choice. It is a big decision for people to give up their own homes. There is also an associated cost. People are entitled to certain benefits depending on what money they have. There is a personal choice to give up a home, and there is a cost, so people have to decide. We have vacancies across all our residential homes.

Mrs Cunning: The plans were for statutory residential facilities. There is a thriving independent residential homes sector, and the Northern Trust has vacancies in that sector that would meet our needs. With the smaller number of people who would fit supported living, a range of residential nursing home placements is available and all the additional issues, such as domiciliary care, to meet the needs of older people.

Mrs McClements: It is important not to see statutory residential, supported home and supported living as being like-for-like facilities. They are not. A lot of people in the Southern Trust area made a choice to go into residential care because no other options were available to them. Some people have been in our statutory residential homes for 18 or 20 years because they did not have options 20 years ago for what may have better met their needs.

The current plan — the bigger menu-based option — has a range of options that allows people to make other choices, whether domiciliary care, supported home, supported living or floating support. For the past six years in our area, the trend in statutory residential homes has been 20 admissions a year. Those are the sort of numbers that we have been gauging, and there is capacity in the independent sector market.

Mr Wells: I was extremely impressed with St Paul's Court. I would have thought that, if a lot of elderly people saw and experienced that type of facility, the demand would rise dramatically. It is not available in many parts of the country. If people only understood what it involves. If I were a few years older, I would sign myself in — that is how good it is. By the way, that is not a promise. For many people, this is a totally foreign concept because no one in their area provides it.

Mr Dunne: Apologies for being late, Chair. How are the trusts publicising supported living as an option for older people? How are they making people aware of what facilities are available?

Mr Corry Finn: In the trusts, people normally have their needs assessed by their social worker and care manager in the first instance. Supported living and housing is one of the things that is available, and people are informed about what is available in their locality. As I mentioned, people really want to live locally. They do not want to move 10 or 20 miles down the road.

Mr Dunne: As local representatives, we are very aware of that. That is a big factor.

Ms Patterson: We have done a lot of publicising of Cedar Court, which is our new facility in Downpatrick. We have developed a DVD, which is being used widely in publicising the facility and what it can offer. That is on our trust website. The needs assessment that the professional undertakes with an individual is a one-to-one engagement, but, as well as that, we are doing all that we can to ensure that the wider public has an understanding of that as an option.

Ms Heaney: In Belfast, we have just opened Hemsworth Court on the Shankill Road, and it is in the process of becoming occupied. Belfast Trust has done a significant amount of work with our partner, Helm Housing, which has driven that. We have also produced a DVD and have done a lot of work with local community groups, local GPs, local older people's groups and local newspapers to try to get it out through word of mouth, because that is most effective.

Mr Dunne: Is Helm providing the buildings — the infrastructure — while you are providing the support in those buildings?

Ms Heaney: We provide the care and support.

Mr Dunne: What about the trusts? Have the Department or the boards asked them to actively promote supported living? Is that a fair statement?

Mr Corry Finn: It is part of what we normally do. I will just add to what Nicki said about the one-to-one engagement. For some of our areas where uptake has perhaps not been as good as we had anticipated, we have had open days, placed advertisements in the press and worked with the housing association to try to promote the use of the provision, and we have had to think about other programmes of care. Ours, which is the one that I am thinking about, is aimed at people who tend to have the early stages of dementia, but we may open that up to other frail or elderly people.

Mr Dunne: Is dementia not being covered more by the private sector?

Ms Patterson: I think that that goes back to the menu of options that we mentioned. So, this model is one of a menu of options, and that applies whether it is for dementia or frail or elderly people.

Mrs Cunning: Both of the supported living accommodations that we have in the trust are directed towards people with dementia and to older people. So, it is a mixture.

Mr Dunne: Is it working?

Ms Heaney: Northern Ireland has the highest rates of dementia diagnosis, but it is important to highlight that the vast majority of people who are diagnosed with dementia live well with their dementia in their local communities with their families. Supported housing is an option for some people who can anticipate the future and make a positive choice. So, most people with dementia are not in the private sector.

Mrs McClements: The independent sector will kick in at the nursing-care stage for dementia support.

Mr Dunne: Yes, there are some new homes opening on the nursing side. Thank you, Chair.

Mr McKinney: I just want to make a small point on the back of what Gordon said. What is best practice in this area? Clearly, you are employing different techniques, although some are similar. How can you identify the population before they reach crisis point? Very often, they interact with you at a crisis point. Is there information and, potentially, a budget set aside for preparing information to allow people to know what is coming forward, given that everything in your documentation is stating that we have an elderly population that is living longer?

Mrs Cunning: The trust has information on its website on the range of older people's services that we provide. We also have a plan for older people's services, which, again, is on our website. I have personally been round a lot of the council areas in the Northern Trust. As you know, we have 10 councils. We have been round those areas talking about our plans for older people's services. We have a publication on Barn Halt, for instance. We also have leaflets, and, as Nicki mentioned, a DVD. So, we go where we get opportunities. We have an older people's panel where we talk about our services for older people. I think that it is important that we talk about the totality of the services for older people, because it is never the case that one size fits all. We provide a range of things.

Mrs McClements: To back Una's point up, I will say that I think that partnership working is even more upstream than that. We have a lot of partners that we actively work with in community development approaches when working with communities, such as Age NI and Pensioners Parliament. We also have age-friendly initiatives with our council colleagues to try to get that bigger approach in society to how we will support our older people in their increasing needs. We have a host of community conversations happening now across the Southern Trust area so that we can listen to what older people are telling us. We are informed by them as we move forward and shape our plans. We obviously have a legislative backdrop that is actively involved with our communities. So, there is a big piece of work that is upstream, and then there is the promotional stage.

Is there a defined budget? Technically, yes. We have a lot of support from our communications department, and, where there is a need to develop resources of whatever kind, there is not a defined budget as such, but there is a communications budget that we can draw from.

Ms Heaney: To go back to your point on best practice, Fearghal, I will say that our experience in Belfast has been that, whoever runs the service, particularly on the care and support side, needs to have quite a significant experience of dementia. The activities for older people have to be meaningful. We have a strong joint-working partnership with our housing partners. We have well-trained, supported and empowered staff, good policies and procedures, strong management locally, and strong community links, particularly with the PSNI, local shops and community groups. We have the use of simple, effective technology to reduce trip risks for people with dementia. So, those are the key components, but this is not an easy model to deliver, as it requires a very strong team.

Mr Corry Finn: As people said, the challenge is to have that conversation as early as possible. I have attended some of the Pensioners Parliaments, and I think that, working in Health and Social Care, you perhaps get a distorted image of what older people are concerned about. That is because you are engaged with people who are in difficulty or whose health is challenged. However, whenever you meet older people who are well, you find that their concerns are about things such as safety, policing, pensions, transport and maybe housing, but they are not thinking ahead about their care. If you asked any of us, I am sure that you would find that we all have an idea about what we would like in the

future, but very few of us make a plan about it. So, I think that we need to have those big conversations with people earlier.

The Chairperson: Is your question on this subject, Mickey?

Mr Brady: Yes. You mentioned the Pensioners Parliament, which I know is on in Newry on Friday. It is an important vehicle for people. However, we have a Commissioner for Older People, and the whole ethos of that is to put older people at the heart of any issues that affect them. Have you had much contact with the commissioner about all this?

Mrs Cunning: Yes, we have had a number of meetings individually as trusts, but all the trusts have met the Commissioner for Older People collectively. With the councils being given the lead for community development next year, I think that it is also important that we are starting to set up a lot of networks and are having those conversations and partnerships.

Mrs Cameron: The TYC draft implementation plan states that the improved availability of supported living places will mean that the demand for places in residential homes will decrease. Can each of you quantify how many people you expect to place over the next three years in supported living who previously would have been placed in residential homes?

Mrs Cunning: We have given you the plans for the places that we have developed or are in development for 2015-16. I think that each of the trusts has given you those numbers. We can generally plan on demographics. In local areas, we consider all that and try to plan for the percentage of older people and the type of living accommodation that they will require. However, planning is also based on individual assessments at the time. So, although the trusts look ahead and try to think about the number of placements that we need, we also think about the type and level of services such as domiciliary care that we will require. We also look ahead at the need for floating support. I think that we need to consider the reality of the situation in what we are doing. We in the Northern Trust have an older people's strategy that we developed in 2006. It was there for five years and was then superseded by TYC. We have been on a journey, because at that stage, when we met older people through focus groups, they said that they wanted to live in their own homes for as long as possible and as close to home as they could. So, our plans and everything that we have done since have been based on that. We have increased our domiciliary care. Over the past few years, we have spent an additional £6·5 million on that. We have seen our permanent placements reduced over the years, because we are actively trying to promote the services that will help people to stay in their own homes.

Mrs Cameron: So, can you not actually quantify that shift?

Mrs Cunning: It would be hard for me to say here and now that, in three years' time, we anticipate that it will be 20, 40 or whatever places. We have general plans for what we see as year-on-year, based on demand.

Mr Corry Finn: I cannot give you an exact number from the Western Trust either, but I can say that, across the geography of the trust, we have sufficient provision with the exception of Strabane, which I mentioned, where there is a gap in supported housing and other types of housing for older people who are in need. We are working to try to promote that. However, I think that, as Una said, there is a broad recipe of things that people may need or choose. That could be from the most basic but critical personal alarm that someone might wear around their neck when they are living alone and feeling vulnerable if they happen to have a fall right up to supported living and everything between.

Ms Patterson: Similarly, the South Eastern Trust is not in a position to give a specific figure. It is maybe important to note that, when we are looking at supported living for older people, it is done on a population-based needs assessment as opposed to being based on individual needs. That is the case, for example, in the resettlement of our learning disability population, where it specifically looks from one individual to where they may go in the future. We are looking at the service needs for a population and at a menu of options for that population.

Where specific numbers are concerned, I will provide the reassurance that, although this is not a scenario that any of us anticipate, were it the case that every single client in a residential home were to require to move to a supported living environment, there would be capacity in our plans up to 2015-16 to enable that to happen. However, we do not anticipate that, because it is only part of a menu of options.

Ms Heaney: In the Belfast Trust area, we have seen a very steady and clear decline in residential care across all the providers. So, again, it is difficult to predict actual numbers, because it depends on turnover and on current and new schemes. Certainly, people are choosing less often to go into residential care. That is very obvious.

Mrs McClements: From the Southern Trust's perspective and as I said, on average, we have 21 admissions. If we look back at the past six years across our five statutory residential homes, we see that 21 is the total across those five. We have also seen a decline of up to 13% in demand for our statutory residential homes, and putting that against the demographic trends, it is likely that we will have 23 to 25 people who, potentially over the next three years, may have come in each year to our statutory residential homes. We do not know how many we will have, because, obviously, we have just closed the stage 1 consultation. It remains to be seen whether we will have some of those or all of those or none of those. Potentially, however, we will be able to divert those who do not wish to remain with a community package at home towards independent sector residential homes. Hopefully, all things being equal, we will have 48 new places coming on board, which will help us to absorb that across the Southern Trust area.

The Chairperson: By way of bringing this to some sort of conclusion, the first question that I asked was about the trusts' understanding of the departmental policy on supported living. Specifically, I heard Marie, and maybe some others, indicate that supported living is for a very small part of the population. Is that a vision that has been interpreted or passed on from the Department?

Ms Heaney: No, I do not think so. This model of care is very specialised. It is very expensive on the capital and revenue side, and it needs to be targeted at people who most need, and could most benefit from, the model. That is not something that would be open to every older person who wants to live in a community-type environment. So, from the Department's and the trusts' point of view, it is very targeted at those who would most benefit from it, because it is expensive for the state and the —

The Chairperson: Do all of you think that there is enough forecasted planning or targeting? I accept what you say about this being a complex issue for the trusts where choice is concerned. We know the population forecast, so is there enough of a strategic approach to the forecasting and targeting that is required?

Mr Corry Finn: I think that it is very challenging, because a lot of different initiatives are all contributing towards meeting people's needs. We all know about the increase in the over-65 population and, indeed, in the over-85s. If you go into any of our hospitals these days, you will see not the over-65s but 80-year-olds and 90-year-olds who often have co-morbidity or dementia so need a lot of complex care. Alongside that, we have things such as long-term condition management, where we try to help people to manage their illness at an earlier stage to help to prevent hospital admission, because nobody wants to go into hospital unless they desperately have to. We have seen some success with that. We then have domiciliary care. So, we have lots of different initiatives.

The Chairperson: But are there enough?

Mrs Cunning: My understanding is that, at the moment, very high-level negotiations are going on between the Department and DSD about supported living, what the requirements are, what the targets should be and what the funding should be.

The Chairperson: We certainly did not get the interpretation from the Department in its evidence that there was any kind of strategic approach to this. We know, and you are quite right about this, Alan, that there will be a 40% increase in the over-85s by 2020. There are 414 facilities and five proposals, so somebody somewhere is applying a ratio. So, again, my question is this: is there enough of a strategic approach to planning?

Ms Heaney: The provision of supported housing is a relatively new phenomenon in the system, and I think that it would benefit from formal evaluation and some strategic thinking about what is needed in the future and how much it would replace high-end accommodation and care, that is, nursing and residential care. However, that is, I think, an unknown to most of us at the moment.

The Chairperson: That has cleared things up.

Mr Corry Finn: Transforming Your Care points the way, but my understanding is that there is not a huge amount of new money coming along. It is about spending the money that we have differently. The whole emphasis is meant to be on reducing expenditure in acute services and spending more in the community. We need to see that coming into reality.

The Chairperson: You need planning to do that and to have an outcome framework attached it.

Mr Beggs: There was a comment that this is an expensive option. I have not got this in front of me, but I remember reading that it costs the health service about £175 a week. Am I right?

Mrs McClements: That would not look at it.

Mr Beggs: What is the cost?

Mrs McClements: Each scheme is priced differently, depending on the level of support. In our area, an older person would pay around £250 or £300 a week into a scheme. That is quite an expensive option, given that people still have to buy their own food because a lot of the facilities do not do meals or —

Mr Beggs: Is it not considerably less than the cost of having to place someone in residential care?

Mrs McClements: The residential regional tariff is about £460 a week, so it is significantly less than that. However, in residential, you get all your laundry done, meals provided and full 24/7 care, whereas people in supported living may have other costs. They obviously have different streams that they can pool from, such as housing benefit, the supporting people allowance, pension credits or attendance allowance. However, for those who have the ability to pay, it is quite an expensive option.

Mr Beggs: I have another question that is specifically for the Northern Trust, but it may relate to others. Una, you mentioned two supported living accommodations, the Brook and Barn Halt. I am curious to know why the supported living provision at Lisgarel residential home is not mentioned. I understand that there are 10 places there. If the proposal to close that is accepted, you will have minus 10 places. Do some of the other residential homes also provide support to separate living units attached to other residential accommodation? Why are the supported living places at Lisgarel not listed?

Mrs Cunning: A wide range of services are provided for intermediate care in the Larne area, including at Lisgarel and at Inver Hospital. There are also a number of sheltered —

Mr Beggs: My question was about 10 supported living places.

Mrs Cunning: I am sorry; your question —

Mr Beggs: Why are they not listed?

Mrs Cunning: Specifically in the context of supported living, Lisgarel, as you know, is a residential home with some supported living units. I understood that we were talking about the model such as the one at Barn Halt. However, you are quite right: there are 10 supported living places at Lisgarel as part of the residential home that is there at the moment.

Mr Beggs: Are there any in this model in any other trust area? I will just highlight that there are negative 10 places and a proposal to close those places with a further proposal to close the residential home.

Mrs Cunning: Again, to my thinking, in any future planning for that area, we need to look at the range of services that are provided there, including the sheltered accommodation and so forth. We need to look at the totality of it.

Mr Beggs: But the trust proposed to close it without doing that.

Mrs Cunning: As you know, when it comes to the proposal for the residential homes, the regional consultation just ended on 7 March. We will get the outcome of that, and we will apply that across the trust area and put forward our plans.

Mr McKinney: I have just two quick questions. Do you all share Mr Corry Finn's opinion that not enough money has been shifted quickly enough from savings into the community side? I hope that I interpreted you correctly.

Mr Corry Finn: Those are your words, not mine.

Mrs Cunning: I think that that is a challenge for everybody, because the services are required in the community. However, as we know to free up funding from secondary care into the community you have to get an infrastructure cohort, comprising beds and so on, so that you can shift that out. That does not happen immediately, so there is a need for a bridging that will operate between shifting those services out and the money, presumably, following behind.

Mr Corry Finn: In days gone by, when we changed from one model to another, we would have had money to do the change in a sort of double run. Clearly, the health service and the country are challenged financially, so we do not have the luxury of having the money to run double.

Mr McKinney: Is that not at the heart of a lot of the stress that is in this system? If you worked the provision from the other side, that would take the stress off you. You are suggesting that, in another environment, that would be possible.

Mr Corry Finn: As I say, in years gone by we would have had the moneys to address that. It was called "change moneys". We are challenged; we just do not have sufficient money in neither the health service nor the country to do that.

Mrs Cunning: There are pressures in the system; you are quite right. Shortening lengths of stay in hospital means that people come out into the community earlier. So, a shift is taking place there even as we speak.

Mr McKinney: I have one other point to make. That was very illuminating, by the way, and I find it very instructional. However, I want to ask another question. All the graphs that we see point to the ageing population growing. Is anybody interrogating those figures to see where people are likely to end up? Are they going to be less healthy? Are their numbers going to be flattening, or is it going to be about maintaining a more healthy elderly population? I know that you cannot read the future, but is there an interrogation of the likelihood of where these people will end up in the health spectrum?

Mrs Cunning: We try to predict as much as possible. A lot of analysis goes on in trusts and, I am sure, in the Department and the board of where spend should go. For example, we have heard about reablement. All the trusts have implemented that in some shape or form, but where it has been evaluated it has been shown that it tends to keep people at a certain level where it works really well for, perhaps, 18 months to two years. After that, it sometimes just delays the deterioration and what is required at a later stage. We are working in a very quickly changing environment. Those of us who have worked in the NHS have seen quite a lot of changes even over five to 10 years, but it is a challenge.

Mrs McClements: There are lived experiences. The financial position across the trusts is well known, and there is demand. When you are assessing need on an individual and daily basis, it is very hard not to respond to that need, because the pressure is there. I think that we have to get smarter with the collective resource, so I am talking about the community and voluntary sector and how we work with families in a partnership model of care. If we are looking at an older person's needs, we need to look at meeting those needs together, because we cannot meet them through Health and Social Care on our own.

Ms Patterson: In answer to your question about analysis, I can tell you that the risk stratification that is taking place through the integrated care partnerships will help us, as a system, to have a better understanding of what the future might look like.

The Chairperson: OK, thank you all. In conclusion, questions were asked about the clear figures on projected demand and projected costs from each trust. With the caveat that it is difficult because

there is a choice element, could you perhaps furnish the Committee with those figures? So, thank you for your time today; that has been informative, and it is appreciated.

Mrs Cunning: For the record, Madam Chair, my name is Una Cunning, not Canning.

The Chairperson: I apologise for that.

Mrs Cunning: That is fine; it is just for the record.

The Chairperson: Thank you for that.

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Transforming Your Care and Older People: Ms Claire Keatinge, Commissioner for Older People for Northern Ireland

9 April 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:
Ms Claire Keatinge Commissioner for Older People

The Chairperson: I welcome Claire Keatinge. I understand that this is your first time before the Committee, so we will make it as easy as possible for you. We are delighted to have this engagement. The normal procedure is that you give a 10-minute presentation, and then we open up the floor to members' questions.

Ms Claire Keatinge (Commissioner for Older People): Thanks very much for the invitation to meet the Committee here today. To those of you whom I have had the pleasure of meeting or working with before, it is very nice to see you again, and to those of you whom I have not met, I look forward to a long, useful and productive working relationship. I will say the same to you as I say to everyone else, which is that my door is open for formal and informal conversations, questions and advice to the Committee. I am always very pleased to provide whatever assistance I can on our services and support in best meeting the needs of older people.

I am very pleased to assist the Committee today in its consideration of supported living options for older people, in the context of Transforming Your Care. As you know, I am the Commissioner for Older People for Northern Ireland, an independent public body established under the Commissioner for Older People (Northern Ireland) Act 2011. I have a wide range of statutory duties and functions, which are available to you, but, essentially, I have a statutory duty to promote and safeguard the interests of older people, a term defined as people aged over 60, other than in exceptional circumstances when I can engage with those aged over 50. My statutory duties and powers are underpinned by the United Nations Principles for Older Persons 1991. They include definitions of words such as independence, participation, care, self-fulfilment and dignity, which underpin my functions.

I will start by briefly summarising my views on the supported living options for older people, as described in your terms of reference for this evidence session. I have followed the debate on supported housing and the need for it, as well as the much wider Health and Social Care reform, through the work of this Committee and more widely, as you will imagine. Health, housing and social care are of the most enormous importance to older people, both in their having confidence in what they need for the future and a certainty that, if they are frail or dependent, the services are available now. Today's older people depend on the fact that somebody has already done the planning and the thinking so that the services are there. Tomorrow's older people depend on planning for their future and their needs being taken into account in a changing demographic.

I am very conscious that the absence of a clear and agreed definition of supported living has led to confusion among members at meetings of the Committee. Quite frankly, you have received conflicting information, not only about supported living projects but about the exact number of existing projects that are financed now and will be in the future. That must be enormously frustrating. Every time that you are confused about something like this, take a step back and ask what the modelling is for, in this case, the future projections for older people. Whether it is supported living, nursing care, domiciliary care, residential care, sheltered housing, supported living or assisted technology, the planning will fall out of the modelling of demand and need much more clearly. The exact detail of whether it is supported housing or sheltered housing is, in some regards, less significant than whether you are confident that you have in place the modelling that lets you know what our population looks like now and going forward: what does it want, and what does it need, based on what we know now; what do other international jurisdictions tell us is the likely pattern of demand; and, with nearly 70% of older people being owner-occupiers, are they likely to be prepared, willing and able to sell their home? Ask what you know about the older people of today and tomorrow and whether the modelling is useful in engaging on whether it is good enough.

I absolutely support the provision of more choice for older people about where they can live because the needs of today's and tomorrow's older people have to be the defining feature that drives service design and planning. It is imperative that that is based on accurate projections of the need and the likely preferences and choices of today's and tomorrow's older people. Those should be transparent and publicly available.

To give great confidence to the public, let them know what the modelling is. Tell the public what the trend in ageing is; what people say that they want; what people need; what the different costing options are; what the regional geography looks like; and how many places you think that you will need. Not only should that planning be transparent and publicly available, it has to include staffing, resourcing and physical buildings, as well as that more qualitative evidence. If the focus is on the evidence of need, the planning is much more likely to fall out of it, and your opportunity for scrutiny and accountability will be much more straightforward.

It is also imperative that the modelling of the additional service and support needs for older people who live in supported housing is provided. I hear a lot of anxiety from older people who currently receive care, as well as people who are likely to need care in the next 10 years or so, about whether the services and support will be available to them. They want to be assured that the modelling for supported living, for example, includes all of those additional services and support needs. That includes nursing care at home, domiciliary care, physiotherapy at home, community meals, befriending, social activities, advocacy support, palliative care, and aids and adaptations. All of those have to be in place for the supported living arrangements to be effective.

I know that you are interested in looking at the extent of involvement of older people in the planning and design of services. Any planning and modelling must involve older people, but not only today's older people; it must involve looking at what some younger people think that they will want in the future. It also has to look at evidence in this jurisdiction and internationally on the trends. It must look critically at why something did not work as well as what did work: why what seemed like a really good idea at the time did not work that well. We want the very best here in Northern Ireland. Without question, we have some excellent Health and Social Care facilities here. Recently, I have been in a number of them, and they are absolutely excellent. We also have some that are not, and we have some very significant pressure points of demand and considerable anxiety among the public about future planning.

I come back to the question of care assessment for individuals. Remember that this is about each individual older person, and care assessment is critical. The care manager assessing the needs of the individual older person must be able to offer a range of options. If he or she is to be able to provide choice, having assessed the needs of an older person, the choice must be available to offer.

Older people must then be able to choose from the most suitable options to meet their assessed needs, and, although there is a need for publicity for supported living and for a range of options, care assessments must not be a vehicle simply to promote one style of choice or one style of living.

Supported living options, and whatever their future developments, will not necessarily reduce the need for domiciliary, residential or nursing care because the overall population rise and the overall demand for Health and Social Care support will be significant as our population ages. For the record, it is very good news that we have more older people in our population. More of us are living longer and healthier lives than ever before. However, it is incumbent on all of us to make sure that the planning is done to also recognise that, particularly among the so-called very old, people over the age of 85, we can age confidently and with certainty that, in the event that we are frail, the services and support will be available to us. To date, I have not seen a comprehensive plan that outlines the need and future demand for supported living, particularly one outlining a variety of models, for a number of years ahead. Much of the planning still seems to be quite short-term within the current short-term envelopes of money, and I think that the Committee could usefully address that.

You asked me to look at the three elements of your terms of reference, which are the structure and availability of supported living; the capacity of supported living to meet the objective of Transforming Your Care, which is to reduce the need for residential home places; and to identify examples of best practice. I am quite happy to outline those if you want me to. I am not sure where I am in the 10 minutes, because we do not have a clock here.

The Chairperson: Go ahead.

Ms Keatinge: Alternatively, I could deal with those in questions, Chair, if that is your preference.

The Chairperson: You have a few minutes left.

Ms Keatinge: First, it is almost impossible to provide an answer on the availability because there is no agreed definition. I suggest that you go back and ask for clear modelling. I am as confident as I can be that the information will be available in a variety of places, and I think that the modelling needs to be put together so that the definitions are clear, the level of need is clear and you can see where the match is or is not. I cannot really assist you on the availability and structure of supported living options on the basis of an unclear definition. I have been to some excellent sheltered housing and an excellent supported living facility, but I cannot give you much more information than that. Many of the figures for supported living are not available, and I have not been able to ascertain with any certainty the exact level of supported living facilities, the definition or the future planning. I think that that would be very useful. I also ask the Committee to consider the need for allied support in that modelling and planning. People in supported living may well need other care and support facilities and services.

You also asked about the assessment of the capacity of supported living to meet the policy objective in Transforming Your Care of reducing the need for residential home places. However many supported living places there are, they will not remove the need for domiciliary, nursing or residential care, but supported living has the potential to meet the needs of some older people. Such a facility can be absolutely excellent at creating a space for people to live independently, confidently, free from fear and with the support that they need in an individual accommodation with communal facilities. It can transform people's lives and rejuvenate their independence.

Of course, there must be a mix of living accommodation available, and supported living will not be appropriate to meet everybody's needs. The lack of planning information available has made it much more difficult to assess the capacity of current and planned supported living options. There is a clear need for planning and modelling that is accessible, transparent and based on the evidence of projected current and future needs.

A number of models have been developed as a basis for assessing further need for supported housing: for example, the National Housing Federation, the Housing Corporation, the Mayor of London's office and the London Supported Housing Forum have published a comprehensive toolkit, which uses key concepts that feed into a predictive model of need. I urge the Committee to consider whether it would like to model against any of those. They include the obvious things that you would expect, such as what is the population in need, what is the population at risk, what is the duration of service need likely to be, the cost and other demand adjustments.

Determining need and demand can be difficult because many people consider supported living only when the need arises. We do not want to think that we will need that in the future. The difficulty can be partially alleviated by careful modelling, which looks at reasonable best estimates and projections based on useful models. I think that finance and projected future costs play a key part in the thinking behind Transforming Your Care and its overall management of Health and Social Care, and rightly so. I recognise the challenging budgetary circumstances in which the Executive are operating, but I urge you, with every ounce that I have, to accept that the very best value for the public purse is delivered when older people receive excellence, choice, dignity and fair treatment. The more clearly that is modelled and planned, the more likely it is that we will have the workforce, facilities and services, and that older people will have the confidence that they need.

Small differences between the editions of Transforming Your Care cause some confusion over the nature of the objectives for supported living. The initial publication set out an aim for people to be supported to live independently at home or in supported accommodation, and the implementation document talked about people living at home or in assisted housing, so the confusion about exactly what the definitions are goes back as far as that.

I know from the Assembly research papers on supported living that you have seen a number of different options that could be regarded as best practice, both in this jurisdiction and outside it. There are some excellent examples, but, if you look carefully across different jurisdictions, you will also find some that are not so good. They are not a panacea; they are a very useful option. They can be absolutely exemplary, but they need to be planned, managed and delivered to properly regulated standards.

That is all I wanted to say by way of an introduction. I am very happy to have any conversation that you like on this topic.

The Chairperson: Thank you, Claire, for that very frank and useful advice, as always.
Prior to your evidence, we had a conversation about definitions. The issue that, in their absence, it is impossible to work on recommendations emerged clearly from the information that you provided today. You took that further and outlined the issue with modelling. We have raised the point continually that we know the statistics and the forecast for an ageing population. In fact, at last week's stakeholder engagement, we were given the statistics for each constituency, so we know the differences even across constituency and trust areas. That information is there. It strikes me that there has been a lack of planning at any strategic level. Is that your experience as well? You said that you had never seen a comprehensive plan. Is your sense that the planning is not in place?

Ms Keatinge: I have not been able to access a comprehensive modelling of future need and demand with service delivery set against it, including workforce planning, allied services and buildings. In the proposals for the consideration of the closure of statutory residential care homes, one criterion in the revised documentation and consultation is to look at what the alternative provision is. Consideration of whether a particular statutory residential home should be retained has to take into account the alternative options. There may well be a pressing need for comprehensive modelling there because no proposals should come forward without that clear evidence and information. I cannot think of anything that would give older people and their families more confidence than knowing that the planning is robust and comprehensive.

The Chairperson: You mentioned the current consultation. Transforming Your Care is focused on shifting to community/primary care, older people being cared for at home and reablement processes. That is why we are exploring what the alternatives are. How do you involve older people in that process?

There is a wider issue, which was particularly stark in the residential homes issue, when there seemed to be no sense of protecting the rights of our elderly population. It is important that we look at how to do that. Are there examples of where that has been done through a rights model or bill of rights? It seemed that the elderly population were almost swept to one side without any safeguarding of their rights.

Ms Keatinge: The question of involving older people is central to any planning that relates to need, where people will live and how they will be cared for. The most important people to consider in the statutory residential care homes issue are those living in them now. Whatever else goes on with planning, that is their home, so they need to be engaged first.

In planning, there is every point to involving older people and asking what they would like, provided that they have enough information on the options and are included in a meaningful way. We also need to ask tomorrow's older people what they think they will want and to look at international evidence on having a trend towards different types of housing or Health and Social Care provision and how that works.

It is not only about asking today's older people what they want; it is about looking at the range of options and seeing which people would prefer. We need to look at what we think we want for the future and at what works and does not work internationally. Dignity and respect are central. Every single person I have ever spoken to about care for older people says that they want to be sure that, in the event of becoming frail, developing dementia or becoming socially isolated, the care and support that they need will be available to them. They want that support and care to be based on their assessed need and available at a standard and level that, without question, meets their need.

I am sure that you are all in the same position. It is probably in your mind now, and you will have heard it from family members and constituents. People are looking for certainty. Central to that is that older people must be involved, and we must look as widely as possible at what does or does not work — let us put in place the best for Northern Ireland.

The Chairperson: What about a rights framework for the elderly community?

Ms Keatinge: In what context?

The Chairperson: The safeguarding of the elderly population. Are there examples elsewhere of the rights of the elderly community being better protected or safeguarded?

Ms Keatinge: There are international frameworks and United Nations principles. Jurisdictions have different legislation that sets out to protect older people from harm or sets out their rights to access services. There is a variety of international scenarios and legal protections.

Whatever those protections are like, older people do not want to have to litigate to get what they need. They want the people paid to plan, provide and deliver services to do so properly in the first place. I get much more pressure from older people to influence planning than I do to influence enforcement. Again and again, I hear very old people saying that they do not have time to go to law. Yesterday, I was in a nursing home, talking to several people whose relative was in their 90s and had had a severe stroke. Somebody had experienced difficulty moving from one hospital facility to one care home and then on to another, and my office had intervened. The only other advice they received was to see a solicitor, who simply said that any case would take years. The man told the solicitor and me that he did not have years and his wife, who had had a major stroke, did not have years. People want these services now, and the planning needs to focus on that.

Mr Gardiner: Commissioner, you are very welcome. It is nice to see you, but I will not be referring to "old people". Will the commissioner tell us whether she is satisfied with the consultation of senior citizens on what the changes in Transforming Your Care will mean for them? How did the Health Department engage with them? Did it engage with the senior citizens or their providers?

Ms Keatinge: I will take it from the statutory residential care home closures and work back. The involvement of older people who reside in —

Mr Gardiner: Senior citizens. They are senior citizens.

Ms Keatinge: What is your definition of senior citizen?

Mr Gardiner: It is your definition of old people.

Ms Keatinge: Those aged over 60.

Mr Gardiner: Whatever age you want to apply, but they are senior citizens.

Ms Keatinge: I am just trying to make sure that I am clear because we have already had issues with definitions. I am just trying to be absolutely clear: are we talking about people aged over 60?

Mr Gardiner: Yes.

Ms Keatinge: OK. Thank you.

There was inadequate engagement with people living in some statutory residential care homes at the point of the initial consultation. The Health and Social Care Board has made very considerable efforts to engage meaningfully with people who live in those statutory residential care homes and their relatives and staff.

As for the consideration of the issues involved in Health and Social Care and Transforming Your Care, there is a wide evidence base about what matters to older people. It is not just about going out and asking older people in the here and now; there is a wide evidence base about what matters to them. There has been some engagement with older people. There can always be more, but every single engagement that I have seen found that older people say that they want certainty and confidence: confidence that the planning has been done and certainty that the quality of service will be right. Probably the best answer I can give you is that any engagement with older people will say that loud and clear.

Mr Gardiner: I hope that you adopt the attitude that they are not old people; they are senior citizens, as far as I am concerned.

Ms Keatinge: I do not have any definition of your use of language —

Mr Gardiner: Treat them with respect. We are not talking about old dogs.

Ms Keatinge: Mr Gardiner and Chair, I am sorry —

Mr Gardiner: We are talking about human beings.

Ms Keatinge: I trust that nobody is suggesting that I am referring to older people in that context.

Mr Gardiner: If you refer to them as "senior citizens", it would be much more suitable.

The Chairperson: We are talking about a title as well. The formal title is the older persons' commissioner.

Ms Keatinge: Thank you, Chair. I am the Commissioner for Older People for Northern Ireland, and my statutory duties refer to people aged over 60. There is a variety of phrases that people use for older people. Some like one and some like another, but that is the definition I use because of the statutory functions and legislation to which I work.

Mr McKinney: I return to the rights issue. It is one thing to turn up for a service or whatever and ask that you and your ambition be respected; it is another thing to say that you have the right or that your family has the right to ask for a service on your behalf. Would a rights-based platform make a difference in forcing or encouraging the Department to define issues with the provision of services for older people?

Ms Keatinge: Honestly, that is a very hard question to answer, because, at this point, we have a system in which people have a statutory right to have their care needs assessed. I think that the statutory right needs to remain and that they should have the right to have their assessed care needs fully met. There should be enforcement of what we already have in a lot of areas involving the health and social care of older people. We are looking at quality of service, accessibility of services and choice. Whether the building in of additional rights would make a positive difference is open to considerable debate.

Mr McKinney: I do not want to get into the personalities, but I am aware of one case in which an elderly lady with dementia had lived in a facility for a long time. That facility could no longer deal with her. It evicted her, to all intents and purposes. She went on, in an agitated state, to fall and break her leg. She got a hospital-acquired infection, spent six months in hospital and died recently. Would rights not have made a difference in that case?

Ms Keatinge: Without looking at a particular individual's case detail, I will say this: it is easy to forget that different facilities provide care and support for people at particular stages of their life or with particular needs.

Mr McKinney: Yes, but the system looked after itself in that case, and the patient got forgotten.

Ms Keatinge: That is inexcusable. I get a number of —

Mr McKinney: So, back to my point: what will copper-fasten the proper treatment for that individual, if it is not rights?

Ms Keatinge: What will copper-fasten proper treatment is proper planning, proper accountability, proper regulation and proper inspection in the first instance. We have to make sure that what we deliver is being properly delivered.

Mr McKinney: But we do not have that is what you are saying.

Ms Keatinge: I am saying that there are a number of flaws; I say that with absolute certainty. A number of complaints and issues come through my office in which older people describe situations similar to what you described and instances in which they have felt that they have not been treated with dignity and respect, where they have felt that they have been subject to ageist attitudes, where they have been denied treatment, or treated differently because of their age, and when they have felt that they have not had a wide range of choice. The question for us as a society is in planning. What is it we want our health and social care services to look like for older people?

Mr McKinney: Yes, but I am asking you what will provoke the system to ask that question, unless it is the need of the patient? If the need of the patient is ignored in favour of the system, the system is not working.

Ms Keatinge: That is absolutely right.

Mr McKinney: So, what will provoke the system to react to the patient need?

Ms Keatinge: Part of the role of the Committee, for certain, is to challenge and hold to account the work of Health and Social Care. However, I think that the question of whether legislative underpinning of additional rights for older people would be the thing that copper-fastens is one that warrants further discussion and debate. I am happy to do that with the Committee, but I do not think that it guarantees anything. I think that the delivery of modelling, planning, accountability, regulation, inspection and the comprehensive, swift resolution of complaints, when something goes wrong, are within the power of the Executive.

Mr McKinney: Without being too broad about it, how far away are we from that ambition?

Ms Keatinge: A large number of older people are very satisfied with the health and social care service that they get. There is certainly some absolutely exemplary health and social care treatment in Northern Ireland. However, a considerable proportion of the public are not confident that, if they need health and social care in the future, it will be there in the way that they would like to have it. There is a lack of confidence. There is a considerable degree of fear about advanced older age, frailty and dementia. That degree of certainty is not always there.

There are particular pressure points, which are quite clear. We have seen them recently in accident and emergency services and in pressures on the services. We have also seen them in dementia care in particular. There are very significant pressures for people who are cared for in the community as well as in hospital and other residential facilities. Those need to be planned for. We need to be absolutely confident as a society that we will talk about what works and deal swiftly and decisively, honestly and transparently when things go wrong.

Mr McCarthy: Claire, I am delighted to see you here. When this place was set up, I co-chaired a group called Age Sector Platform. One of our requests was the appointment of a senior citizens' commissioner, and here you are. I am delighted that you are here talking to us. I have to say that you

have given us an excellent address. Long may you continue. I am sure that our senior citizens will continue to avail themselves of your expertise in the months and years ahead.

My question is simply this: what would you have to better signpost our senior citizens to the services that are out there when they need them?

Ms Keatinge: At the point at which somebody needs health and social care support, particularly social care support, it is brokered through our social services system through care management. Most older people have never had a social worker. They do not know what they can expect, what their rights are, what their entitlements are, what a reasonable expectation is or what the range of services should look like. They are not experienced in that. Why would they be? Why would most people have any idea what the services and support are until the point at which they need them?

At that very point, care managers need to be supported to assess the needs of the individual and then be confident that there are a range of options available to them that they can then put to the older person so that the older person can then make the best choice, along with the care manager, about what will best suit them. That is absolutely fundamental to promoting choice and promoting options. Nobody who does not need a nursing home now is going to choose one for the future. People generally need to make that choice at the point of need.

On promoting choice for older people more widely, there is considerable mileage in having much more open conversations about the future. Listen to younger people. You may have somebody who is single, in shared housing and a student. They may get a house of their own. They may set up home with somebody else. They may have a family. They may then talk about changes in their living accommodations. They may need a bigger house because they have more children. They may need to move somewhere cheaper because their partner has gone into part-time work. People make all sorts of choices.

When it comes to older people, what we talk about is older people wanting to stay in their own homes as though that is a fixed state of affairs. When I listen to older people, I generally hear them saying to me, "I want to stay somewhere that means something to me with people I know, I trust and who care about me. I want to live in the same locality as the things and people that are important to me. That may be in the same home or the same locality, but it needs to tick boxes that are important to me". Publicising choice and confidently talking with older people about what matters to them and what is important going forward is a big challenge. We do not do it enough. A lot of older people continue to live in their home because they want to and because of a lack of knowledge about the realistic choices that are available to them.

Mr McCarthy: Thanks. Isolation must play a major part in senior citizens coming to a point at which they need help. The last thing that we want to see is those people being isolated, for example, in a rural area. They want to feel part of supported living, community living or whatever is there.

Ms Keatinge: That is without question. Social isolation and loneliness are profound issues for our society. Whether you are in a rural area or at the top of a tower block, if you are frail and not able to get out and about and have few visitors, you will feel imprisoned in your home. You will feel like the walls are closing in around you, and you may very well feel isolated, pressured and afraid. Some of the demand for supported living and residential care comes about because people need company. We are social animals, and we need company.

Mr McCarthy: Thank you very much. You keep the flag flying for our senior citizens.

Ms Keatinge: All of them or just one, Kieran? *[Laughter.]*

Mr McCarthy: We are all heading in that direction. Good on you.

Ms Keatinge: Thank you. It is nice to see you.

Mr Beggs: Thank you for your evidence. You said that you feel that it is important that older people — senior citizens —

Mr Gardiner: I will have you all converted before it is over.

Mr Beggs: — are able to continue to reside close to family and friends. As regards the different options that are provided, what evidence have you found that sheltered housing or supported living is available so that they can be close to family and friends?

Ms Keatinge: The evidence that I have found is that sheltered housing has been very popular. There have been very high levels of satisfaction with it. There have generally been very high levels of satisfaction with on-site wardens and that degree of security. There is some degree of anxiety that those wardens are being taken away and becoming more peripatetic. However, there are high levels of satisfaction that sheltered housing meets people's needs.

From listening mostly to older people, I know that they do not know what supported living is; that is my general sense. It is not just the Committee that is confused about the definitions. Older people are largely unaware of what the choices might be for supported living. Yet, when I have gone to supported facilities and met the residents there, they very much welcome them. They like where they are living and enjoy the independence and freedom as well as the support and care. So, there is a lot of confidence that, when people live in supported living facilities, they are suitable. There is a lack of knowledge about them from the outside, and there is a paucity of comprehensive modelling about what level we should have.

Mr Beggs: Older people who have spoken to me have indicated the importance that they place on being close to family and friends in whatever accommodation they are seeking.

You indicated that 70% of older people own their homes and that that can create a barrier to moving. Are you aware of models elsewhere that facilitate those who own their home in transferring that asset into a sheltered housing or supported housing model?

Ms Keatinge: Across the water in England, there are a number of private sector developments of supported living-type arrangements or sheltered accommodation — I am loath to pick either title at this point, because some of them fall between the two stools. However, there are a number of private sector options for people to purchase. There are a number of schemes in which there is mixed tenure of ownership and rental. In the main, we do not have those sorts of schemes here in Northern Ireland.

On the question of 70% home ownership, that is a barrier to a degree because people do not want to lose their home. There are cost implications for homeowners in going into supported living, sheltered housing or residential or nursing care. That is a consideration.

Mr Beggs: Would you agree that, if there is some imaginative thinking, perhaps it could actually help solve the financial situation in terms of providing suitable accommodation? Getting the necessary finance to build such accommodation seems to be a problem for the social housing sector but also perhaps on the health side of it. Is that a possibility?

Ms Keatinge: Sorry, I do not understand your question.

Mr Beggs: Essentially, I perceive limitations in supported living that come about partially because of the limited capital budget that is available. Are you aware of any other devolved regions that have perhaps extended the capital budget through a mixed model?

Ms Keatinge: I am aware of mixed models. I am not so much aware of the detail of exactly how that funding has come about regarding the mix of housing associations and private sector organisations. However, I do not detect any appetite from the private sector for building those kinds of schemes here.

Mr Dunne: Thanks very much. I think that this is the first time that we have met. What is your understanding of how DSD, through the Housing Executive, identifies demand for housing in particular areas?

Ms Keatinge: I think that that is the first time that I have been completely stumped. *[Laughter.]*

Mr Dunne: How is it identified in the existing system?

Ms Keatinge: There is obviously an existing points system for assessment for housing at the point of need. We have care management, which assesses people's health and social care need. It comes

back to this question: what is the modelling in the Department for Social Development, linked to Health and Social Care, for housing that is specifically tailored towards older people? And —

Mr Dunne: Even generally, are you aware what triggers it in the system? How does DSD identify an area for newbuild?

Ms Keatinge: No, I am not a specialist in that area at all. I cannot assist you on that question.

Mr Dunne: It is my understanding that it is done through waiting lists. Areas where there are waiting lists and a high demand for housing will be targeted for newbuilds. It is just a general point. What do you think of that?

Ms Keatinge: My instincts say to think longer term and not wait until there is a waiting list. If someone is an older person now, they need that housing now. They may not have 15 or 20 years to wait for budgets and planning permissions to come through, for planning objections to be overcome, for building to be done, for staff recruitment to be done and for the facility to be up and running. I think that it is incumbent on planners to take that very seriously and to model in advance and plan on the basis of our population projections for what it is we think is reasonable for our society rather than waiting until there is a waiting list.

Mr Dunne: OK. We have several examples of what, to me, is sheltered housing. It includes Fold, Habinteg and so on. In my constituency of North Down, we have had a number of schemes for a number of years, and those are successful schemes. A lot of those originally had wardens in them, and those wardens have been removed. How do you see that? Do you feel that that is a positive way to move forward or not? Do you have reservations about it? In many cases, a call system has been put in and calls are transferred to a call centre. What is your opinion on that?

Ms Keatinge: Sheltered accommodation has a very good reputation and is generally very popular with the people who live in it. Wardens generally have a very good reputation and provide that degree of confidence. Indeed, quite a number of older people will say that they have made the choice to sell up or move out of somewhere else because of the additional confidence that comes with having an on-site warden. So, inevitably, a degree of anxiety is caused when the warden service moves to something more peripatetic with call services and when more domiciliary care goes into people's homes with people staying there for longer. I am not aware of anyone choosing to leave sheltered accommodation because of the removal of wardens and the change in the structure of the service. I am aware of some concerns that have been raised about it, but sheltered accommodation continues to be a popular option. Again, of course, safety and fear of crime are very significant features for older people, and sheltered accommodation is one of the things that a lot of older people feel makes them safer. They like having a warden on site, but, of course, there is then also a group of older people living together, who may also perceive that to make them more vulnerable. The residents like having wardens a lot, but I am not aware of anybody leaving sheltered accommodation because of the removal of wardens and the change in the type of service.

Mr Dunne: Finally, what is your general opinion of the work that has been done by housing associations in the provision of such care regarding the standard of build and the type of accommodation?

Ms Keatinge: I have a general view based on the popularity of those schemes with the residents. They get very high satisfaction levels, and a number of them that I have visited are very comfortable and well-maintained schemes that provide for independence and security. Clearly, there are some where the fabric is not in as good a condition, and there certainly is demand among a lot of older people for accommodation that is large enough for them to have relatives to stay over and to provide care. That is not always available in the smaller sheltered accommodation provisions, but, generally speaking, sheltered accommodation continues to get very strong ratings from older people.

Mr D McIlveen: Claire, this is the first opportunity that I have had to meet you, and I welcome the opportunity to work with you in the future. I have a very quick question. Obviously, we have limited scope over housing associations and so on, as you will accept, but where we do have influence is over the trusts. In your opinion, have the trusts been doing enough to sell the concept of sheltered and supported living? I ask that question very deliberately, because there obviously was quite a lot of concern, some of it justified and some of it perhaps a little hysterical, about the statutory care home issue. In my constituency of North Antrim, we were very vocal and took a bit of a Nimby approach, if I

may put it that way. The Northern Trust, at the same time as putting these proposals forward, has been doing a lot of work to build new and very attractive facilities. I suppose one would say, quite selfishly, that it is the job of the trust to try to get the point across that there is a viable, and probably much better, alternative to a number of the domiciliary homes that are there. I take the point you made earlier that there will always be a need of some description. I agree with that entirely. Do you believe that the trusts should be taking more of a lead role in working with organisations, such as your own, in order to try to make the landing a little softer than what it has been so far?

Ms Keatinge: I think that there is a very useful approach by the trusts, the board, the Assembly and by everybody connected with housing and health and social care. When we do stuff right, when it is good and when people are content and feel safe, secure and treated with respect and well cared for, we should talk about it, give it that confidence, have material in the local press and have material in the media that is confidently out there and assertive when it works.

Yesterday, I was in a nursing home, and a gentleman said, "I don't want my wife to need this kind of care. She has had a massive stroke, but, given that she does, I can't imagine that she'd be cared for any better anywhere else". That degree of confidence is what we need to see. Regardless of whether it is the trust or, more widely, through the Health and Social Care sector, I think it would be very useful to talk positively about the services and support that are available to let and support older people lead dignified, fulfilled and as independent a life as possible without question.

Those kinds of options should also be promoted at the point-of-care management. Care managers are very aware, and should be very aware, of all the options that are available to people and of what they are like. They should have time in their workload to go with the older person to have a look at different facilities so that they can exercise meaningful choice. So, you are promoting it to the individual, based on their assessed care needs, as well as talking more widely.

When things go wrong — when they are not right, or when there have been problems — we need to deal with the situation as a society more quickly, more decisively, more effectively and more transparently to recreate that confidence. Talk about it, especially when it is good; create that confidence.

The Chairperson: OK, Claire, thank you very much for that. You have been very frank and honest. We certainly look forward to exploring with you the big messages around the modelling, the need for planning and the definition as the situation moves on. I think that there are particular issues around the likes of inspections, the role of the RQIA, the increasing levels of dementia and the planning that is required for the large sections of our population who will suffer from that illness. That has to be part of the workforce planning and the Department's planning moving forward. Thank you for that today. You have been very frank and honest, and we look forward to continuing the conversation with you.

Ms Keatinge: Thank you very much, Chair. As always, it has been a pleasure to meet and engage with our elected representatives.

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Transforming Your Care and Older People: Fold Housing Association/Northern Ireland Federation of Housing Associations

30 April 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Transforming Your Care and Older People: Fold Housing Association/Northern Ireland Federation of Housing Associations

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Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen

Witnesses:

Ms Fiona McAnespie	Fold Housing Association
Mr Cameron Watt	Northern Ireland Federation of Housing Associations

The Chairperson: You are both very welcome. We have Mr Cameron Watt, who is the chief executive of the NI Federation of Housing Associations (NIFHA), and Ms Fiona McAnespie, director of care services at the Fold Housing Association. The normal procedure, which I am sure you are aware of, is that you make a 10-minute presentation, after which I will invite questions from members. In the coming weeks, the Committee will take evidence from Age NI, the Centre for Ageing Research and Development in Ireland (CARDI) and a leading academic. The Committee will also take further evidence from the Department of Health, Social Services and Public Safety (DHSSPS) and the Department for Social Development (DSD). So there are another few stages of the process to go through.

Mr Cameron Watt (Northern Ireland Federation of Housing Associations): Thank you, Chair, and the Committee, for the opportunity to address you today. Housing associations provide 44,000 homes to people across Northern Ireland. Around one quarter of those are sheltered, supported and specialist homes for people with particular needs. Many of our member housing associations' roots are in providing housing, care and support to older people. We remain as committed as ever to strengthening and expanding that provision, and we are part of the broad coalition in support of Transforming Your Care (TYC) and its vision to help people to live as independently as possible in the community, with appropriate care and support. However, with the relentless pressure on budgets, realising that vision is an immense challenge, but it is our contention that Transforming Your Care can succeed only with a proper joining up of housing, health, care and support. As I tried to set out in the paper to the Committee, housing associations provide a range of housing, care and support options for older people, not only for those living in housing association homes but across the community.

Historically, most provision has been through sheltered housing, which remains very popular with most of its residents, but for those with more intensive care and support needs there is now the increasing provision of supported living homes. Fiona will outline the advantages of the supported living model.

Ms Fiona McAnespie (Fold Housing Association): Thank you, Cameron, and thank you, Chair. Fold Housing Association is one of the largest providers of housing, care and support. One key advantage of supported housing for older people and those with dementia is, first and foremost, security — in many ways. There is the security of tenure and of the building. People feel safe and secure, day and night, and it is a home for life. The assistive technology used in supported living means less intrusiveness. People have support needs, but the assistive technology means that they do not have people calling in and out. They can use that technology: it promotes independence, and autonomy is maintained. It leads to a better quality of life, so people in supported living have a life of their own. Supported living is also cost-effective. It may well be quite costly at the outset, but, in the long term, it produces efficiencies. It reduces hospital admissions and is less expensive than the alternative residential accommodation. The use of assistive technology reduces the need for people on the ground. So it is a good, cost-effective way of providing care.

Another key advantage is for the carers. They get their life back but can sustain their caring ability because they have people there to support them. They can go out, do their shopping or get their hair done, knowing that the person for whom they care, who is frail and older or has dementia, has the security of support. So carers' health and wellbeing are improved, and research has shown that. They have social interaction with others in the same position, which also provides them with support.

As Cameron said, we believe that supported living meets a lot of the criteria of Transforming Your Care, such as maximising independence, being cost-effective, helping to improve physical and mental well-being, reducing hospital admissions and delaying admission to more costly residential and nursing home care. We feel that those are the key advantages of supported living for older people.

Mr Watt: Our sector, therefore, believes that supported living has the potential to provide a good and value-for-money option in meeting the housing, care and support needs of a significant proportion of our ageing population, but, although our movement is as committed as ever to providing care and support services, it is certainly the most complex and risky area in which we operate. Key budgets underpinning the provision of these services have been frozen for many years, threatening their viability and quality. Of particular concern is the future of the Supporting People (SP) budget, which is a £70 million programme to provide a wide range of housing support to vulnerable people to help them to sustain their accommodation and live as independently as possible. The SP funding level for individual schemes has been frozen for the past six years, equating to a real terms cut of at least 15%. That means that housing associations and our managing partners in the charity sector are struggling to hold on to staff and sustain the quality of services.

Supporting People is subject to a major review that DSD is leading. That has just commenced and has significant input from DHSSPS. There are major uncertainties about the nature of the Supporting People programme that will emerge from the review and the level at which the revised programme will be funded. That adds significantly to the risk for housing associations that are considering new supported living schemes. Therefore, we ask that Supporting People be retained as a properly funded, ring-fenced and dedicated housing budget that is often complementary to health services but distinct from them. We also ask DSD to review the way in which it calculates the capital grant for new supported living schemes to ensure that it reflects the standards of good practice that the dementia centre at Stirling University and others have set, and to which we should aspire, in order to ensure that the schemes are suitable for the next 20 or 30 years.

In providing a wide range of care and support services, our sector values our good working relationships with health trusts, but, for supported living's potential to be maximised, we feel that it needs to be complemented by much closer working between health and housing at a strategic as well as a working level. Notwithstanding the huge pressures on all budgets, we believe that greater certainty and alignment can be achieved in the various health and housing budgets that underpin supported living on the capital and revenue sides.

As these services really are delivered in a true partnership, there needs to be a fair sharing of risk for that partnership to be meaningful. Some flagship supported living schemes for older people are incurring major losses for housing associations, particularly because they have taken longer to populate than expected. Some assurances on revenue funding and voids are vital to enable that fair sharing of risk. All key partners, including housing associations, any charitable managing partners

and the Regulation and Quality Improvement Authority (RQIA) as the regulator for domiciliary care, need to be involved in the planning and commissioning of new schemes.

Beyond the ongoing commissioning of new schemes, we think that we all need to find time and space to explore in depth the potential of various housing, care and support options for older people, including supported living, and plan for at least the next 10 years. We have to do much more collectively to educate professionals and the public about supported living and the other housing, care and support options for older people. It is true that good efforts have been made to promote individual schemes, but I do not think that we have done enough collectively to promote the whole range of options available. To help to rectify that, we suggest the creation of a supported living champion and have included the outline proposal for that in our written submission to the Committee. I should stress that much in that proposal builds on the work that DHSSPS and DSD have been leading after meetings between Ministers Poots and McCausland on unblocking barriers to supported living schemes. The Departments' work has resulted in some very useful meetings between the key people in housing and health, including the board and trusts.

As a result of that work in the past few months, we believe that there is a much better understanding of the challenges on both sides in delivering new supported living schemes and agreement on the broad areas that we need to work with to address those. NIFHA and its members look forward to continued joint and intensified working with colleagues in health and housing to maximise the potential of supported living and other housing options in fulfilling the vision of Transforming Your Care.

Chair, I will conclude by asking Fiona, as a major provider of the services, to outline Fold's position on existing and future supported living schemes.

Ms McAnespie: Fold Housing Association provides housing, care and support. We are not seeking to develop any further newbuilds for supported living at present because we have lost £1 million to one of our schemes in Enniskillen, which has challenged our board. I agree with Cameron that strides are being made between the Department of Health and DSD. However, until that works its way down and we can see it being realised, we will not consider any supported living newbuilds. We will continue to maintain what we have.

Cameron made the point about a supported living champion. People need to understand the model and the type of client group and person suitable for that model of living, because it is an excellent model and the schemes that we have work really well.

Another issue for us is to ensure that assistive technology is included in the capital cost. We find that when it comes to assistive technology, nobody is really sure who will pay for it. That is key in ensuring that supported living moves forward. We feel strongly that it is a good model of care. However, we incur all losses on any void properties, and those losses have led to a reluctance to move forward.

The Chairperson: Has £1 million been lost to date?

Ms McAnespie: Yes, over three years.

The Chairperson: Is that because the entire loss is borne by your organisation?

Ms McAnespie: Yes. We accept the loss on any void property; it is not divided. In the initial year, we got some assisted funding from the Health and Social Care Board (HSCB) and from Supporting People as a gesture, but they cannot continue to do that. So, over the past three years, Fold has faced a total loss of £1 million on the scheme in Enniskillen.

The Chairperson: If that loss had not been incurred, could you be building more?

Ms McAnespie: We would probably be looking at building more. However, as you can imagine, a board will be cautious about looking at new projects when we have incurred that kind of loss. We do not have a facility to claim back or get assistance from anywhere else.

The Chairperson: Just so that I am clear, are we are talking about vacant properties within schemes?

Ms McAnespie: This is just one scheme. It has 15 supported living bungalows, five of which are occupied and 10 that have not been occupied. The maximum number occupied at any given time was six.

The Chairperson: Do we have any sense of what the figure is for schemes throughout the North?

Mr Watt: There are probably pretty good rates of occupancy overall, but most schemes have at least one or two vacancies. A particular issue is that it often seems to take longer to fill the schemes than a housing association and its respective trust expected. That means that very good schemes, which everyone agrees are the right model, can take twice or three times as long to get up to their viable level. That means that housing associations are incurring very big losses from the outset, and those losses are not sustainable. The experience of Fold — I think that Helm and Trinity have had similar issues in their supported living schemes for older people — means that housing association boards now have to be mindful of that as they consider whether they can take forward new schemes.

The Chairperson: Thank you both for that. A layperson looking at addressing the particular needs of an ageing population and the process of reablement, which is the cornerstone of Transforming Your Care, will be surprised to hear that there are vacant units and properties in schemes.

Mr Watt: The respective trusts in almost all the schemes are confident of achieving full occupancy eventually. However, in the 12, 18 or 24 months that it could take to achieve that, housing associations incur unbudgeted and unsustainable losses.

The Chairperson: One recommendation refers to sharing risk. Is that what the Department and trusts need to do?

Mr Watt: I think that, in ensuring a fair sharing of risk, there are ongoing issues about revenue funding and void sharing. There are particular pressure points at the outset of these schemes. Achieving a better sharing of risk overall, but particularly for the first 24 months, would be really helpful.

Ms McAnespie: We understand that housing associations cannot fill schemes overnight. However, to fill schemes, we need to have joint risk. We need someone to share the risk of void properties with us.

The Chairperson: I just want to be clear on that: is that across DSD and the Department of Health or specifically the Department of Health?

Mr Watt: I suspect that, because most of the revenue funding comes from the Department of Health, it would have to lead in the sharing of that revenue risk.

Mr Beggs: You said that there were 10 voids for a considerable period. I understand that, in my area, there is a huge demand and a waiting list for this type of accommodation. Is there a blockage with the trust allocating its proportion of the funding, or is there a lack of applicants?

Ms McAnespie: There is a lack of applicants. I have to be fair: the trust, the Housing Executive, Supporting People and Fold are working very closely and very well together on this. The trust has done many things to try to identify clients for the properties, so it is not that there is a blockage.

The Chairperson: You reflect on the domiciliary care issue in your paper and suggest reviewing the regional rate for that. Can you expand on that?

Ms McAnespie: The regional rate for domiciliary care for people in supported living is the same as that for people living in their own home. It does not reflect the different level of care that these tenants receive, which is the next step up, so we seek a review. Also, sometimes rates are struck individually with trusts. We want a regionalisation of the rate to ensure that everyone gets a fair and equitable share.

The Chairperson: I think that that is important. You also suggest:

"Earlier and more formal involvement of RQIA in commissioning of schemes".

Are you suggesting that the process for earlier involvement is not in place? What needs to change? What is not happening?

Mr Watt: Fiona can clarify this, but I think that the position of the RQIA, as a care regulator for new supported living schemes, is a bit unclear. These are primarily housing schemes in which care is provided, but they are not care homes. Therefore, the RQIA needs to be happy that these are suitable environments in which domiciliary care can be provided, and, therefore, the scheme will not go live until the RQIA is satisfied of that. However, because it does not have a formal role as a housing regulator — it is not a housing regulator — we do not feel that it is involved early enough in the commissioning process. What can happen is that, quite late in the planning of new schemes, the RQIA requests changes. All sides recognise that this is an issue. We value the RQIA's input, but it has to be formalised in a more appropriate way. To be fair to them, DSD, the Housing Executive, the Department of Health and the RQIA are working to change the commissioning process to ensure that the RQIA is involved at an earlier stage. We would welcome that.

Ms McAnespie: I know that the RQIA is working with the Department of Health and Supporting People in developing standards specific to supported living. At the moment, the RQIA has only the domiciliary care regulations to regulate supported living, which do not necessarily fit that neatly. Work is ongoing, but it can be a difficulty because our primary task is to ensure the security and safety of our tenants. Sometimes, if supported living is looked at simply as a domiciliary service, that cannot be easily maintained.

Mr McCarthy: Thank you very much for your presentation. I have three quick questions. Cameron, you may have touched on this in your presentation. How effective is the collaboration between the Department, the health board and the housing associations in planning for the future? How can older people have an effective say in the development of supported living provision? What steps can be taken to better address social isolation in such provision?

Mr Watt: In planning for the future, there is a pretty good working relationship between the Housing Executive, which administers Supporting People on the capital and revenue side, and the trusts in planning individual schemes. We are less good at working at a more strategic level, looking overall at the level, scale and type of housing, care and support that will be required over the next five to 10 years and ensuring that we align our work at a more strategic policy and funding level.

I will ask Fiona to talk about how older people can have an effective input into the future of supported living and how we can reduce social isolation.

Ms McAnespie: Supported living really works when it comes to combating social isolation, but it also provides independence and a connection with the community, which, perhaps, I did not point out in my presentation. That is the big thing about supported living. That is how you can keep social isolation to a minimum. People can be on their own if they want to be. Some people want to have time on their own, but they also have the opportunity of a common room and voluntary social activities.

The involvement of older people in the design of supported living can be done through working with them through the various groups, agencies and advocates: the Older People's Commissioner, for example, is coming out to see one of our schemes. We work very closely with the Stirling design centre and the Alzheimer's Society to get the voice of older people and discover how they want the design and where they want the dwellings to be.

Mr McCarthy: Will you be open to any suggestions coming from older people themselves to ensure that you know what their requirements are?

Ms McAnespie: Very much so. If we build something that is not what they want, it will not work. You have to include people at the design and build stages.

Mr Brady: Thanks very much for the presentation. I am surprised to hear that premises are unoccupied, because that simply does not happen in Newry.

Ms McAnespie: I know.

Mr Brady: There is a waiting list, as far as I am aware.

Ms McAnespie: There is.

Mr Brady: So that does not apply to all areas. When representatives of the Royal College of Nursing (RCN) appeared in front of the Committee a few weeks back, they described Transforming Your Care as a vision without action. They said that unless proper infrastructure is put in place, it will not work. They also said that there had to be measurable outcomes. That does not seem to be working.

A few months back, Minister McCausland admitted that he had failed to reach supported housing targets. I sit on the Committee for Social Development and am very aware of the overarching issues. A couple of years ago, the Committee for Social Development visited Fold Housing in Gordon Dunne's constituency, in the very leafy suburbs of Holywood.

Mr Dunne: I do not think so.

Mr Brady: It was very nice, I have to say. We saw telemonitoring working when we were there: a woman had fallen, and the telemonitoring service was able to get an ambulance to her within a few minutes. That works, but obviously there is not enough of that. There needs to be more.

A couple of years ago, in my constituency, Trinity Housing built five houses designed as lifelong housing, in that they had wider doors for wheelchairs and ramps. The water was recyclable, and they had panels in the ceiling to accommodate a floor-to-ceiling lift. A huge amount was spent on adaptations, and that seems to be the sensible way to go in future. Is that being addressed? It would save money in the long run.

Mr Watt: I will pick up on the overall point about supported housing delivery, and Fiona will talk about the technology. Overall, housing associations have been meeting the headline targets for social housing delivery, but Mr Brady is right to say that the delivery of supported living has been below the level set in the targets by some margin. Part of the reason for that is that a lot more capital was provided at short notice at the beginning of the spending period three years ago, and we have been working to catch up. Much more needs to be in place before all partners will buy in to a supported housing scheme. Some good work is being done by the housing and health sectors, and reviewing the commissioning process for SP will ensure that housing providers, housing associations and any managing partners are involved in the commissioning and planning of new schemes at a much earlier stage so that lots of schemes are not rolled over from one year to another, with a backlog accumulating. I am cautiously hopeful that the delivery of supporting housing will improve.

Mr Brady: When we were in Holywood, we had a presentation from the RQIA and the housing association. I think that it was before your time, Cameron. The special needs management allowance (SNMA) was a big issue. We visited some of the facilities, and the allowance was a bone of contention. We were getting two completely different views — one from the housing associations and one from the RQIA — on the need for the special needs management allowance, which has been in place for quite a while. Has that impacted on supported living facilities? Has the money been replaced? There was a lot of discussion around that.

Mr Watt: Fiona is more expert on the SNMA than I am. The funding remains in place, although it was reduced last year. It has been frozen, and I think that Minister McCausland indicated that he intends to phase it out completely at the end of this business year. That causes us great concern. The budget is only £2 million a year, but it funds a lot of good housing and care provision for vulnerable people, including frail elderly, some of whom Fold provides for. We think that a lot of work still needs to be done to ensure that, if the SNMA is withdrawn at the end of this year, those schemes and that vital provision for frail, older people or people with learning difficulties remain viable. It is a particular concern for Fold. Perhaps Fiona will comment.

Ms McAnespie: It would not have an impact on supported housing. It is a special needs management allowance with our housing with care schemes, so it would not affect our supported living schemes. I totally agree with you about the technology. As I said, we need to find a way to include that in the builds and find some Department to fund it, because we are now coming up against people who are telling us that funding has run out for assistive technology, telecare, which you spoke about, and telehealth, which is used at Fold.

Mr Brady: I saw that.

Ms McAnespie: It is an excellent service. There is an example of somebody being at A&E 60 times in one year but only three times in the following year, because they had the value of telehealth monitoring in their own home. Assistive technology is a big thing, and it needs to be built into the properties. I spoke to the director of development just before I came here, and she is aware of one supported living scheme with another housing association that has had to be halted because £400,000 is needed for assistive technology, and the association cannot find anybody to fund it. Assistive technology is vital in providing supported living, because, as I said, it cuts down on intrusion and provides the safety and security of being able to press a button and, as you have seen, getting somebody at the end of a telephone.

Mr Brady: We saw that. Blood sugar levels were being monitored from afar. Is it intended to look at lifelong housing more closely? If such houses were built, they would save money in the long run.

Mr Watt: At the moment, all housing association homes are built to lifetime homes standards. That means that they can be more easily adapted as people age. We would like that standard to be applied to all new housing through building regulations. We think that it is time that we aimed higher with the provision of new homes being suitable for older people.

Mr Dunne: Thank you very much, Chair, and thank you, Fiona and Cameron, for coming along. You sound as if you are not rushing out to embrace change under Transforming Your Care. Is it fair to say that you are not overly enthusiastic about getting involved or going down the route of Transforming Your Care?

Mr Watt: I do not think that that is fair at all. Housing associations and our charitable managing partners have been in the lead in providing housing, care and support for vulnerable people. If you are looking at provisions that allow Transforming Your Care to be realised in terms of community-based intervention and helping people to live independently in their homes, there is no better provision than the services that are funded by Supporting People, which our members and their partners have been in the lead in providing since the programme was established about 11 or 12 years ago. Housing associations completely buy in to the vision of Transforming Your Care, and the whole range of housing, care and support options that we provide are vital in delivering it. However, the realities around blockages and funding issues have to be addressed if we are to work with partners to step up and do a whole lot more.

Mr Dunne: You said that you are not prepared to take any further risks in future developments.

Mr Watt: No. We recognise that we are businesses, and we cannot expect all our risks to be borne by others, but there has to be a fair sharing of risk. At the moment, for example, the Northern Ireland Executive are reasonably certain about their funding over the spending period. Whether it is care funding or Supporting People funding, we are getting only year-long indications of funding. Therefore, the Government are expecting relatively small housing associations and charities to deal with an unnecessary level of uncertainty on funding that they are not subject to, and that is not fair. We recognise that we have to be willing and able to take calculated risks, but, at the moment, on far too many of these schemes, we reckon that all the risk lies with the housing association and a charitable managing partner if there is one. That is neither fair nor sustainable. The board of Fold Housing Association would not be acting prudently and doing its job correctly if it were to press ahead with lots more supported living schemes for older people when it is bearing a £1 million loss on Gnangara in Enniskillen. Therefore, the issues that have come to the fore there need to be dealt with. As and when they are dealt with, Fold and other housing associations will step up and provide more schemes.

Mr Dunne: What was the problem there? Generally, as I understand it, housing associations identify demand and then build to meet that demand. What was the case in Fermanagh? Did the requirement change?

Ms McAnespie: It was a commissioned build: we did not build at risk. It was a commissioned building by the Western Trust, designed with it to meet what it said was the need at the time. Reflecting on what Cameron said, I know that it takes a number of years to get from the planning and building stage to the actual opening. In that period, we had the reorganisation of the trusts and the RPA, and there was also a change in personnel. When it came to opening the building, there was not the demand that had been assessed as being needed at the time the building was commissioned.

We made a point today about assessment of need — true assessment of need. We all know the demographics, and we all know that there is an ageing population and that there are more people with dementia. However, we need to know that we are building schemes where the real need is now and into the future. Mr Brady referred to lifetime homes. We are building homes and properties that will be here in 40, 50 or 60 years' time, and they need to meet the need reaching into that time. It was really down to the assessment of need at the time, but it was a commissioned build.

Mr Dunne: We are aware of Fold, and Mickey has covered our constituency quite well. You have two types of schemes in North Down: housing with care and sheltered accommodation. Will you clarify the difference in how they operate?

Ms McAnespie: The housing with care schemes are registered with the RQIA as registered residential care homes, so they provide 24-hour care and support, and someone is there 24 hours a day. In sheltered accommodation, a scheme coordinator is there, usually from 9.00 am to 5.00 pm, Monday to Friday. The people there have independent living, and they are really quite well and able to live on their own. They live in flatlets with their own kitchen. That is primarily the difference between —

Mr Watt: Supported living sits between sheltered housing and housing with care.

Ms McAnespie: It is the next step up.

Mr Dunne: The schemes in Holywood are very popular. There are waiting lists for them, and people are always trying to get in. To be fair to housing associations, I think that they have done a good job in the provision of purpose-built housing, and things have moved on tremendously in past years. I know that there are issues about the management of housing associations, and that has still to be resolved in a number of cases. However, as elected representatives, we certainly appreciate the good work that has been done in the provision of purpose-built accommodation in areas of need. It is perhaps not always appropriate for the type of house that is required but, to be honest and fair, a lot of good work has been done. It is important that we record that. What you need, basically, is more engagement from the trusts. You need to know what is going on and to be involved. Is that fair to say? You need commitment from the trusts towards funding and support?

Mr Watt: We need earlier commitment from the Department of Health at all levels and, as I said, some sharing of risk. We are not asking for all our risk to be removed, but some fair sharing of risk in taking forward these schemes is vital.

Mr Dunne: What about sites generally? We have talked about that before. Is finding sites an issue?

Ms McAnespie: It can be difficult. Perhaps Cameron could talk about that.

Mr Watt: At the moment, access to land supply is the biggest single blockage for all new social housing delivery. That applies to new supported living schemes as well as to all social housing. Perhaps there is less local opposition to supported living schemes for older people than there might be to other forms of social housing, but it remains a big challenge. In meetings with the DSD and the Department of Health, we discussed whether the trusts could bring forward more of their own land, where suitable sites exist but are redundant. There might be a way of setting that aside for new supported living schemes that meet the trusts' objectives without the trusts having to go through a bureaucratic process of disposing of land on the open market. Perhaps there is an opportunity there.

Mr Beggs: I want to get back to the definitions of "supported living" and "sheltered housing". In the housing sector, is there any doubt about the difference between the two? What are the key differences between sheltered housing and supported housing?

Ms McAnespie: Sheltered housing is the lowest level. Most people in sheltered housing will not have a care aspect to their accommodation. They may have domiciliary care, but, generally speaking, they are much more independent. Supported living is the next step up. It has the added advantage of 24-hour security and safety. It is usually for people who need an element of support to maintain their tenancy and an element of care. It is the next step up from sheltered housing.

We see sheltered accommodation as near enough to independent living, with a little bit of help, such as someone being there to point you in the right direction. The scheme coordinator will be there, 9.00 am to 5.00 pm, Monday to Friday, with a luncheon club once a week and other activities.

Supported living is geared towards people with more complex needs, such as people with early onset dementia. As I mentioned, it also supports carers. We are very clear about the definition.

Mr Watt: This inquiry has demonstrated that different terminology is used, including by different parts of government. I hope that one of the outcomes of the inquiry will be that we clarify, at a government level, the various definitions and that those definitions will be used across government, so that we have clarity about what is being provided where.

Mr Beggs: My question is whether you perceive that there is any doubt in the housing sector about the definition of sheltered housing and supported living.

Ms McAnespie: The answer is no. We are very clear about that. Also, sheltered housing is allocated through the common selection list, whereas supported living is allocated through the health trusts, in conjunction with the Housing Executive and Supporting People. It is very clear to us from that perspective.

Mr Beggs: Like me, you were perhaps a bit surprised that some people decided to introduce ambiguity. I was aware of a very clear distinction, but the Department has sent us a letter indicating that it is now reviewing the definitions.

The Chairperson: At least that is a positive piece of work and a positive outcome.

Mr D McIlveen: I want to touch on something that Gordon Dunne mentioned. Let us home in on this scheme in Enniskillen where you are holding quite a bit of risk. What does that scheme actually look like? Is it self-contained, or is it a communal-type building? What does it actually look like?

Ms McAnespie: It is beautiful, I have to say — although I would say that, I suppose. When you approach the scheme, it looks like 15 ordinary bungalows, in which any older person could live. When you enter a dwelling, it is exactly like a bungalow, but when you go out the back door, you are into a link corridor. It is secure. I use the word "secure", but it is a corridor that leads to common rooms and access to other services. That is what it physically looks like. If you are the main carer and are living there with your spouse or your partner who has dementia, if they go out the back door, they can go off and have a walk round a secure garden. There is that security and safety aspect to it. That is what the scheme looks like when you drive up to it.

Mr D McIlveen: I ask because, if void periods are putting such a risk on you as an organisation that you are almost timid about investing more in new schemes, that has to be dealt with.

In my private sector life, I have managed hundreds of properties, maybe even thousands if I counted them up, and when there is a void period, you try to fill it, even for the short term, if you have to. I have certainly been involved in transactions in which people have gone into a property knowing that they are going into it for a maximum of three months, six months or whatever period it may be. What is standing in your way of doing that with these cases?

There is demand for emergency housing; we see it in our constituencies every day. I struggle to accept the fact that there are not 10 people in the Enniskillen area who would give their right arm to get out of a hostel into a property like this, even if it is only for a short period. At the end of the day, it will generate cash flow for you, so that risk will not be as high as it is at present. What are the restrictions? What is stopping you from doing that? Surely that would be sharing the risk with the trust or the Department as well, because the Department is taking the risk by giving you more flexibility in order to supply what is needed at a particular time. It may have to wait for a month, which may not be ideal. What is stopping you from doing that? I hope that you get what I am saying.

Ms McAnespie: I do. I will give you a brief history. We mentioned the properties that were void for three years, and, throughout that period, we have been working with the trusts and have changed our category of care. We reduced the age for applicants. First, we are registered with the RQIA as a domiciliary care provider in this scheme, so we have a regulation and are registered for people over the age of 60. Secondly, given that the properties were built with DSD and housing association grant

(HAG) moneys, any change in criteria or client group would have to go for approval to our colleagues in the Department for Social Development.

We also have to take into account the fact that we have five tenants there who meet the criteria, so we have people there with dementia and people with mental health problems. The scheme has 30 units: 15 units are housing with care, so we have 15 people with dementia on the same site. Therefore, we have to take into consideration the needs of the other clients — the other five tenants and the 15 people with dementia.

We explored those areas, had workshops and have been, with the assistance of NIFHA, consistently looking at different ways, but the blockage for us is registration, because we could no longer be registered. That would mean our becoming a general needs landlord, and we have considered that. That would probably mean looking at the five people who are currently there. From our perspective, although it would bring in some income, it is not the income that we need. We need to maintain the 30 units, the income that comes from the Supporting People moneys, the rent and the care charge. It would also mean that the trust would not be involved, and it commissioned the build. We would have to negotiate with it. It would be difficult for us to do.

Mr Watt: On the tenancy side, housing associations are routinely expected to provide secure tenancies rather than temporary tenancies, so as well as registration, regulation and allocation issues, there are tenancy issues. We routinely provide secure permanent tenancies, and all that would have to be unpicked. Those four or five areas would have to be addressed if we were to provide temporary general needs tenancies. As Fiona said, general needs rent levels would be only a small proportion of the overall funding that Fold has budgeted for in rent. Supporting People and care represents a much bigger package.

Mr D McIlveen: I am not suggesting that the rules would have to be completely rewritten. This is sometimes the frustration of being outside the public sector looking in because it does at times seem to operate very different rules compared with what happens in the real world outside.

We are not suggesting putting every crisis tenant — for want of a better or more politically correct term — into high-quality accommodation. I am not suggesting that at all. It is difficult for me to hear that you are shouldering the risk. There is a possible solution to generate cash flow. I accept Cameron's point that it would certainly not be at the level that you should be getting from the trusts. I suppose that, at the minute, it is all or nothing, whereas there may be opportunities with a slight diminishing of the restrictions that could generate some cash flow for the housing association until the trusts' commitments come to fruition.

Ms McAnespie: In partnership, the trust and Fold are looking at changing to a learning disability client group for this scheme because there is demand in that area. That is on our list and will be one of the lower-down options. However, if we do not get to capacity soon, we will have to look at something along the lines that you are speaking of.

The Chairperson: I thank you both. That was extremely useful, more so from the point of view of the various definitions that were given. As you rightly point out, Cameron, the information that we have been gathering since starting the inquiry has been clouded and confused. It is difficult to plan, strategise or develop actions that would be required for Transforming Your Care and supported living if you do not have an agreed definition. I welcome the fact that the Minister has acknowledged that and is reviewing it.

The issue of voids is also interesting. There is an increasing demand for this type of accommodation yet we have vacant properties. We need to be able to do something about that, which goes back to the definition issue. The Older People's Commissioner said that, if we do not have an agreed definition, where is management planning and pre-planning, and where is the information about choices? If that information is not in the public domain, how do people know about or even be attracted towards this type of accommodation?

We will certainly take your recommendations on board. The session has been very useful. As I said, we are working through a number of organisations and will be happy to share the Committee's findings with you and certainly have your input into those findings. Thank you very much.

Mr Watt: Thank you very much.

Ms McAnespie: Thank you.

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Transforming Your Care and Older People: Age NI

14 May 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Transforming Your Care and Older People: Age NI

14 May 2014

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Samuel Gardiner
Mr Kieran McCarthy

Witnesses:

Ms Judith Cross	Age NI
Mr Duane Farrell	Age NI

The Chairperson: I welcome, from Age NI, Ms Judith Cross, strategic policy adviser in health and social care, and Mr Duane Farrell, director of policy. You are very welcome. Let me advise you, as witnesses, that the Committee has read your briefing paper, and we thank you for it. We note that it is very broad in scope and that a lot of detail is provided on important issues, such as domiciliary care, community meals and so on. However, we want to be very clear that the focus of our review is supported living for older people within the context of Transforming Your Care (TYC). We want to maximise the time we have with you as best we can. Normal procedure is that we ask you to make a 10-minute presentation, and then I will invite questions from members.

Mr Duane Farrell (Age NI): I hope that we can do better than 10 minutes for you and move to the substantive business of questions and answers. The first thing I want to say is thanks to the Chair and Committee members for inviting us here. We welcome the opportunity to give evidence to the Committee on cases for older people and Transforming Your Care, particularly around enabling older people to remain at home. We understand that the Committee is looking at the scope of this in its review of assisted living and we are happy to provide evidence.

Let me just quickly say something about Age NI. It is a regional organisation which, over the past year, has had about 125,000 engagements with older people across domiciliary care, day care and residential care, as well as the work we do with older people's groups and networks across Northern Ireland and the advice we provide through our advice line. Our comments, and the evidence we provide, is on that basis.

Older people have been clear that they want to remain at home, and die at home where possible. Given that this is Dying Matters Awareness Week, it is probably quite an important point to make. We have engaged with many of you as individuals, Committee members and through your political parties. Many people have given support for Age NI's vision of social care. We talk about:

"quality integrated social care that recognises the rights, aspirations and diversity of us all, and is based on the right to live with dignity, independence, security and choice."

We welcomed the vision of Transforming Your Care. Home as the hub of care is what older people want for themselves, and we have been very active throughout the process of Transforming Your Care and have made a series of recommendations to enable that to happen. Home as a hub, as a concept, like everything else, does not happen in a vacuum, and housing is a vital component in enabling older people to remain at home and is central to the Transforming Your Care vision.

It is probably important to say, at this stage, that we are not a specialist housing group provider, but our evidence highlights how the importance of services and housing options for older people are pivotal if we are to realise the vision in Transforming Your Care to enable older people to remain at home for as long as possible.

Just by way of establishing some context, the arguments are probably well rehearsed, but it is always important to point out demographics. We are living in an ageing population that is not as healthy as we would like it to be, and levels of disability significantly increase with age. Poverty and fuel poverty are rising; levels of pensioner poverty are stabilising, but we have a view that that is about broader issues. We have high levels of owner-occupying and higher levels of older people in nursing and residential accommodation when compared to England.

We also highlight the current situation with regard to how social care is provided across Northern Ireland, and it is probably important to flag up our concerns about how services are potentially being rationed on the basis of meeting only high, critical and substantial levels of needs. We know that enabling older people to remain at home does not happen in a vacuum and is the responsibility of more than health and social services. DSD and housing are significant factors. However the capacity for Health and Social Care to deliver on a range of social care services to enable older people to remain at home or in a supported housing environment is seriously called into question as, we believe, the evidence in our paper shows.

Age NI makes no apology that any discussion of future housing options must include older people as part of that debate. It is about choice.

In order to live at home, and for home to be the hub of care, people need a decent suitable home in which to live. We believe that this aspect receives little or scant attention in public policy. The evidence is clear that bad housing has a knock-on effect for the NHS and other areas of public policy. Many of the chronic conditions experienced by older people have a causal link to, or are exacerbated by, particular housing conditions.

The context section that we included our paper shows that a great number of old people are living in fuel poverty. Increasing numbers of the older old-age cohort are likely to need care and support. Increasing levels of ill-health and chronic conditions amongst older people — coupled with restrictions in care packages and calls for the reform of funding of adult social care through the Who Cares? The Future of Adult Care and Support in Northern Ireland consultation — potentially make for a perfect storm.

The Committee is aware of Age NI's call for a regional prevention strategy led by the Department of Health, as we believe that prevention, in many instances, is the key to the promotion of good health and reducing health inequalities. For older people, investment in preventative social care services is cost-effective and can increase their quality of life. Housing needs and solutions should be part of any regional strategy. Age NI believes that a regional prevention strategy can reduce the need for the provision of social care, both at home and in a care home setting. It can reduce attendances and admissions at emergency departments and enable older people to remain at home where they want to be.

A regional preventive strategy, driven by the DHSSPS but including Departments such as the DSD, has the added advantage of bringing together the key elements so that we can ensure provision of supported housing in all its forms. That is what older people want and desire for themselves. I made the point earlier that the voices, experiences and desires of older people must be central to any discussions on supported housing options.

I think that those are probably the useful key points to start off on, Chair.

The Chairperson: OK. Thank you, Duane. Let me just pick up on the overall message: it is about the voice of older people in issues such as supported living. One of the issues that we have been confronted with through this inquiry is that of choice. We learnt very recently about vacancies in facilities. We visited one of the facilities last week, Cedar Court in Downpatrick, and I think we all agreed that it was a modern, vibrant facility with quite a number of characters as tenants as well. They seemed to really benefit from that particular model of care. The staff seemed to be very enthusiastic about the model that they were delivering, but there were still vacancies in the facility. My question is this: do you think that there is a general lack of awareness among older people about supported living as an option? Are you coming across that?

Mr Farrell: Anecdotally, that is a fair comment. There is a lack of awareness. The Committee has also discussed how we use language and the terminology of "supported housing" and "sheltered accommodation" and the confusion between those models. Very clearly, I think that there is a greater awareness of fold and sheltered accommodation, but of the more specialist housing models, housing-with-care models, there is probably not huge awareness among older people.

The Chairperson: OK. One of the things in your paper that jumped out at me was the number of care assessments. I put this in the context of supported living and I am staying on that as an issue, but the number has actually been decreasing. Is there a rationale for that?

Ms Judith Cross (Age NI): We asked the Health and Social Care Board to explain that and it was unable to do so. Our view is that there is an increasing number of older people but, as you can see from the chart, the number of domiciliary care assessments is actually going down. We know from evidence, as Duane said, from anecdotal evidence, that trusts are meeting only critical and substantial need. Those people who, in the past, would have been entitled to some form of low-level help are not even being assessed. Our advice line also has evidence that older people are being told that that type of service is not being provided any more — services that they are supposed to be providing. Trusts seem to be cutting back on the number of packages.

The Chairperson: Should issues such as supported living be factored into those care assessments?

Ms Cross: Yes. The Northern Ireland single assessment tool should capture the need for some sort of supported living if the older person is in a house that is not suitable. It should capture that, yes.

The Chairperson: One of the things that the Committee has been discovering throughout this process is the more strategic issue around the ageing population. In her evidence session, the Commissioner for Older People said that there were no clear plans or projections. There was not even, in essence, a clear definition of supported living, but there were certainly no clear plans or projections available from the Department. Would that be your sense?

Mr Farrell: Absolutely. I would go back to the start of the Assembly term. We believe that population ageing is a brilliant success but requires policy planning, housing and health and the interface between housing and health is one of those areas. We asked at that time that ageing should be seen as a key driver for the Programme for Government to drive the types of culture changes that were needed in policy and services. Population ageing is to be seen as a success, but what does that mean in policy terms and for the challenges that are faced in our society? The interface between housing and health is one of the areas that we have to see coming through in policy planning and service planning.

The Chairperson: Is there any sign that that is now shifting or that organisations such as yours are in the room when it comes to projections or planning?

Mr Farrell: We are, in different spaces. We have been very heavily involved in health and social care and in the Department's work on Who Cares? The Future of Adult Care and Support in Northern Ireland and the Health and Social Care Board's consultation on Transforming Your Care. We are probably less involved in the spaces relating to housing, but that is not a surprise to us; housing is not a particular or discrete focus for Age NI.

The Chairperson: OK. Finally, in Transforming Your Care and the implementation plan, it was suggested that the whole notion of supported living and its development would reduce the need for statutory residential provision. What is your sense of that?

Ms Cross: I suppose there is a view that a lot of people in residential care could be easily cared for in some sort of supported living environment. However, for Age NI it is about choice for older people. Our view is that there will always be a need for some sort of residential model and that there is a need for different models across the age spectrum. No one model will do it all; there have to be different models of housing need for older people just as there are different levels of housing options for the whole community. It can reduce the need for residential care, but I would be concerned that they would say that there is no longer a need for the residential model of care.

The Chairperson: OK, thank you.

Mr McCarthy: Thanks very much for your presentation. How effective is the collaboration between the Department, the board and housing associations in planning for the future for supported housing? Duane, you said that it is important that senior citizens have a very strong input into the type of supported accommodation they require. How would you assess those?

Mr Farrell: There are two questions there, Kieran. I suppose, in light of what I said, which was that housing is not a specialist area for Age NI, I probably feel slightly ill-equipped to comment authoritatively on your question about collaboration with the Housing Executive and housing agencies.

I feel a lot more equipped to answer your question about participation. We have a significant journey to travel with respect to how we enable the effective participation of older people. Age NI operates an initiative called Peer Facilitators, which are groups of older people who we have trained in facilitation, listening and reporting skills. They engage with older people in the community and feed back to us on the issues that are there. They have spent the first four months of this year in residential and nursing homes across Northern Ireland listening to the voices of older people in those facilities.

It is not a straightforward process; there are people with complex needs or cognitive impairments, and the communication skills required are significant. In addition, when we are potentially running consultations, the questions we ask on policy consultations are complex and not the easiest for older people to engage with. I do not think that there is a strong culture of participating with people, particularly those with complex needs, in a way that allows them to participate effectively. Age NI and others are looking at innovative ways to bridge that gap, but a lot more work has to be done if we are serious about the meaningful engagement and participation of older people in service design and policy development.

Mr McCarthy: Do you agree that it is important that senior citizens are consulted as far as possible so that provision can be made?

Mr Farrell: We believe that it is a fundamental element of a rights-based approach.

Ms Cross: It is also a significant part of section 75 of the Northern Ireland Act. They have to consult; it is a legal duty.

Mr McCarthy: OK, thanks very much.

Mr Brady: Thanks for the presentation. You said that the type of housing involved can impact on a person's health. Part of the difficulty is that a lot of older people live in rural areas, where housing is not fit for purpose. I am a member of the Committee for Social Development, which deals with housing. Not as much supported housing is being built as should be built, so there is a dearth there.

When the Commissioner for Older People was appointed, the argument was that she would be at the heart of policymaking for older people. That does not seem to have happened, and people such as you should be an integral part of policy decision-making affecting older people, or senior citizens as Sam refers to them.

Irrespective of the type of housing people have, they need enough money to live on. At the moment, there are people on £145 a week, which falls about £30 short of what was projected three or four years ago that they would need to live on to have a reasonable quality of life. Therein lies part of the problem. You could have the nicest house in the world, but, when we talk about fuel poverty, it is about poverty. It does not matter what sort of heating system you have, if you cannot afford to put oil or gas into that system, forget about it. That is an inherent part of the difficulties that older people face.

Very few housing associations look to lifelong housing when they build houses. Those types of houses have wider doors, facilities for ramps and lifts, walk-in showers, and all that. Forward planning is very much lacking, but ultimately it is about the amount of money that people have. We have one of the meanest, if not the meanest, pension systems in the developed world, and that is the reality. People need to be aware of this, because one can provide all the services, but people do not have the income that provides the quality of life that they need and deserve. If you have enough money to live on, that creates independence and reduces social isolation; it helps quality of life, helps people to live longer and gives them a better quality of life, which is important. Would you like to comment on some of that?

Mr Farrell: There are a couple of areas there. From Age NI's perspective, more people campaigning, advocating and bringing the voice of older people to the fore, whether that is the Older People's Commissioner, age sector organisations or specialists in housing, with a focus on older people, is to be welcomed. There is a huge interface, and I appreciate that the Committee has a very specific focus on supported housing and on this issue. Some of your points are valid and important. The ageing strategy that the Office of the First Minister and deputy First Minister has out for consultation indicates that, for one in every 230 older people, the house that they live in fails to meet decent homes standards. Obviously, that will have a knock-on impact on their health, their ability to live independently and their ability to have a decent quality of life. There are interfaces, and I suppose that, as the Committee takes forward its role and looks at those broader interfaces with the Department for Social Development, it is quite important that it looks at a range of policies.

Mr Beggs: Thank you for your presentation. You indicated that you have facilitated engagement with older people over the past number of months. Did you pick up their level of knowledge about supported living?

Ms Cross: We did not consult them on the concept of supported living. We were working with older people in the statutory residential homes and we also worked with older people who lived in nursing homes, because the Department is looking at reviewing the standards for nursing homes. That was why we were in those facilities.

Mr Beggs: Have you had any wider discussions beyond what exactly supported living is?

Mr Farrell: Not on supported living. We have had conversations with older people about what their home is to them. It is important to flag that up. For some older people, it is the home that they are currently in. However, for a larger swath of older people, a home is a more nebulous concept. It is about their links into the community, and their ability to live independently and engage with the resources around them. That indicates a more flexible approach — to a spectrum from the building they are in to a place where they feel valued, safe and secure.

Mr Beggs: One of the aspects of supported living, where it exists in Northern Ireland, is the very limited geographical locations involved. How important is it for older people who need supported living to be able to continue living in their home, to have access to their local community, friends and family and to issues down the street etc?

Mr Farrell: It is hugely important in our work with older people living in residential care, although I do not think that it is unique to supported living. In a world in which our families are becoming a bit more geographically diverse, the ability to have people in close contact, with regard to the point that I made a minute ago, is essential to them feeling safe and secure. On a broader level, Age NI believes that access to certain services should not be a postcode lottery. If we are serious about supported living being a means to enable older people to remain at home, there should be an ability to access that wherever they are.

Mr Beggs: With regard to planning for the future, do you accept that it is also important to consult those who are still in their own homes?

Mr Farrell: That brings us to the point we made earlier, which is that the voice of older people should, absolutely, be central, whether their own home is currently residential, a nursing home or whether it is their family home that they have been living in for a number of years. That provides a challenge to policymakers and service developers, because I do not think that we have good mechanisms to do it.

Mr Beggs: As representatives of older people, and as people who, to a degree, are involved in policymaking, do you have a clear definition of what supported living is and what is just an older person's home?

Ms Cross: No.

Mr Farrell: No, is the straight answer to that. We do not have a very clear definition. We feel that terms are used interchangeably to describe a fold or sheltered accommodation, through to the Mullan Mews/Sydenham Court type of model, which is probably what we are more fully —

Mr Beggs: As do some others.

Ms Cross: I think that that is probably part of the problem.

The Chairperson: No other members have indicated that they wish to ask a question. I think that you are right and that that is part of the issue. How are we supposed to plan, project and forecast for types and models of accommodation that we have not properly defined? That is the real challenge to come out of this.

I want to thank you for that —

Mr Brady: I have just one final question. With regard to the definition of supported housing, I attend the Pensioners' Parliaments, and supported living does not really feature as a major topic. That is indicative of the lack of understanding of what it actually is. People talk about fuel, money etc, but they seldom talk about supported living and supported housing, which is such an important issue for them as they go forward into the future. Maybe that indicates a lack of understanding of the definition of what it actually is. Maybe it is time that a more definitive assessment was done of what it actually means and what it is for people.

Ms Cross: It is probably similar to the whole issue of care and residential homes and domiciliary care. You tend to deal with it only when it is your own personal circumstances. Our advice line gets lots of calls from people who just find the whole situation baffling. They find that what they are entitled to with regard to social care and domiciliary care is confusing. My instinct tells me that the situation with supported housing is exactly the same. You deal with it only when you know that you have to do so.

Mr Brady: It is a challenge for all of us to get that message out, because there are so many types. It is about trying to tailor individual needs to the individual type of supported living or supported housing that the person needs. I do not think that that diversity is clear to people. I have spoken to people who are in sheltered accommodation, with a warden, or who are in fold-type accommodation. We visited Cedar Court last week, and it is such a refreshing place. However, there is so little of that available, and therein lies the problem. Then again, it is underoccupied, and why is that? You do wonder. It is a challenge for all of us.

The Chairperson: Thank you both. That was very informative for us. The first message that we take out of this is the need to have a clear definition of supported living. The second message is that the voice of the older population should be included in processes and that there is a need to forecast and plan. Thank you for your time.

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Transforming Your Care and Older People: Professor Anthea Tinker

28 May 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

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Members present for all or part of the proceedings:
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Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr David McIlveen
Mr Fearghal McKinney

Witnesses:
Professor Anthea Tinker King's College London

The Chairperson: Professor Tinker, you are very welcome. I will give you a minute to gather yourself. You are here on behalf of the Department of Social Science, Health and Medicine at King's College, London. The normal procedure is that we ask you to make a 10-minute presentation, and then we will invite comments, questions or queries from members. So, I will hand over to you.

Professor Anthea Tinker (King's College London): Thank you very much for asking me to come here; I am very honoured to do this. You have asked me to discuss specifically best practice, particularly in relation to Europe, lessons about supported housing where perhaps Northern Ireland might learn. I will draw mainly on research that was done for the Technology Strategy Board on long-term care. We were looking specifically at Europe, but we also had a case study from the Netherlands. You can ask me about that, and I will refer to it. I am doing it on behalf of my fellow researchers, Professor Jay Ginn, Professor Leonie Kellaher and Eloi Ribe . There were four of us involved in the specific piece of research, but I will draw on other research as well.

I have produced some notes for your Clerk, including headings that I will go through. I will make a short introduction, and then you may want to focus on some more than others. I thought that it would be sensible for me to say a few words about where we are starting from so that we all agree. Secondly, what do we know? Thirdly, what can we learn from Europe? Fourthly, some of the findings from the main study and from the Netherlands, what wider issues come out of the research, and a note of caution about drawing conclusions from the Netherlands. We have done that, but there are reasons why it might be advisable to have some hesitancy about it. I start by saying — and this will all be very familiar to you — that the numbers of old people will increase dramatically, particularly very old people. I am sure that you know that, in Northern Ireland, the number of people who are 85-plus will almost double by 2025. Therefore not only do we have more old people but we have more very old people. Specifically, this will mean not just a need for more services, particularly housing, but that

there will be a drop in the number of people of working age to provide those services. I suppose that the most challenging thing that we all have to face all over the world is the percentage of pensioners who will have dementia: about one in five people aged 85 and over. If you think about how many people are in this room and how many of us will end up with dementia, it is pretty frightening. That is the main thing that we have to bear in mind.

What do we know? I will just say something about that and then we can go on to what we can learn from elsewhere. The first thing that we know from research abroad, particularly from the EU and the Organisation for Economic Co-operation and Development (OECD) is that housing, which is one of the main foci of your Committee, is increasingly recognised as being the key ingredient, if not the only one, in well-being. It is not just health, which we tend to think about, but housing.

The second thing is the growth in solitary living. When you are planning supported housing, we all have to be aware of that. It is not just that people are surviving more into old age, often it will be a spouse, but people are also choosing to live alone. They may be older people. People are divorcing much more in old age, but there is also an increase in solitary living in middle age. Whoever is involved with housing later on will be faced with more and more people living alone. That is not necessarily a bad thing because living alone does not necessarily mean that you will be lonely.

The third thing is the growing evidence, which we have known for a long time and a lot of my research when I was in the Department of the Environment and, subsequently, as an academic, is that people want to remain in a home of their own. In our research, we do not dismiss institutional care. In fact, we say that there is a demand for it and a case for it, but there is growing evidence that people want to remain in a home of their own and not in an institution, although that may have to come afterwards.

Fourthly, housing is increasingly being bound up with the environment. We are not just talking specifically about the bricks and mortar of housing; we are talking about the environment. The work that I did for the World Health Organization on age-friendly cities showed that. It is often the little things in the environment that, when you are looking at supported housing, you need to link in with, such as the need for loos, which is very mundane, but that is what older people said to us. Work that we are doing on a big new grant with the University of Edinburgh is on mobility, mood and place. One of the ingredients of that, which is quite novel, is called co-design, where groups of architectural students — we are catching them early — are working with older people to co-design housing. They have done the first part in Manchester where architects and older people work together to think about the sensible thing to do about that area. It is the link with housing and the environment.

The final thing is the shortage of housing. It is a mundane thing to say, but perhaps we can discuss how to get over it. Those are the four ingredients that we need to think about — where we are and what we know. I do not know whether you want to start with learning from Europe or whether you want me to say anything by way of introduction.

The Chairperson: Go ahead.

Professor Tinker: With regard to the context of what we did when we looked at Europe — I have to say that the research is based on evaluated schemes — you can read about all sorts of things, including people writing to the press, journals and so on saying, "We have this fantastic scheme. It is a pilot or whatever", and you do not know whether it really is good or not. So, in Europe, with the exception of the Netherlands, where we looked at pilot studies, we are looking at evaluated schemes. That is a word of caution. People are very keen to show what they are doing, particularly in supported housing. They say, "This is what we are doing. It's fantastic." However, we were looking at evaluated schemes, whether they were on costings or on the views of older people or staff.

Our starting point was that we realised that certain things provided the context. I mentioned the growing numbers of very old people; we knew that. We also realised that there is an increased prevalence of long-term conditions. If you survive into old age, you are likely to have some measure of disability. Although women live longer, they will be more disabled in old age than men. We do not know the reason for that, but they will be. There are rising expectations, and we all expect more. There are more older people in employment, and I am an example of that. Some people will choose to retire in their fifties or sixties, but many older people will want to, or will have to, work because of income. That is a lesson for us as well. We all know that the numbers in institutions and the associated cost will have a knock-on effect; we know that there is very poor care in institutions; we know that there are financial constraints; and we also know about the key role of informal carers and the complexities of funding. That is the background.

How do we crack this problem, which is, I imagine, at the heart of what we want to discuss? The first thing that I said — perhaps we can have a discussion on this now — was about the lessons that we learned from Europe, the most important of which was putting older people at the heart of provision. I do not know whether you would like to comment or ask questions on that.

The Chairperson: We can come back to it if members want to reflect on it when you are finished.

Professor Tinker: Do you want me to finish?

The Chairperson: Go on with your presentation if you are happy enough, and we will come back to it.

Professor Tinker: Absolutely. It is about putting older people at the heart of services and ensuring that we do not just pay lip-service to that. We are all very different. Men and women are different, as are black and ethnic minorities. We should not generalise about the over-65s, the over-70s or very old people. We are all very different.

When we did our work in London on age-friendly cities, we found that older people knew very much what they wanted. They knew that they wanted to be involved in the design of housing, where it was placed, whether it was a one-bedroom or two-bedroom flat, and so on. Part of that involves the scenario of reablement, which is the technical term, whereby we start with older people and find out what advantages and skills they have and how we can use and involve them. So I say this: let us start with older people, and let us involve them.

I chaired the Technology Strategy Board work, which was carried out by the Design Council. That work was not evaluated, but I mention it just to spark things off, because older people were highly involved in it.

Another example is a cooking club where older people teach younger people. Another one is where older men in a neighbourhood felt that they were not being listened to, so they set up a scheme to work together to do all sorts of things. Another example is where an older person shares their home with a younger person and has a say in who comes to stay with them. We can talk more about those schemes later. The older person can choose, through a properly vetted scheme, to have someone live with them, particularly an intern. The young person pays very little or no rent, and in return for staying with the older person, they will say, "I will guarantee that I will sleep here seven days a week and that I will give you a little bit of help". There are all sorts of things that we need to do to put older people at the heart of services.

Before schemes are designed, and, in fact, during the research now, some researchers will say, as disabled people do, "Nothing about us without us". That should always be the case. It is a hard lesson for some of us researchers: start with the older people. I do not know whether you agree with that or if you have examples.

The Chairperson: Do you want to continue?

Professor Tinker: It is entirely up to you. I do not want to talk at you all the time.

The Chairperson: We will just finish your presentation, and then we will come back to it.

Professor Tinker: The second lesson is about the importance of housing and the key role that it plays. That fits in with objective 3.2 in your Northern Ireland Active Ageing strategy.
Being at home and staying at home is incredibly important, because you are familiar with it and it has a role in prevention, such as preventing falls and so on and, in particular, the key role of adaptations, which I know that you stress as well. Therefore, if you turn to ways in which older people can stay in their own homes, the first thing is that we need newbuilds. There is newbuild; however, it is expensive. Ideally, it should be a lifetime design so that it is there from day one. If you design for a lifetime, you are designing for children, pregnant women, people with buggies, people who happen to break their leg for a short time and so on.

I thought that it was ironic when I was preparing this that I saw an article in 'The Sunday Times' that said:

"After the bombs comes the buzz of Belfast"

That attracted me, as I was coming here. On the other side was a fascinating article. Home sweet home. Shed: all mod cons for £30,000. You may think that that is a jocular thing to say, but if you provide a very inexpensive pod for younger people, then that will also help older people. Indeed, you could have a group of them, if possible. Perhaps that is at the ridiculous end of the scale, but I do not think that newbuild should be ruled out.

The second way is home modifications. Sadly, money has often been withdrawn for them, but clear research has shown that it is cost-effective to provide modifications — aids and adaptations. There are one or two schemes developing in the UK, which have not been evaluated, where people — a doctor or care worker — can phone in to a central point and get something modified that very day, such as a loo changed or grab rails. That is also the case in the Netherlands. It can happen the very day they have been assessed, and that prevents someone having to move. Those schemes need evaluating, but it sounds as though it is a good idea to have them. We have a lot of well-evaluated handy person schemes in the UK. Somebody can come in, obviously properly supervised, and do something small to the home. It may be something larger, and they may enable someone to get a grant. They will help with all the cost and the things that come from the firms, such as the tenders, evaluate them, make sure that the work is done properly, and make sure that the person is safe back in the home. We can learn a lot about the ways in which people can stay in their own home.

You may not think that sharing a home with a family is supported housing, but it is a way for someone to stay in their own home. It can be the family moving in with the older person if the older person's home is too big, and that is being encouraged with the bedroom tax in the UK. However, think about the reverse, where the family builds a granny flat. That was actually my PhD. Granny flats are very cost-effective, and it can be very helpful when the older person can give help to the younger person, and that can work in reverse. I do not know whether any of you have experience of granny flats. It is not particularly good in the public sector, because what happens when granny dies? Do you move another granny in? Actually, it worked quite well in the social housing schemes that I looked at. What happens if the family moves? However, granny flats are one way of enabling an older person with a large property to move in with a family, and you have saved on that kind of housing.

What about fostering, which is developing in the UK and across Europe, shared lives and adult placements, in much the same way as it is done for children? Provided that it is properly vetted, that is another way of saving accommodation where an older person may give up their home and move in with the family, although it has to be very carefully vetted.
Do you want me to carry on?

The Chairperson: Yes, sure.

Professor Tinker: One of the interesting things from Europe, which we hardly do here at all, is called co-housing. It is most widely practised in Denmark, where there are 350 schemes. It started with younger people, but now it involves older people and some mixed communities. A group of 10, 20 or 30 people come together and decide to live together in old age. They have separate apartments but with some shared facilities, such as a club or a laundry room. This model has been very well evaluated, particularly in Scandinavia and the Netherlands, and a scheme has just started in north London where a group of older women have decided, "why not?" If people are going to save accommodation, they can group together. The evaluation in the Netherlands showed that a scheme has to be very clear in order to cope with conflicts. This did happen; people have to have a sense of responsibility and there were some conflicts, but co-housing is something that we might possibly want to foster.

I have mentioned home sharing, where an older person shares their home. One of my own students did this; she lived in a lovely big house, which she could not have afforded to rent. In return, she had a very close link with the older person and she went far beyond what she was bound to do, which was to sleep there and give a little bit of help, although she did not provide personal care such as bathing. This is another thing if you are thinking about supported housing — you can think widely.

Then there is specialist housing. Do you want me to pause here for questions?

The Chairperson: No, no, go ahead if you are comfortable.

Professor Tinker: You do not want to discuss co-housing or any of the other options? No?

The Chairperson: We will come back to the individual issues.

Professor Tinker: OK. I will move onto specialist housing. It is interesting: if people come from abroad to the UK, the thing that they always want to see is sheltered or very sheltered housing. It is completely bizarre, given that less than 10% of people live in it, but it is the one thing that people from abroad always want to see. I am sure that you are familiar with sheltered housing. The Commissioner for Older People for Northern Ireland, from whom you heard evidence — I have done my homework — said that there is confusion about terminology. I suggest that we do not get hung up on terminology; it is called assisted living and all sorts of things. I would prefer to talk about sheltered housing and extra-care housing.

Let us think about sheltered housing first. It was the best thing since sliced bread in the 1960s; it was developed in the UK. Although I say that we are learning from Europe, there are some things that England and Wales were very good at, including sheltered housing, in the past. These schemes developed, and groups of people were together in bungalows or flats with communal facilities and a warden. Everybody thought that they were wonderful, but they are not. They are no good for frail older people. Why would you move to one of these if, in fact, you could stay in your own home? Sheltered housing does not offer you very much, apart from being grouped with other old people.

The research on it discovered that most schemes, whether they were social housing or private, were difficult to let. People could not believe it: how could a scheme like this be difficult to let? What seems more promising is where you add on to these schemes and either call them very sheltered or extra-care housing. This is where you provide one meal a day, 24-hour care and extra communal facilities where, in fact, a frail older person can be supported quite well. Amazingly, however, some of these are difficult to let, too. I have provided the Committee Clerk with a summary of the research that I did, which was called remodelling. This may or may not resonate with you, but we looked at sheltered housing, extra-care housing and residential care homes, which are very unpopular, to see how they could be remodelled to provide extra-care housing. How could all these, particularly the residential care homes, be remodelled?

We found that it was difficult to do if you have a listed building. In nearly every scheme, they ran into problems, quite often asbestos; it is not necessarily cheaper to remodel than to provide from scratch. Of course, you do not want to knock down all those schemes mostly, but subsequent research into extra-care housing by Ann Netten and colleagues at the University of Kent showed that extra-care housing is one of the ways forward. It is certainly one of the things that the Government are giving money for because it does seem to provide at least care and ways in which people can join together.

Subsequent research by Richard Best and Jeremy Porteus suggests that it may not be economic to have all the range of communal facilities. I am sure that you have such schemes, but it is a positive way forward.

The more trendy thing is retirement villages, which they have a lot of in Australia and the States. Caution about these, particularly where they are private: in the States, they found that, according to their terms, people can be turned out when they become frail. Some have gone bankrupt. We have had them in England for a long time, such as Licensed Victuallers. Imagine it, spending the rest of your life with fellow pub owners. However, there has been very little evaluation.

Two famous ones have been evaluated in the UK, one at York and one at Berryhill, in the Midlands. Retirement communities might be popular and research has shown that, so that is a possibility. We have an example from the Netherlands where they have villages, but they have been unusual. One, for example, is called a care co-operative village, where they have pooled out a lot of the facilities. They have one care co-ordinator for everybody in the little village. They pool their personal budgets. The gardens are done by workers in the area who are in sheltered employment, so it is giving employment to people.

They use volunteers, so there is a lot of social interaction. They loan out motorised scooters. A care co-operative village is a possibility. You may have an existing village where you can do this, but it is bringing in resources, volunteers and people who need employment.

Do you want me to talk about some really radical alternatives? Do you want to go on to the cruise ships and hotels?

The Chairperson: Yes, we like radical.

Professor Tinker: You do? OK. You probably read about the couple who went to a Travelodge and stayed for 22 years. They found that they had everything in the Travelodge that they wanted. They did move out after 22 years. That is not being evaluated and was a one-off.

More seriously, there are cruise ships. There has been an evaluation and a cost/benefit analysis by a geriatrician. If you have a lot of money, it is very cost-effective to go on a cruise because you have all the facilities there. You are not far from a loo at any time. You have fantastic medical backup, and you will be very popular when your grandchildren and children want to visit because they have all the facilities.

I joke, but I had a friend, who, sadly, has since died, who had terminal cancer. One of the things that she did at the end was to go on a cruise because everything was to hand. They are much cheaper now. We need to think not just about the very poor but about people with a bit of money. Now, of course, you can spend all your money when you get your pension, although perhaps we should not go down that route. However, there are radical options. Of course, people in the 1930s went to boarding houses on the south coast of England, and that is where they lived. Who is to say that you sell your home and go to a hotel — would you like that?

Mr Dunne: No, thanks.

The Chairperson: I do not think that our constituents would.

Professor Tinker: You would not like to stay in a hotel for the rest of your life? No response from anybody who wants to live on a cruise ship or in a hotel. Shall we move on to technology?

The Chairperson: Yes, sure.

Professor Tinker: We are incredibly hung-up on words. Nearly every time I look at anything to do with technology, it is called something different. It is telecare or telehealth or whatever, so we should not get hung up on that, but the use of technology in supported housing is important.

Telecare provides simple personal alarms, like a pendant to press, through to smart homes, which I will develop on in a moment. They can do a whole lot of things, including reminding people to take their medication. They can press a button, and it will alert someone.

Telehealth is delivering healthcare at a distance. You assume that there is a health professional at either end of the technology. So, a carer in your home could say, "Put your hand under the camera", and someone at a distance can make an observation.

Vital signs and monitoring: I am sure that you are going to have to have that installed in supported housing in the future, where someone does not have to go and have their heart monitored or blood glucose and weight checked. It can all be done at a distance. I am in a longitudinal study and wore one of these for seven days. Everything that I did went through to a central point. That is incredibly useful, so I am sure that has to be built into things. I gather that you have an extensive telehealth programme, supported by the Centre for Connected Health and Social Care, although I do not know an awful lot about it.

It has great potential, but there is a word of warning about technology and the hype. The findings of the only randomised control trial of telehealth in the world was paid for by the Department of Health in England. It was called the whole system demonstrator. The trial was with 6,000 people in Kent, Cornwall and Newham who had certain conditions. It was about the transmission of data between patients and professionals. Early findings came out about lowering mortality and emergency admission rates, which was fine as far as it went. However, a word of caution: the response rate to the study was not high and the sample included people at very low risk. One has got to be aware of that.

The thing that has come out of all research on technology is the value of simple gadgets. Make it simple. We got together a group of engineering students and a group of older people. We had asked the older people what were their major problems, and they said walking up and down stairs. They worked with the students to devise a simple rod that ratchets up the stairs. They said that they loved that it was shiny wood and not plastic, which a lot of things are, and simple.

I think that greater use of mobile phones is the way forward. You may or may not have noticed that I carry my phone — which is, of course, switched off *[Laughter.]* — everywhere. I do that because my children told me that I need to be accessible at all times. They need to contact me, and I may need to contact them. I carry my phone the whole time. Mobile phones, smart tablets and so on have an enormous impact on people. I do not know whether you feel that.

There are ethical issues to do with surveillance. How would you feel if you were in a home, had a lot of equipment around you and knew that someone was monitoring you and could see you? Parents can now see the childminder or the nanny looking after the child 24 hours a day. How would you feel about that?

The Internet is extremely important. Here is an example of older people working with Internet companies, and here again is the potential for investment: in Almere, they got together a group of older people and Internet companies and set up and invested in a high-speed broadband network. That enabled older people to do what they wanted to do: to join in exercise classes and to be involved in art, music, theatre and so on. The evaluation reported not just increased social contact but stimulated economic growth. I have given the full reports of the research to your Clerk. You may want to look at that. It is an interesting example of an area slightly beyond your supported housing, but it is a good lesson for stimulating the economy while involving older people.

Finally, on technology, there are smart homes, where you link everything up in one home; you have the whole lot. Again, I pause. Do you want to ask anything about technology?

The Chairperson: I am conscious that you have given us quite a range of themes and information. At this point, do members want to ask any questions on what they have heard specifically?

Mr McCarthy: Thank you very much for your presentation. It has been very interesting. In fact, you have probably answered all the questions. The main one was this: how can older people have an effective say in what their requirements are? I think that you touched on that. What steps can be taken to better address social isolation in such provisions?

Professor Tinker: It is difficult to involve older people. Let us make no bones about it. You can go to the conventional groups, the well-known suspects and the people who will always say, "I speak up on behalf of older people". It is very difficult to get hold of — this is in research as well — people who are at home and housebound. One has to make very deliberate attempts to get hold of the people for whom there is no voice at the moment. There is a problem of social isolation. The most isolated people, in other research, are in southern Europe, where they have the highest rate of living with families. The families go out, they come home and they do things. The lowest rate of loneliness and social isolation is in Scandinavia, where they have the highest rate of solitary living. One should not make assumptions.

Mr McCarthy: Are there any examples of best practice in a shift of resources from acute services to support the emphasis now being placed on community services?

Professor Tinker: Most countries in western Europe, because of welfare cuts, are doing that. One way they are doing it is by giving personal budgets. I do not know whether you want me to talk about them, because there is a word of caution. This is slightly off what you are saying. Research on personal budgets — giving money to people individually rather than hospitals — is very mixed about it. The Netherlands had them for a long time, but they have now stopped them completely for new applicants, partly because of cost and partly because of abuse. They were being abused. So, there is a word of caution about giving the money to people individually. It is fine in theory, but if you have the money, how do you choose yourself? Does the older person vet the person who is going to provide the service? Do they check references? It is difficult. It is part of the shift.

Mr Brady: Thanks very much for a very interesting presentation. Kieran alluded to having older people at the centre of making policy and legislation that affects them. We advocated having an older persons' commissioner for a long time. Older people should be very involved in the issues that affect them. This week, we will have the Pensioners Parliament, and the Age Sector Platform and Age NI are very effective in their advocacy roles for older people, which is very important.

Many years ago, the Housing Executive built old persons' dwellings (OPDs), but it got subsidies to do that. When those subsidies stopped, those dwellings became single persons' dwellings. They were one or two-bedroom bungalows, but there were not that many of them. Initially, they were being

retained for older people to move into and would not have been made available to younger people. In my constituency, some of the housing associations have built limited numbers of lifelong houses, but you can see the benefits, such as wider doors, ramps, recyclable water and panels in the ceiling for persons who might need a floor-to-ceiling lift in future. Those are relatively straightforward to install, and you do not have to rip ceilings out and that kind of thing. There is a bit of foresight and forward planning involved.

You mentioned granny flats. One of the issues that I have come across is that people find it difficult to get planning permission here in many instances. That is something that could be looked at, because they can be effective. You talked about social isolation and mentioned Sweden in particular, where a lot of people live alone but social isolation is not a problem. Maybe we, as a race here, are more gregarious and we have extended families; maybe that is something, again, that we could look at.

I sit on the Committee for Social Development, which deals with housing and benefits etc. One of the big issues for older people is the amount of money that they have to live on. Here, and in Britain, we have one of the meanest pension schemes in the developed world. You get paid a basic flat rate having contributed for many years and you get very little out of it, depending on how long you live. That is an issue that affects people, but it seems to me that there is not enough interconnection between the Health Department and DSD on issues that affect older people in particular. That is something that needs to be looked at. Both Committees and the Assembly should be looking at having much more interaction between Departments, because a lot of the issues that affect older people are very much interconnected with the different Departments that deal with them.

I was interested in your radical stuff around cruises and so on. With my luck, I would probably end up on a cruise ship with retired DUP members. *[Laughter.]*

Mr Dunne: There are very few of them about.

Mr Brady: That was just a final thought. Thanks very much.

Professor Tinker: The older people's parliament is extremely important.

You talked about housing; the number of bedrooms is an interesting one. Many schemes have become difficult to let because there was only one bedroom, and two bedrooms is the way forward because couples, for all sorts of reasons, may want to live separately or with a carer and so on. Interestingly, at the last Housing Learning and Improvement Network (LIN) conference before Christmas in London, it was suggested that there may be a reversion to bedsitters for people with dementia. We can mention dementia specifically at the end, but it may be sensible to provide a bedsitter for people with dementia. One or two-bedroom flats may be the way forward. Planning permission in England for granny flats has been slightly modified.

Interconnectivity is crucial; it is extremely important that government Departments speak to one another. Pooling budgets and all sorts of things like that can do that. A lot of it is about personalities; do the people in the Health Department get on well with people in housing? A lot of it is about that.

Mrs Cameron: Thank you very much, Professor Tinker. I am really enjoying this evidence session; it is fascinating. I want to ask about the co-housing issue, with people living independently in their own accommodation as a group. You mentioned groups of 10, 20 or 30 people, which are very large groups. Can you tell us some more about how that works? Is this based on them living in their own homes?

Professor Tinker: They normally buy a large building. It might be an ex-hotel or a big Victorian house, or they might build afresh. I think that the development in north London is being built afresh, but I am not sure. It is possible. There are blocks of apartments in the Netherlands. One has about 30 people, men and women, living together in apartments, but they share a lot of things, including the cooking and laundry. You can have all sorts of sizes. It is an interesting concept.

Mrs Cameron: Yes, it is a very interesting concept. Is that provided by the local council?

Professor Tinker: There can be subsidised schemes, but quite often it is provided by people chipping in their own money.

Mrs Cameron: That is interesting because we are always looking for ways in which the state will provide but a lot of the examples in your presentation are more common sense —

Professor Tinker: Of course.

Mrs Cameron: — kind of empowering people to look at what they can do themselves and decide how they want to live into the future. I think that you mentioned — I hope that I got this right — that residential care homes in England were very unpopular.

Professor Tinker: Yes. But you are right: most of what I said is common sense, and a lot of things in life are common sense. Another thing that we have not touched on and that we can learn about particularly from the Netherlands is dementia care. As part of the village community, groups of demented people may live together. Others are together according to their interests, so people who are maybe ex-civil servants or interested in art live together in a community but separate.

There is another village of older people living together there where they are even more creative, and which, I think, is subsidised. Not only do they bring in volunteers but schoolchildren aged from 16 to 19 are employed in the evenings to cook meals for the older people. Again, you are encouraging the mixture of generations but also creating employment. The use of volunteers and people coming in is another way we can learn from the Netherlands.

Mrs Cameron: Fascinating. Thank you.

Mr McKinney: I am just thinking back to Mickey's comments. It is clear that, by the time Mickey retires, he does not believe that he will have a united Ireland and, in fact —

Mr Brady: I do, actually.

Mr McKinney: He might set about trying to unite the ship going round it.

I am interested in the legislative platform that can drive some of this. Here, the absence of such legislation means that older people can be discriminated against. What form of legislation do we need to make sure that people can demand that they get provision as opposed to earnestly pleading for it?

Professor Tinker: It is difficult in housing. In health, there is legislation, under the national service framework originally and then it translated into legislation. You cannot discriminate. You cannot have, as we used to have in London, for example, a stroke unit not accepting you if you were over pension age.

There is still discrimination in employment in the UK even though there is legislation. You may be able to legislate, but there are ways around it. It is a change of attitude more than anything. I am not sure how far you can go with legislation.

Mr McKinney: Are you saying that there are productive ways around it?

Professor Tinker: It is a change of attitudes that we do not treat older people as different from others and we do not discriminate just because you are a pensioner, of a particular age, gender or anything else. I am not sure: do you think that you could do it by legislation?

Mr McKinney: In England, for example, the Equality Act brought in the goods, facilities and services that allows for people to demand or expect certain provision. Here, we do not have that yet.

Professor Tinker: I did not know that. Maybe that is one way forward. You know more about that than I do.

Mr McKinney: I have one other point, and it is down to how people are grouped. You talked about artists. Even among artists, some may favour music whereas others may favour a different version. How does the individual get a voice?

Professor Tinker: It depends on —

Mr McKinney: Many of them do not have a voice because they have dementia or whatever. How does the individual with a voice get it heard, and how does the individual without a voice get their needs catered for?

Professor Tinker: I think that this was mentioned by the first questioner. You start with your older people's parliament, which we do not have, and then go right down to an individual scheme, a local authority, or people like me doing research involving older people from day one. It is not easy to get groups of older people or individuals. You can do it by research. As a researcher, I would say that, wouldn't I? One way of getting the views of older people is through qualitative interviews in particular. You may find quite unexpected things. For example, when we were doing our remodelling, we found very mixed views where older people were left in situ; in other words, they were left, and the scheme was remodelled round them. By doing the interviews, we found that there was disruption, which we expected, but, on the other hand, they absolutely loved having electricians and all sorts of people around them who they could interact with. There was something exciting going on all the time. We thought, "Oh, they're not going to like it; it's all going to be incredibly disruptive and dangerous". When we interviewed them, it was quite the opposite: there was a buzz. They really loved it. Would we have found that without asking them individually? I do not know. It is not easy to find out views of older people.

Mr Beggs: It is interesting to hear of evidence from elsewhere. You mentioned that there were same-day modification schemes in various parts of the country for older people living in their own homes. Recently, I came across a constituent who needed a raised toilet and support etc to make that a safer area. She was told that it would be five, six or even 10 weeks before someone would be out to assess whether that was what she needed. Can you advise of particularly good schemes? Have any of them been evaluated in terms of how much benefit it brings to the individual and how much longer it keeps them in their own home?

Professor Tinker: Yes, I have given evidence in the paper that I gave to your Clerk about staying-put schemes that have been well evaluated and are cost-effective. The new one that I mentioned — the first contact scheme — has not. I have details of the Derbyshire one. That has not been evaluated. That is where somebody — it can be the doctor — rings up and gets that adaptation immediately. You have that in housing associations in the Netherlands. That has not been evaluated, but it sounds like a good way forward. There have been very good evaluations of the conventional staying-put schemes.

Mr Beggs: Is there evidence of how many accidents and costs to the health service have been avoided by that very speedy response?

Professor Tinker: Offhand, I think that there is one about the prevention of falls. I am not sure; I cannot give you chapter and verse.

Mr Beggs: Could you perhaps come back to us?

Professor Tinker: Of course.

The Chairperson: Thank you for the presentation. What is apparent is that you can be creative with some of the models of supported housing and living. You said, "Don't get too hung up on definition".

Professor Tinker: Yes.

The Chairperson: That is the first time we have heard that message. Consistently, we have found that there has not been a clear definition of "supported living" or "supported housing", particularly from the Health Department's point of view. It has now agreed to look at what that is. You talked about very sheltered and extra care. Flowing from that, is there an agreed cross-departmental, cross-agency definition of "extra care facility"? What about information on choice? Who is responsible for — for want of another word — marketing the availability? One of the things that we are finding is that there is a real issue with choice of the types of supported housing or supported living that are available. Who, in your experience, which might come from European models, has been responsible for marketing or providing that information?

Professor Tinker: It depends on the providers. The Department of Health has one model, and the Department for Communities and Local Government, of course, had a series of supported housing

grants. There is no agreement, and I am not sure how you will ever get it. Will private providers in particular not call it whatever they think will sell? I do not know how useful it is to have one common definition. I use mine. I use the term "sheltered housing", as I described to you, and I use "extra care housing", but some people use "supported housing" or "assisted living". Do you think that it is really important that we agree?

The Chairperson: I suppose that the issue concerns forecasting the population. We know the forecast and statistics for the elderly population, and we know where we will be in 2020. We even know some of the geographical areas where the growth will take place, so I suppose that, for us as a Committee, it has been very much about understanding that the whole strategic change in health is about care at home, care in the community or reablement, which is not always an option. If we have this elderly population and a growth in the ageing population, this is about asking how we plan for that and what types of models or living arrangements we need. For example, in the past number of weeks we visited what I think members will agree is an excellent supported living facility in Downpatrick. It was interesting that there were people with different levels of need, including mild to moderate levels of dementia. It is an excellent facility with some real characters living in it, but there are still empty places. So, you wonder about the flow of information about choice. How is that information relayed through the system so that our elderly people know that there is availability in these models?

Professor Tinker: Maybe by asking me to talk about supported housing, you have defined it for yourself. I would include anything that you want under that, but it is difficult to try to explain to someone what it is. Most people know what residential care is and what a nursing home is, but there is a whole plethora of options, some of which I described, including staying at home or in what used to be called sheltered housing. I think that it is very difficult. Maybe you should say what you think the definition should be.

The Chairperson: To take you up on that, the Department has come back and said that it is reviewing and looking at an agreed definition. I am sure that the Committee will have a view on that as we move forward.

I am conscious of time, Professor, and we probably stopped three quarters of the way through your information. Is there anything that you want to add at this point? We have the information, and we will, obviously, reflect on that in going forward. Are there any other comments that you want to make as your concluding remarks?

Professor Tinker: I have given all the information. The only other thing to add is that we have to do something about the low status of the staff who care for older people. That is incredibly important. They receive low pay and have low status, but they are the key, really, to the care of older people, whether they are in supported housing or wherever. So, I think that that is probably the most important thing. We need to change attitudes towards these people and give them training. If they earn less than they could get in a supermarket, what does that say about us as a society? That is really important.

The Chairperson: Thank you very much. That has been extremely useful. Obviously, the Committee will reflect on all that. I think that there was a lot of common sense in your presentation. I thank you for taking the time; it has certainly been of benefit to us.

Professor Tinker: Thank you very much. If there is anything that your Clerk needs to get back to me on, I am sure that she will do that.

The Chairperson: I appreciate that. Thank you, Professor.

Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Review of Transforming Your Care and Older People: Department of Health, Social Services and Public Safety, Department for Social Development, Health and Social Care Board and Northern Ireland Housing Executive

11 June 2014

NORTHERN IRELAND ASSEMBLY

Committee for Health, Social Services and Public Safety

Review of Transforming Your Care and Older People: Department of Health, Social Services and Public Safety, Department for Social Development, Health and Social Care Board and Northern Ireland Housing Executive

11 June 2014

Members present for all or part of the proceedings:
Ms Maeve McLaughlin (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Mr Mickey Brady
Mrs Pam Cameron
Mr Gordon Dunne
Mr Samuel Gardiner
Mr Kieran McCarthy
Mr Fearghal McKinney

Witnesses:

Mr Stephen Martin	Department for Social Development
Mr Seán Holland	Department of Health, Social Services and Public Safety
Mr Michael Sweeney	Department of Health, Social Services and Public Safety
Mrs Fionnuala McAndrew	Health and Social Care Board
Mr Brian O'Kane	Northern Ireland Housing Executive

The Chairperson: Folks, you are all very welcome. We have Seán Holland, deputy secretary of the Department of Health, Social Services and Public Safety; Michael Sweeney, acting director of mental health, disability and older people's policy; Fionnuala McAndrew, acting chief executive of the Health and Social Care Board (HSCB); Stephen Martin, deputy director of housing policy delivery in the Department for Social Development; and Brian O'Kane, acting assistant director of strategic partnerships in the Housing Executive. Again, you are very welcome.

The Committee wants to discuss some key areas and issues with you today; we want to work through each issue in turn. We want to use this as an opportunity to understand the position of the Health Department, and indeed the Department for Social Development, on the issue before we make any recommendations in our report. We would welcome open and constructive debate, which we normally have.

I ask you to make a short opening statement. Then, we will open it up to members.

Mr Seán Holland (Department of Health, Social Services and Public Safety): Thank you, Chair, for the opportunity to give evidence on supported living for older people. I am aware that the Committee was disappointed that we were unable to give you answers to some of your questions in the previous session on 26 February. You have subsequently written to the Department, and we have provided

you with further information on a few occasions. Today, I am joined by Michael Sweeney, Fionnuala McAndrew, Stephen Martin and Brian O'Kane. I think that the number of witnesses whom we have brought today reflects the range of roles and responsibilities across government with regard to supported living.

I am aware that one of the main issues for the Committee to date has been a definition of supported living. The Minister's letter to the Committee dated 28 April advised that the definition was under review. The DHSSPS, the Health and Social Care Board and the Housing Executive met in April to discuss the scope of the definition. As members will be aware from Professor Tinker's evidence, there is no agreed, fixed definition in UK law, but we are trying to reach a common understanding as to what would be a useful definition of supported living.

As set out in the briefing paper that we shared with you at the end of last week, we consider "supported living" to encompass a range of health and care provision, health-related adaptations, housing accommodation and housing support services that are designed to help vulnerable people to retain their independence in their community.

Supported housing is one key supported living option. It relates to accommodation that is provided for vulnerable people who require housing support and/or an element of care, and is intended to help individuals to lead as independent a life as possible in their own homes. Supported housing can vary in type and nature and can be designed to meet very different levels of need. I believe that that might have been the cause of confusion in our previous evidence session regarding the extent of provision of supported housing. The Committee was advised that there were 414 schemes for older people, while the health and social care trusts, at a subsequent session, indicated a much smaller number. If I may, I will take the opportunity to clarify that those 414 schemes represent the entirety of supported housing schemes for older people in the social rented sector.

Sheltered housing, which is managed by the Housing Executive and housing associations, makes up the majority of the 414 schemes and is intended for people who remain relatively independent but who may, from time to time, need to avail themselves of support, which is normally available from a scheme supervisor or — some people might be familiar with this term — a warden associated with such a scheme. It should be noted that there have not been any new developments in sheltered housing for some time.

In recent years, trusts have identified a need that is more specialist in nature. Given that, the focus for newbuild social housing for older people has been on frail elderly schemes. The facilities, which the trusts report on, are designed for people who need greater levels of support to remain independent. That includes help with personal care and tasks such as dressing, eating and bathing, all of which are provided or arranged by Health and Social Care (HSC).

There are 18 schemes in Northern Ireland, two of which — Cedar Court in Downpatrick and Hemsworth Court in Belfast — have been completed during the comprehensive spending review period. Planning for such supported housing schemes takes place within three- to five-year periods, with the current period ending in March 2016. The number of proposed developments is driven by trust assessment of demand as part of ongoing service delivery. In the current planning period, there are plans for a further seven facilities, one of which is Cuan Court in Ards, which is scheduled to be ready at the end of this month. We believe that the process has worked well over the last number of years, but we recognise that there may be the potential for a centrally established target to drive the number of future developments, and that is why we have established an indicator of performance for supported living for older people this year.

Notwithstanding the need for an agreed definition, we contend that the central purpose of supported living is commonly understood. Similarly, we are of the view that the roles of respective stakeholders in the Supporting People programme are understood, as outlined in your paper. To summarise, trusts have a responsibility for identifying need for new supported housing and developing business cases, which are then considered through the Supporting People commissioning arrangements. Trusts also provide funding for any social care required for tenants of supported housing schemes.

DSD, through the Housing Executive, provides grant funding of up to 70% of the build cost to housing associations. Housing associations then project-manage the construction of supported housing schemes for social rent and become the landlord of the scheme once it has been built. Housing associations then either manage directly the housing support services to tenants or contract those out to specialist support providers, usually in the voluntary or community sectors.

The Housing Executive, through the Supporting People programme, provides funding for housing support services, including those using supported housing. Those services are designed to help people to develop the skills and confidence necessary to live independently without support or to maintain independent living with ongoing support.

At the beginning of the year, the Minister of Health and the Minister for Social Development met officials and the Northern Ireland Federation of Housing Associations (NIFHA) to discuss the future of supported living for older people and other client groups. The Minister subsequently asked officials to arrange a workshop in February with key stakeholders, including both Departments, the HSC Board, each trust, the Housing Executive and representatives from the Federation of Housing Associations. The workshop was very helpful in identifying a number of areas where improvements could be made, some of which are listed in your briefing paper.

Both Departments are in discussions with potential funders. We are driving a number of projects on supported living for older people, although we are not in a position to discuss the detail of the funding arrangements at this time. However, if we can secure the funding, the work would include a project to identify and develop appropriate future models of supported living for older people, including those with dementia, and people with physical disabilities. That work would take into account factors such as geography, needs, including care, affordability and assistive technologies. It would also include an assessment of whether existing models, particularly sheltered housing, are being used effectively and for the purposes intended. The study would also highlight situations or client needs for which supported living is not appropriate.

There would also be a project to identify any lessons learned from legacy or existing supported living schemes. A small number of such schemes have run into financial difficulties due to places being unfilled; "void" is the common term for an unfilled place over a sustained period.

The purpose of the project will be to identify and share lessons learned from the commissioning, design, construction and operation of these schemes with a view to identifying how they can be made sustainable over the medium term and pinpointing lessons for future development. Finally, we will be piloting a supported living champion to promote the benefits of supported living.

Success in securing funding for these projects will enable us to address many of the concerns raised by stakeholders throughout the process initiated by Ministers as well as build on learning from the Committee's investigation.

The Chairperson: Thank you for that, Seán.

Mr Gardiner: Thank you for your presentation. How many, in your words, "older people", although I prefer the term "senior citizens", can live in a supported living environment and how many are too frail or too much in need of constant medical care to do so? Does that vary between board areas?

Mr Holland: The number of people in supported living varies between trust areas, but I would not say that the definition is purely on the basis of frailty. As we said when we attended last time, two components will determine where someone lives in these schemes: the first is an assessment of their need; the second, and most important, is choice. It is a combination of those two factors, which is why exact projections can be difficult. You have to account for those whose needs could be met by supported living as well as the number of people who would chose to live in supported housing. Obviously, that varies from person to person.

Mr Gardiner: So, can you not give me the figures? Does the number of senior citizens vary between board areas?

Mr Holland: There is a variation in the numbers of people in supported living —

Mr Gardiner: Do you have those numbers?

Mrs Fionnuala McAndrew (Health and Social Care Board): The number of people in a supported housing —

Mr Gardiner: — environments. How many are too frail or too much in need of constant medical care?

Mrs McAndrew: It is important to say that a range of services is provided, so those who need constant medical or nursing care would be assessed as needing nursing-home care. We have roughly, off the top of my head, 5,000 places in nursing homes across Northern Ireland. I would need to add up the number of places in supported housing in order to give you the number of people living there, but I think that the number of supported housing places that we have was given in your briefing paper.

It is down to the definition of need, and, overlaying that, the number of older people who might be living in a locality, a ward area or trust area, and the projected shift in the number of people who might live there in future. There is a continuum of care need that needs to be addressed, and that is the purpose of the planning process: to make sure that we have that range of services available.

To briefly pick up on Seán's point, one of the key issues about community care over recent years is that we discuss their care needs with people and they have some choice in how their care needs are met and delivered, where possible. There has been a trend where people prefer to stay in their own home or they prefer to live in an environment such as a fold where they have their own front door and self-contained accommodation. However, knowing that there is a shifting and ageing population and that long-term conditions are increasing, the likelihood is that that cohort of people will mean that we need to have 5,000 nursing care places to be available in the future.

Mr Gardiner: You cannot tell me how many are in each bracket, that are living in —

Mrs McAndrew: I can tell you, but I do not have the cumulative figures in front of me

Mr Gardiner: Maybe you could send them.

Mrs McAndrew: I can send that to you.

Mr Gardiner: Thank you.

The Chairperson: Specific themes came out of the work that the Committee was doing. One of the key issues, which you mentioned, was definition. I think that Roy wants to lead on that.

Mr Beggs: The trusts and the Northern Ireland Federation of Housing Associations (NIFHA) indicated that they believe that there is a very clear definition of supported housing.

The definition in common use was that such housing was where there were supported living facilities for older people whose facilities were commissioned on the Supporting People programme. It is very clear. I am just trying to understand how that definition has suddenly changed.

Mr Holland: I do not think that it has "suddenly changed". It is important to bear in mind that there are different types of definitions. You can have a very strict definition set out in legislation, which would clearly define entitlement or a legal description. There is no such definition relating to supported living or supported housing. I think that the other kinds of definitions are what people generally understand to be the case to describe it. What you have given is a definition that they believe clearly describes it. I would not question that. I think that there are other elements that you could include or exclude from that definition, and that is what the current discussions are around: what is a good, working definition that everyone could commonly agree on? Substantively, we have provided you with this in the briefing material. There is agreement on what the core elements of supported living and supported housing are. Would my colleagues from DSD like to add to that?

Mr Stephen Martin (Department for Social Development): Yes. In the housing strategy, 'Facing the Future', the definition that we have given you is the definition that we use. "Supported living" is an umbrella term for a range of services aimed at supporting people to live independent lives. One element is supported housing, but there are others, as Seán mentioned, such as adaptations and so on, which support people to remain in their own home. I do not think that the definition that we have given is at odds with the definition that the Federation of Housing Associations has given or the trusts or, indeed, with that of Professor Tinker who, I believe, gave evidence to you fairly recently on what she calls "extra care" schemes or what we have referred to as "the frail elderly" schemes, because that is what we call them, and sheltered housing is for those with lower support needs. Different terms are sometimes used, but we are all talking about the same thing, and we have a common

understanding across our Departments and organisations. I do not think that it is at odds with what you have been told before today.

Mr Beggs: When you change the definition it starts to cause confusion. That is my view, and I think the view of the public, certainly locally. You are aware that Barn Halt is a major supported housing scheme in my constituency, there is other supported housing at Lisgarel, and there are a number of sheltered housing accommodations. That terminology will be all mixed up if this is put into play and bought into. What was the purpose of changing the definition? How can the Committee have confidence in the Department? How can the Department give trusts a clear policy direction in the area when, before the review began, it was working to a completely different definition of supported living than they were?

Mr Holland: I do not think that we are changing the definition, and I do not think that there has been a fixed definition prior to this point. As I said, there are some situations where you have a fixed legal definition, and sometimes those mirror phrases that are in common usage. I will give you an example. If I were to use the phrase "children in need" to you, I am sure that you would have an understanding of that; most people would. There is also a very strict legal definition of a "child in need". The position with "supported living" and "supported housing" is that there is not a strict legal definition; there is a common understanding of what they mean.

The work under way is to see whether we can make sure that we can reach an accepted definition that everyone finds useful, but I do not think that there is any significant evidence that the absence of a fixed definition is causing any difficulties. Indeed, Professor Tinker made that very point when she gave evidence to you.

Mr Beggs: It gives me the impression that you are trying to change what is commonly known "supported housing" to a new definition "frail elderly" schemes. How easy do you think —

Mr Holland: No.

Mr Beggs: You are now referring to what people commonly know. Under the supported housing programme, you are now referring to them as "frail elderly" schemes. Is that correct?

Mr Holland: We would consider "frail elderly" schemes to be one possible expression —

Mr Beggs: Right

Mr Holland: — for supported living.

Mr Beggs: So what was previously known is "supported housing" will be relabelled "frail elderly" schemes. Is that correct?

Mr Martin: May I clarify? There are many types of supported housing, and for older people there are two main types. There is sheltered housing that many people know as folds, which have been around since the 1970s.

Mr Beggs: Sorry, I contacted the Housing Executive and asked whether there was any supported housing in Larne, and it tells me "no". It told me that there is sheltered housing in Larne, but there are vacancies; we have no supported living in Larne. So how can you say what you have just said? Please explain.

Mr Brian O'Kane (Northern Ireland Housing Executive): Stephen was making the point that there are two main types of supported accommodation. There is sheltered accommodation, which most people tend to refer to and understand as folds. So, there is provision of sheltered accommodation in the Larne area.

In terms of supported accommodation and the frail elderly, there is not a service or project in Larne like Barn Halt and what will hopefully happen in Greenisland in the near future. I do not want to speak for staff in the Larne area, but my sense is that they are referring to what they understand to be sheltered accommodation. There is common parlance for, as John said, what they understand that to be. It would commonly be referred to as "a fold", even though there may be other housing associations delivering sheltered accommodation.

The issue for us is defining and understanding what the frail elderly service is, because Barn Halt, and, hopefully, the services at Greenisland that we plan to develop in the near future, will be different from sheltered accommodation.

Mr Beggs: Surely, in the past that would have been referred to as "supported housing"; that seems to be being relabelled as a "frail elderly scheme". How easy will it be to convince an older relative to go into a frail elderly scheme as opposed to a supported living scheme? How easy do you think it will be with that label?

Mr Martin: It is probably an unfortunate term.

Mr Beggs: It is a very unfortunate term.

Mr Martin: It is an unfortunate term. It is common parlance in the housing world among housing professionals, but I take your point. We thought that Professor Tinker's definition of extra care housing was quite useful. We are talking about the same thing, but the terminology is probably unfortunate.

Mr Beggs: Finally, a number of older people in supported living facilities are treated and contained under the HSC's 2014 indicators of performance direction. What exactly are the trusts measuring?

Mr Holland: The trusts know the number of schemes.

Mr Beggs: Which schemes? I am trying to be clear about what are they measuring at present.

Mrs McAndrew: We will be measuring the 18 supported living schemes.

Mr Beggs: OK. So, that is different from what you are actually talking about with this new definition. Is that correct?

Mr Holland: The new definition includes those schemes. We have not actually arrived at a new definition. As reflected by the difficulty that you found when you contacted the Larne Housing Executive, we are trying to work up a definition that everyone would agree on and understand.

Mr Michael Sweeney (Department of Health, Social Services and Public Safety): We had hoped that the definition that we provided in the briefing would have been helpful, but, as was said earlier, "supported living" is a generic or umbrella term. In the briefing, we detail underneath the various types of support provided by the frail elderly schemes. It is just a good working definition in the absence of an academic or legal or one.

Mr Beggs: It will cause problems for those who wish to use the service. Under future projections for supported living places, you have included those listed in the three-year Supporting People programme. Are there no sheltered housing programmes planned within the three years if you have come up with this new definition?

Mr O'Kane: In the briefing, reference was made to the current comprehensive spending review (CSR) period. The focus, despite the definition issues referred to, has been on the frail elderly, Barn Halt and the Greenisland service. We have not planned to commission any new sheltered accommodation, but it is something that we are talking to the federation about.

We are looking at the future planning cycles coming out of it and some of the work that we referred to and that Seán referred to. We want to look again at the future role of sheltered housing.

The important thing from a service perspective, and I take your point about the customer — the older people themselves — needing clarity about the offer. So, we take your point about the confusion of the other issues, but we have been focusing on developing Barn Halt and the higher level of delivery that goes with those services that you would not get in a traditional sheltered scheme.

Mr Beggs: Can you understand why I am getting confused when you do not even apply your own new definition in the document that you provided us with?

The Chairperson: Just on that, for clarity, are you saying that the definition is still being reviewed, Seán?

Mr Holland: Yes, there is work ongoing. People are coming together to ask, "What do we commonly understand to be supported living and supported housing, and can we agree a definition that encompasses it?"

Meanwhile, it is worth noting that in the Departments and agencies, the absence of a fixed definition has not arisen as a difficulty in working together.

The Chairperson: Do you not accept that it becomes a difficulty when we hear evidence from the trusts about 18 facilities and evidence from yourselves about 414 facilities?

Mr Holland: I do not see that as a difficulty. The trusts are reflecting the schemes that are likely to require intensive personal care services because of the needs of the individuals living in them. The broader definition includes housing schemes that, although they provide a degree of support, do not require intensive support for people requiring personal care.

The Chairperson: Let me put it a different way. In the absence of an agreed definition, there is a performance direction that has been issued by the Department. That is a legal document.

Mr Holland: That is a performance indicator that relates specifically to that part of the supported housing market that we are heavily involved in, which are schemes where people require intensive personal care. We have no need or interest in issuing a performance indicator related to supported living situations where the support is not provided by —

The Chairperson: Sorry. Fionnuala just outlined, in answer to Roy's question, what is being measured in the 18 facilities.

Mrs McAndrew: Under that performance indicator.

The Chairperson: What about the 414?

Mrs McAndrew: I think, Chair, that it is about how care is provided. In the 18 supported housing arrangements, or whatever we call them in future, we make direct care provision. It is part of the design of the service that the trust is providing the care hours into that facility. Under the sheltered accommodation, which is the old fold definition, any care that is required — not everybody living in a fold will require care services — is provided in a different way. That would be provided as a domiciliary care service if it is required into the individual living in fold or sheltered accommodation. So, from our purposes when we are counting, and I know that it is just about how we count things, there is a clear difference in how we provide the care that leads us to separate out the 18 supported living arrangements under the performance indicator that we have from the Department from any domiciliary care service that we might provide into sheltered accommodation. That is covered in our overall domiciliary care figures.

Mr Holland: Indeed, there are people living in sheltered schemes where the only support that they receive will be from the on-site supervisor or warden, so we will not be performance-managing that at all. That is a service that we are not directly inputting to.

The Chairperson: I suggest that, if the Committee cannot have confidence in the Department's policy direction on the area when before the review began it was working under a completely different definition of supported living than where we are at now. I suggest to you that we will come back to this. It is certainly causing confusion. If we do not have an agreed definition, across both Departments, what hope is there for forecasting planning, strategic direction and the wider community with all the issues that you raise about choice?

I want to move on to the theme of awareness and the promotion of supported living. Pam and Gordon indicated that they wanted to lead on this.

Mrs Cameron: Thank you for your presentation today. As a Committee, we have obtained evidence that there is a lack of awareness of the option of supported living for older people, both among older people themselves and the public at large. When departmental officials were questioned about the

promotion aspect of supported living, they stated that people become aware of it once they come into the system, either via the Housing Executive for people already in social housing or through a social worker. For people who are having their health needs assessed, the Department did not seem to see the need to promote the concept of supported living more generally and to the public at large. I am sure that you will agree that it really is much better for our older population to be prepared for those later years and to have the knowledge and awareness of any schemes that are or will be available to them for that time of life. On the back of that, I have a few questions. The Committee has also spoken to key stakeholders in the age sector such as the Older People's Commissioner and Age NI. They told the Committee that there is not a wide awareness of what supported living is among older people. What can the Health Department or other Departments do to change that?

The Northern Ireland Federation of Housing Associations stated that there is a lack of awareness and suggested a champion for supported living. What are your views on that suggestion?

Mr Holland: The evidence that was presented the last time still holds, in that, for many people, the point at which they will want to know about supported living is the point at which their needs are being assessed. My expectation is that, when that is happening with a social worker or a housing officer, all options will be discussed, including supported living.

I am aware of the federation's proposal for a champion for supported living, and, as I said in my opening statement, we have taken that into account, along with comments from our last appearance at the Committee, and we have now identified that as a proposal for which we are seeking funding. We are in the process of trying to negotiate funding across the range of projects that I outlined, one of which is to establish a champion for supported living who could take on that broader role of publicising the option and benefits of supported living, both to the community and to other stakeholders.

Mr Martin: Research was done on two cohorts by the Housing Executive, which the Committee might find useful. The University of Ulster did research a couple of years ago that focused on the housing needs and aspirations of the current older generation or senior citizens. That focused on the fact that people said that they wanted to live in their own homes for as long as possible.

We then commissioned, along with Housing Executive colleagues, a piece that looked at the next generation, those who are currently in their 50s or early 60s — the so-called baby boom generation — many more of whom are homeowners than the current generation of senior citizens. That fairly small survey — the sample was of only around 400 people — showed that people had not thought about housing options for their older years. They were not particularly interested in advice at this point, but, as Seán said, they wanted advice closer to the point at which they had to think about it. Many more of them wanted to stay in their own homes for longer. If it would be helpful, we can send links to that research to the Committee, but it reaffirms some of Seán's comments.

The work that our organisations led resulted in the proposal from the Federation of Housing Associations for a champion for supported living, and we are now working together to try to secure the funding to make that happen.

Mrs McAndrew: From a health and social care perspective, I believe that the older population should be fully informed about the range of opportunities as they move through different periods of their life into old age. As a consequence of that, work has been ongoing in the health and social care trusts to get more information. We have developed DVDs setting out the range of services that people might expect to find if they are living in a particular area. That includes the Supporting People programme. Some of our residents who live in Supporting People units are also involved in that process.

Mrs Cameron: It strikes me that, just as we are all much more aware of pensions and taking more responsibility for ourselves in the later years of life, this issue needs to come up earlier. Awareness needs to be put out there.

We recently visited the Pavilions in Lisburn, and, although it is for a limited market of people who would provide for themselves, it still generated a lot of thought and discussion about how people are going to live out the next number of years of their life. It is a good idea to impart the information to people and even to give them ideas of how they could provide for themselves, especially given the increased burden on the health service in particular, which will increase in the future because of the growing number of elderly people in society.

The Committee has been made aware that there are vacancies in supported living facilities across the trusts. Is that a concern for the Department?

Mr Holland: Yes, I think that it is a concern for both Departments, but it needs to be kept in perspective. In any local scheme, there may be some vacancies and some people on a waiting list, but if you step back and look at it regionally, you see that the number of voids is not significant, and nor is the number of people waiting, as far as I am aware. Retaining the confidence of housing associations for future builds is an issue, because, while the numbers might be small and the number of voids is not significant in the overall planning, for an individual housing association or individual scheme, the voids are significant.

Mr O'Kane: It reflects a number of the Committee's points about getting education awareness out there. It relates to the proposals that we are looking at on the scale and size of models, particularly outside large urban areas. It is also reflects Fionnuala's point about giving people choices. We need to be smarter going forward in informing older people so that they can make choices for their future.

By and large, the 18 schemes that we recognise as supported living for older people are working well and have a high level of occupancy. Some new schemes tend to take a while to get up to full occupancy, but they do so for valid reasons. One or two services in Fermanagh — I think that this is well documented and we have had reference to it before — have a large number of unfilled places. We are looking at that and are actively working with the housing association and the Western Trust to find a positive solution.

We recognise that we need to do more work on the three proposals that we set out in the briefing about what we want to do. We want to learn from the lessons of those legacy schemes, what went wrong and what we can do better. Some of that is about providing information and education, and promoting the service. It is also about looking at what is the right model when we get into more remote areas or areas where there is a large mix of urban and rural communities and how you serve that population. So, we recognise that, and we need to do more. However, the majority of services are working well and are at high occupancy levels, and they do not cause us any concern. There are challenges in one or two services, and we are working with those agencies to find a solution. It impacts the sector's confidence about getting the model right and understanding what that is.

Mrs Cameron: We have looked at different accommodation and supported living models and been really impressed with them, and many members and I are pretty astounded that there is not a big long waiting list of people wanting to get into them. So, I think that awareness is definitely a big issue. If people are not aware, I do not think that they have the full range of choice. If they wait until they get to crisis point in their life, they are limiting their choices as well.

Mr Holland: The point about raising awareness among people planning for their old age is very well made. We have taken that on board from the Committee and will hopefully address it. The federation's proposal will be part of the response to that. Individual people who require some care to meet their assessed need, and are assessed as having needs, will be made aware of available supported living schemes in their area, but people are making different choices. That is what often leads to a situation in which there is a void.

The schemes were built in the belief that there would be a demand, but people have chosen to have their care needs met in other kinds of ways. That is not fixed; it is changing significantly. From the first point at which there is an idea to have a scheme, with people looking at the assessment of need, through to the front door being opened, the lead-in time for building a scheme lasts a number of years.

Over the past five years, for example, there has been a significant change in the range of services available to people, which might result in their choosing not to go into a supported living scheme. It is fair to say that, five years ago, reablement services, for example, were very limited, whereas we now have fairly significant reablement schemes in all five trusts. Were those schemes not there, a number of the people going through them might have opted to go into a supported living scheme, but now they are maybe fit to, able to and want to stay in their own home.

Mrs Cameron: One theory for there being vacancies is the lack of a shared understanding between trusts and housing associations about which types of older people are suitable for supported living. What is the Department's view on who supported living is aimed at?

Mr Holland: Fionnuala will come in on this in a moment, but it is based on the individual. As I said, there are two factors: the assessment of need and how that need can be met; and the choice that someone wants to exercise. There will be situations of very high dependency when it is not practical to provide for someone's needs in a supported living scheme, so a nursing home would be more appropriate. However, I think that the boundaries as to where that difference exists have been pushed significantly in recent years.

Mrs McAndrew: In a nutshell, the people who are suitable are those who need care and support. Some of that is housing-based support to allow them to be able to live in their own accommodation, and some of it is care. I do not think that we have ever made any secret of the fact that the easiest correlation are those who would previously have gone into residential care. Maybe 20 years ago, much younger, fitter people moved into residential care than in the last five years. It is that cohort of people who cannot live, or chose not to live, on their own for any longer and need a level of care and support. They do not need medical or nursing care. They are not ill as such, and they can make a choice that they want that companionship. If you visited some of the facilities, you will have seen that there is provision for communal space and that they can have friendships and so on, but the key point is that they do not need medical or nursing care because, if they did, they would be in a nursing home.

The Chairperson: I will pick up on that point. When the trusts were before the Committee, they told us that supported living is a very specialised model of care that is suitable only for a small minority of older people. In contrast, the housing associations told the Committee that the model is suitable for a significant proportion of older people. How does the Department respond to that?

Mr Martin: I think that that is because we are talking about two different things. When housing professionals talk about supported housing, we mean both extra care schemes for what we call the frail elderly — an unfortunate term — such as Cedar Court, which I think that you have seen, Hemsworth Court, Gnangara and Seven Oaks, and sheltered housing schemes, which are the traditional fold schemes. When housing professionals talk about supported housing, we mean both.

The Chairperson: We have been specific about the concept of supported living in the inquiry. We are not talking about the overall package. We have been very clear and knew exactly what we were requesting, and that is the response that we got.

Mr Holland: If you are talking about people with significant care needs, they are by definition a minority of the elderly population. The majority of older people are fit, well, independent and active, and a significant number of older people are able to manage what limitations they have because of their health or through disabilities with minimal support. The people whom we consider to be suitable for the 18 schemes are not those people; they are people with significant care needs. That is a very small group of the overall over-65 population.

The Chairperson: Gordon, you wanted to come in on this issue.

Mr Dunne: Thanks, Chair. Thanks, folks, for coming in this afternoon.

I want further clarification on some points that have been made. Does the Department believe that it is possible that there are vacancies in such facilities because the trusts are under-referring, as the models are only for those with complex needs? Is there a risk that that is happening?

Mr Holland: I cannot see any possible motivation for the trusts to under-refer. When you are trying to respond to someone who has care needs and, as a result, requires assistance, it is in your interest to consider all the available resources. There is no motivation for a trust to try to withhold information about a supported living scheme from someone who is presenting as needing one.

Mrs McAndrew: I will go back to the assessment. People are referred to social services, and we undertake an assessment and look at what the needs are and how they can be met. In some cases, the family or individual may think that they would like to go into supported living, or they would like to stay at home, but the assessment of their care needs indicate that that is not feasible and that they need an alternative type of care. I have no evidence to suggest that we are under-referring.

To go back to Seán's earlier point, a lot of this concerns confidence in the style of the delivery of the service. It is about choice: people are making choices, and, significantly, people are making choices to stay at home if at all possible.

Mr Dunne: Is cost an issue?

Mrs McAndrew: It should not be. The care is provided by a trust. If people are on housing benefit, they are entitled to benefits that help them with costs. I am aware, having visited some of the facilities and talked to the staff, that some individuals who would have alternatively gone to residential care are better off in supported living because of their income status. It should not be a prohibitive factor.

Mr Holland: If you stay at home or go into supported living, the care costs are met either way; there is no difference.

The Chairperson: Is cost not an issue for the trusts?

Mr Holland: I am saying that a trust will meet the costs whether you are at home or in a supported living scheme. In Northern Ireland, we do not means-test domiciliary care. If you are in a supported living situation, that is non-means-tested. That is different to the rest of the UK where you would be means-tested, but here, we do not.

Mr Dunne: Are there no top-up fees?

Mr Holland: People encounter top-up fees if they choose an enhancement that is not to meet a basic need. Someone might want Sky Sports, for example, and we do not pay for that. People will sometimes pay a top-up fee for a "better-than" service.

Mrs McAndrew: To be clear: there is no top-up fee on the care element. Rental or maintenance charges may be applied in Supporting People schemes, but balancing that out with the cost of alternative care in residential care, it should not be prohibitive in making a choice.

The Chairperson: Is a cost analysis done? I assume that it costs a trust more to facilitate someone through supported living accommodation than at home.

Mr Holland: No, not necessarily.

The Chairperson: Not necessarily for domiciliary care.

Mr Holland: No. They will need domiciliary care if they are at home —

The Chairperson: There is no additional cost to accommodate.

Mrs McAndrew: Not necessarily.

Mr Holland: If you are in supported living, additional support is provided through the DSD supported living fund.

Mr Dunne: Surely buildings and services have a cost, which is not the case when someone lives at home.

Mr Martin: There are two sets of costs. Brian can talk a bit more on this. There are care costs, which are a matter for health and social care, and there are the costs of rent, service charges and housing support. There are housing support services as well as care services. Housing support services help people to live independently, so it will provide them with advice and support that we take for granted — paying bills, things to support their tenancy and so on. If someone is on housing benefit, those support costs will be paid; if a person is not on housing benefit, there will be a cost to them for those services. Our services are not necessarily free. They are free if you are on housing benefit or at a lower cost band.

Mr Holland: Either way, those costs do not fall to us in the health and social care sector.

Mr Dunne: Can you clarify, for my own interest, how people are selected for accommodation? Do they go onto the common selection scheme and come off the list?

Mr Martin: There are two separate processes, and Health colleagues can talk about the complex cases who go into the 18 extra care schemes. For sheltered housing schemes, people are allocated from the housing selection scheme — the common waiting list.

Mr Dunne: Is that done through the Housing Executive?

Mr Martin: Yes, for around 400; for the other 18, it is a different process.

Mr Dunne: Is it assessed on need?

Mrs McAndrew: Yes, it is assessed on need.

Mr Dunne: In areas like north Down, where there is limited Housing Executive stock, your options for this type of accommodation are even fewer. How are you going to address that? How are you going to address those needs and demands that are, as my colleague said, increasing as the population gets older? In some estates, just 25% is left, and the rest have been bought, leaving a mix of houses and a loss of accommodation.

Mr Martin: Those are separate issues. Trusts do the assessment of need in the 18 extra care schemes. For general and sheltered housing, there is a top-down and bottom-up system for assessing need. There is a demographic projection called the net stock model that looks at projections of future need for general and sheltered housing. The bottom-up system looks at waiting lists and the needs of an area. An assessment is then done by the Housing Executive, which has statutory responsibility for that, and that will inform a newbuild programme. That is how it is done for general and sheltered housing. The extra care schemes come through the board and the trusts.

Mr Dunne: Is there no tie-up between both? Are you not the main driver for housing, no matter what?

Mr Martin: We are not the main driver for those that are based on care. We work jointly.

Mr Holland: There is an arrangement for us to work jointly in the commissioning of those extra care or frail elderly housing schemes.

Mrs McAndrew: I will talk a little about how we are planning and assessing need. We have developed a GIS system. It is not fully fledged yet, but we are building it up. Remember that our planning cycle is between three and five years, and that is normally what we work on.

The map goes down to ward level across Northern Ireland. It will show us what health and social care services are available in each ward. At the minute, we have residential, nursing, supported housing and sheltered accommodation. We can overlay community-based services on that, so we know what community-based services are being provided in a ward.

Our ambition — our next step — is to overlay that with demographic information. We will be able to see where the demographic growth will be. We will have to make some assumptions about demographic shifts, because sometimes people choose to live in different places. Members will know that at one time a lot of older people went to the north coast in retirement. There is evidence that, in the future, older people may congregate more in cities rather than going out to more rural areas. We will overlay that on our mapping system so that we will be able to look at where the potential gaps are, based on some planning assumptions.

That is exciting. We have not had the benefit of that kind of visual information before, and we will be able to bring that forward. We have joint arrangements on supported housing with our housing colleagues. We can bring their information on housing need together with our information about care need and be able to plan for the future.

Mr Dunne: Given the regional differences between the trusts, what is the Department doing to make sure that trusts are not at variance with one another?

Mr Holland: It is not be an ambition of ours to make sure that there is no variation across trusts. Populations will be different in different areas, so there will be variations. The ambition is that we plan effectively for the needs in each trust area. Those needs will not be the same across the trusts.

Mr Dunne: How will you allocate? A point was made earlier about voids and how important it is that allocations are consistent.

Mr Holland: It is important that we try to plan to make sure that there are no voids. However, I suspect that we would have a far greater number of voids if we were to try to plan for consistency by simply saying that we would have the same number of places in each trust area.

Mr Dunne: What I am getting at is the need to apply policy and guidelines consistently across the trusts. What are you doing to ensure that that happens?

Mr Holland: I have no evidence to suggest that the policy or guidelines are not being applied consistently across the trusts.

Mr Dunne: We will see. It is early days.

The Chairperson: Roy, you wanted to ask about awareness.

Mr Beggs: Earlier, Seán, you indicated that you thought that the reablement programme may have contributed to the voids. I notice that, in your evidence to the Committee on 26 February, you said:

> *"Reablement has been rolled out in three of the five trusts, and plans are in place for a full roll-out across the region."*

I am curious —

Mr Holland: I think that we now have schemes operating in all five trusts.

Mr Beggs: Yes, but I am trying to ascertain how reablement may have contributed to the voids. Can you tell us, or come back and tell us, when reablement was fully rolled out to all the trusts, and, in particular, when reablement was operating in the Enniskillen area, where there are a significant number of voids?

Mr Holland: I do not think that reablement is a significant feature in the Enniskillen example. I was saying that reablement is an example as to how the picture can change. I do not think that I would attribute any voids today to the existence of a reablement service. I am sure that there are circumstances in which that is true, but I could not identify those. I am saying that services are developing all the time, and that is having an impact on the choices that people make. Some of these have had very long lead-in times, and some are new services that are changing.

Mr Beggs: You said that reablement was a feature.

Mr Holland: Reablement is a feature and will become a more significant feature. Generally, domiciliary care and the growth of domiciliary care over the past number of years has been a more significant feature. Another feature that we have not discussed so far, which is probably starting to affect the choices that people make, is that, since 1997 in Northern Ireland, all social housing has been built to a standard that is called a "lifetime standard" — colleagues may correct me on that. The idea is that you build a house that can easily be adapted to different needs, so that the house that you live in and bring your children up in, and the house that you live in through your middle years, can be adapted to be the house that you grow old in and may end your days in. I imagine that, as people living in those homes have been approaching their old age, a growing number have been able to stay in those houses, which has probably contributed to people choosing not to go into supported housing.

The Chairperson: Seán, we are mindful of that and aware of it. That is not what we are looking at with the supported living issue.

Mr Holland: Madam Chair, the point is that it is probably not helpful to look at supported living in isolation. Supported living is one way in which we can respond to the wishes, desires and needs of older people for their accommodation and care.

The Chairperson: That is the remit of this inquiry.

Mr Holland: What I am saying is that, when we provide that care, we do it in the context of a range of services, and people make choices between them.

The Chairperson: Roy, are you finished on that point?

Mr Beggs: Yes, thank you.

The Chairperson: Before we move off the awareness issue, it is important to make this point. Costs have been raised, and both of you indicated that there is no additional cost. The Belfast Trust said:

> *"This model of care is very specialised. It is very expensive on the capital and revenue side, and it needs to be targeted at people who most need, and could most benefit from, the model ... So, from the Department's and the trusts' point of view, it is very targeted at those who would most benefit from it, because it is expensive for the state".*

Mr Holland: The capital cost is expensive, but the care package is the care package, whether you stay at home or are in one of these schemes.

Mrs McAndrew: We have given you a breakdown of the costs of each scheme.

The Chairperson: I am sorry, Fionnuala and Seán. A few minutes ago, we were trying to tease out the cost to a trust for a supported living model. The response was that there is no additional cost. That is contrary to the Belfast Trust's comments. Who is right? What is accurate?

Mr Holland: Could they have been referring to resettlement?

Mrs McAndrew: I possibly misinterpreted the question. I hope that I am not misleading the Committee. I was focused on the cost to the individual, because I thought that part of the question was about the cost to the individual.

The Chairperson: Sorry, Fionnuala, with respect, we asked specifically about the trust.

Mrs McAndrew: I probably misinterpreted. There certainly is a cost to the trust, and some of the Belfast provision is for people with dementia, which necessarily will have a higher cost than some of the other schemes, because the annual care costs are quite varied. It depends on the layout of the building, the nature of the residents, the people who are going to live there, and so on. Are you asking me whether it is additional, above and beyond what other service might be provided? There has to be an additional cost. It is a new facility, so we have to put some money in to provide the care. We are increasingly providing additional amounts of care to individuals every year, so the cost to the health and social care trusts is increasing generally.

The Chairperson: There is an additional cost.

Mr Holland: There will be a cost to caring for people wherever they are.

The Chairperson: There is an additional cost to the trust.

Mrs McAndrew: Yes, there is.

The Chairperson: Will that impact —

Mrs McAndrew: On its decisions to place people? I do not believe so, because in setting up the facilities, we have a business case. We develop the business case, aligning the Supporting People income that is available for the facility and the care income available. Therefore, there is a

commitment to that care income for the number of places in the facility. If there are vacancies, you could say that that is costing us money because we are not getting the full value of the care costs that we are putting in, so I think that it is the reverse: we would encourage people to move in, because, that way, the unit costs for the facility are lower. I do not believe that it is a reason that trusts would not be referring or admitting people to sheltered accommodation.

The Chairperson: OK. We will move on.

One of the other themes was the issue about housing associations being cautious about building any new supported living units. Mickey and Roy have indicated that they want to lead on this.

Mr Brady: Thanks for your presentation. It is encouraging — unique, almost — to see people from DSD and DHSSPS sitting together giving evidence. It certainly does not happen often enough, and, as someone who sits on both Committees, these are the type of overarching issues that should be addressed by both sets of officials.

Seán, I take issue with one thing that you said about there being lifelong housing since 1998. In my constituency, around four years ago, Trinity Housing built five houses to provide for lifelong housing. They were hailed as being wonderful, and they are. They are very well-built houses, but I do not accept that housing associations are doing that regularly. There is a wider issue, and I know, Stephen, that you are very familiar with the whole social housing issue. The reality is that we have a public housing body that does not build public housing. Government policy on borrowing means that we rely on housing associations, and that is the issue.

In the Enniskillen example, Fold has lost something in the region of £1 million in revenue. That is being replicated in places such as Glasgow because of the bedroom tax. There, there are huge swathes of houses that people will not move into, so housing associations have been going out of business. It can be a wider issue. Enniskillen may be a different example, because I know that, in Newry in my constituency, people are queuing to get into Fold, so that void issue does not exist. If flats or whatever are vacated, people are moving in on referral from the trust, but it may be just in that area. Obviously, the issue has been made people more aware.

The difficulty that we have is that Fold has said that it is not going to invest in newbuilds for this kind of facility. If housing associations are not going to build them, it does not matter what you plan to put into them, because they will not be there. That matter needs to be addressed urgently. You can have the best plans in the world for what is available, but if the actual physical housing is not there, that is the difficulty. It will increasingly become a problem, because we have 30-odd housing associations here — some quite large and some smaller ones — in a relatively small area, and there is all kind of competition. Houses are being built to the Decent Homes Standard. The Savills report from 2009 stated that we had some of the best housing in western Europe, but we do not any more, because planned maintenance does not happen. There are all sorts of issues around that. Housing associations need to keep the houses up to a particular standard. What happens if, like Fold, they say, "We are not going to build any more because of the voids, and it is costing us money"? They rely on housing benefit and rental to service their loans.

Mr Martin: I will deal with the lifetime homes issue first. All housing associations have to build to the housing association guide, which has a Lifetime Homes Standard, and there is an incentive for that. Therefore, all housing that they build is built to the Lifetime Homes Standard. During the downturn, housing associations did buy some properties off the shelf and took opportunities, and those would not necessarily be built to the Lifetime Homes Standard.

I can give you an example, and I think that this does exemplify it. The adaptation costs in housing association properties for older people who want to age in place are significantly lower than those for Housing Executive properties. Around £11 million a year is spent on adaptations in executive properties. Around £1 million a year is spent on adaptations in housing association properties to support people to age in place. That forward thinking that we have shown by putting the Lifetime Homes Standard into the design guide allows people to age in place. That is really positive.

On the point about risk, we jointly managed, on behalf of the Ministers, the session that Seán referred to with housing associations and trusts back in February. The housing associations came to us with two issues. The specialist nature of some of the schemes means that it takes quite a long time to fill the places. Hemsworth Court in Belfast is a good example. The Belfast Trust is taking about 18 months to fill the places. While the places are being filled, the money from the trust follows the

person. If there is no person there, there is no money. The Ministers have asked our colleagues to look at a risk-sharing arrangement, and colleagues in DHSSPS can update you more on that. There is a loss being sustained by housing associations in the period during which full occupancy is being achieved.

The Enniskillen example is a particularly challenging one. One of the things that we want to look at in the piece of research that Seán referred to is that model of very specialised housing. To make the schemes stack up, there has to be a certain number of places. Small schemes with specialist services do not stack up economically. They do not work financially. As such, it is questionable whether a very specialised housing model will work everywhere in Northern Ireland. In some places it will work, while in other places it will not. Therefore, we want to do two pieces of work. First, we want to look at the model and look at what will work where. A lot of financial stress-testing will be needed, and, hopefully, that will help give housing associations the confidence that they need to re-engage with the work.

The second piece of work is to look specifically at Gnangara and Hemsworth Court to see what went well, what did not go well and what we can do to fix what did not go well. We are very aware of the problems.

Some associations are continuing to develop schemes, but more are becoming more cautious, because there is considerable risk involved. There needs to be some element of risk-sharing, and that is something that we are looking at.

Mr Brady: Going back a number of years, old persons' dwellings were built because, at that time, the Housing Executive was building houses and got a subsidy to do so. As time went on, they then became single persons' dwellings, so they were one- or two-bedroom bungalows. Initially, the executive did not sell them because they were being retained, and supported living and supported housing took over in a sense.

In the Enniskillen example, or, indeed, if there are voids, because you are talking about 18 months, has there been any rethink about the facilities being used as social housing? It seems to me that you have very specialised facilities but that they are not being used. You have mentioned perhaps sharing the risk factor with the housing associations. If people were living in them, irrespective of their health or disability, at least revenue would be generated through housing benefit or rent. How long can you leave them sitting there?

Mr Holland: My understanding is that the Western Trust is working with the housing association to look at how those void units can be used.

Mrs McAndrew: I have been involved in meetings with Fold about Gnangara. I am aware that we have taken quite a number of measures to look at extending the scope of what the facilities could be used for.

Mr Brady: By changing the criteria, in a sense.

Mrs McAndrew: By changing some of the criteria. A particular need has been highlighted for people with physical disability, so we are looking at whether the chalets or the flats would lend themselves to housing people with physical disability. To be honest, there is a lesson to be learned from the design, because it is on-site with a residential care home. We need to think about that in future as well. We need to get the design flexible and right so that we can accommodate a range of needs, if and when those needs arise. One of the things that we are saying to you is that people make choices, so there is a level of unpredictability about how quickly the facilities might fill up, but the point is well made, and we have been in discussions with Fold and the Western Trust on that. As a result, I think that the occupancy had increased, but there are still a number of voids that we need to consider.

Mr Dunne: I have done a bit of research and understand that half of the units were for dementia patients, is that right?

Mrs McAndrew: In the residential sector?

Mr Dunne: Yes.

Mrs McAndrew: That is right.

Mr Dunne: Is that not an issue? I take it that the Department tasked the housing association with tendering and competing for the work to build the units, is that correct?

Mr Holland: The Department does not directly. It is the commissioning process.

Mrs McAndrew: We have a joint arrangement with the Housing Executive and the Health and Social Care family, if you like — the trusts and the board. There is a Supporting People commissioning body, which is chaired by the Housing Executive. The purpose of that is to identify the need and then commission those kinds of developments. I am not sure whether Brian will agree, but we have got more sophisticated as the years have gone on with the needs assessment and the commissioning arrangements. When I look at the voids and the vacancies, Gnangara obviously stands out as being a particular issue.

Mr Dunne: The housing associations are now shying away from such projects because of the mistake that has been made here on the assessment of need. Is that where it went wrong? Earlier, you clarified that people were allocated on the basis of need and that you build where there is a demand. Where was the mistake made? Did you get it wrong on demand? Was the wrong assessment made by DHSSPS and transferred to DSD?

Mrs McAndrew: I think that, at a point in time, we felt that our assessment of need was accurate. Things have happened in that time that mean that people have different options. You could say —

Mr Dunne: What time are we talking about? Three years?

Mrs McAndrew: No, Gnangara has been open since —

Mr O'Kane: Gnangara has been open for close to four years, but, if you take the point that Seán made, the planning and commissioning process probably started two or three years before that to get it on-site. We work very closely with the Health and Social Care family across the five trusts. There are lessons to be learned from the Gnangara experience. We know that the demographics tell us about the growth in the number of older people in an area and also the growth in the number of people with dementia, so the planning assumption was that need and demand would follow.

On the point made by the member who spoke previously, we are working very hard. There is a meeting next Tuesday with the Western Trust to try to find a solution, because there is good quality housing sitting there empty. I take your point. It is something that, from a housing professional's point of view, we find easy to take.

Throughout the process, we have continued engagement with the trust, because, at the same time, as the Committee knows from the demographics and the stats, there is an issue to plan for more and to develop more. Some of the lessons to be learned are around the promotion work and understanding, which the Committee mentioned a number of times. We are looking at alternative uses of accommodation to address those issues and to give confidence back to the sector. I think that Fold's experience has been particular. It is a potential outlier, but we know that it has an impact on the confidence of the rest of the sector. However, you will have seen in your briefing that seven schemes are being planned. A new service has just opened taking in people in Newtownards this month, and there are plans to develop a service in your constituency in Bangor. The associations are on board, and you heard from the chief executive of the federation, who said that it is what the sector wants to do. The sector has talked to us about what it needs from us to reassure them about the future of the services, and we are trying our best to respond to that.

The Committee has been to Cedar Court. From a housing perspective, we are very proud of the quality of the work there and what you saw. We need to make sure that those services are delivered elsewhere, so we are doing a lot of work with our partner organisations. There are lessons to be learned about needs assessment and planning. Part of that is reflected in talking to people about what they want, and Committee members have made that point today. We need to be smarter at asking older people what their preferences are. They will have choices, and they will want to make choices. Older people will want to make informed choices about whether they stay at home or move and about what sorts of services will come to see them. We recognise that and are doing that.

As Stephen pointed out, the other three projects that we put forward in the briefing all have an impact: dealing with the design; making sure that the project is sustainable; and providing reassurance to the sector. Hemsworth Court, which is just off the Shankill Road, is an interesting project. It comprises 35

self-contained units and is a very worthy project. The association is making an application to a design award competition. It is 35 units of high-quality accommodation. As of today, there are 24 tenancies in place, and a further seven people are being assessed. There is a balance to be struck on the health side in working with individuals and their family and carers about making a planned and appropriate transition from where they are now into Hemsworth Court. We have to be conscious about working with individuals. There are a further seven people in assessment. There are lessons to be learned there about how we make sure the assessment processes are sensitive to the needs of families and individuals. We and the trusts are confident that the project at Hemsworth Court will be fully occupied by September or October this year. From a housing association point of view, that is probably a bit too long, because it was opened last July. We are looking to reassure the associations on those issues.

Mr Dunne: Is there a lesson to be learned about the mixed use of accommodation for supported living and for people with dementia?

Mrs McAndrew: It is about how we adapt the accommodation. The fact that there is a residential unit and supported living on the same site is an issue. Brian will agree that, if we had built in a bit more flexibility around the design, it might have meant more take-up earlier. As I say, we have learnt those lessons and are taking them forward into our planning processes.

Mr Beggs: If I picked it up correctly earlier, someone spoke about the deadline for the business case from the housing side and the health side and that there would be a commitment to care income. Can you explain the commissioning process for such a new development, which is what we now know as supported housing?

Mr O'Kane: When Supporting People started in 2003, we talked to our colleagues about what the right kind of commissioning structures would be. There is a regional commissioning body that is chaired by the Housing Executive's director of regional services and made up of representatives from five local Supporting People partnership groups based on the trust boundaries. The trusts use those structures to identify their need for supported housing in future from across a number of programmes, including programmes for older people and for people with dementia.

If a need is identified, a business case is produced at a local level that comes through the commissioning process. That business case is to bring forward and align the capital and the revenue from the Supporting People side and from the care side for the need for and type of services. That translates to the housing side, where, once we get to a certain point, we bring in the housing associations and nominate names so that they can bring forward the development process and find a site suitable for development. Through the lifetime of the business case, we engage with our colleagues in the trusts and with the housing associations and other agencies around the project planning of each service. In that structure, we have an opportunity to learn lessons and reflect on what has worked well elsewhere.

We are looking at restructuring and reforming some of that commissioning process so that it has a more regional structure, whereby we bring the five trusts, the board and us together more regularly to look at lessons learned going forward. The process is a bottom-up one, informed by local commissioning decisions by the trusts, which will then bring forward a business case for the Supporting People programme, while we look to align the capital and revenue — capital from DSD to fund the building and, from the revenue side, from Supporting People and the care side — so that all the bits of the funding jigsaw are in place. By doing that and by having the housing associations involved earlier — that is another lesson for us — gives added confidence to the sector that we were keen on that working. There are things that we can do better. The business case is to provide a reassurance that there is a need and that the various bits of the funding pot are together to make the schemes happen. It can perhaps take too long because the site search and the planning can, as you probably know from your own experience, be a lengthy process.

Mr Beggs: I have followed the progress of the Greenisland House development, which has still to commence on the ground after four or five years. Having gone through a planning process, my understanding was that the trusts would OK the business case for what they thought was required in the area. As I understand it, the business case is to service the Carrickfergus and Newtownabbey area, which is quite a wide geographical area. I am curious as to what the care commitment — the income — is if the numbers do not hit what the trusts say is needed in the area. What care commitment is made by the trusts so that what they say is needed actually comes about?

Mrs McAndrew: The business case would identify the allocation of funding that the trusts would be making to that facility to cover the care costs. Therefore, it is based on the number of people and an assumption and by aligning it with the Supporting People revenue that might be available. It is all worked out on the income that has to be set aside as a commitment from the trusts to the building assuming full occupancy. Our colleagues in DSD and the Housing Executive are saying to you that, where there is not full occupancy, that becomes problematic for the trusts, because they have to pay for the person somewhere else, as the money follows the person.

Mr Beggs: If that were the case in Enniskillen, the housing trust would not be losing money. Is the health trust paying for those vacancies in Enniskillen?

Mrs McAndrew: No, it is not currently, and that is the point that was being made about coming to a position in which there is more risk-sharing between the housing association —

Mr Beggs: Have you changed your policy so that you will commit to pay for vacancies on the caring side?

Mr Holland: It is currently under discussion, but if we were to pay for those voids, that would be money that would otherwise be paying for the care of older people. We are keen to make sure that, when we spend money on the care of older people, it is delivering care for older people, as opposed to paying for a void.

Mr Beggs: Has there been a policy change made by the trusts to support people with care packages in their home rather than care packages in another establishment?

Mr Holland: If I understand your question correctly, no.

Mr Beggs: I was picking up on comments that some personnel may have changed in the planning process and that that may be a contributory factor.

Mrs McAndrew: I am not aware of that, but I will take your comment away.

Mr Beggs: I dealt with some constituents a couple of weeks ago who are in rented accommodation. They explained that they could get only a one-year tenancy agreement, as that was all that was on offer from various landlords. If the properties are sitting vacant, can you not at least allow a temporary tenancy arrangement to be utilised so that income could be generated for the housing trust, rather than it suffering the expenditure without getting any income whatsoever?

Mr Holland: Do you mean for them to be used for general housing purposes?

Mr Beggs: On a purely temporary basis.

Mr Martin: If it were a highly specialised scheme, as Fionnuala mentioned earlier, we would need advice from the health and social care professionals around that. Putting people with different needs together in a facility with a lot of common spaces might be problematic. Although allocations of sheltered housing are done through a housing selection scheme, if there are longer-term voids, there are opportunities for housing associations to advertise those outwith the selection scheme. The specialist schemes are a bit more difficult, and a discussion between us and the housing associations would be needed.

Mr Beggs: Frequently, frail elderly people are awaiting bungalow accommodation or something similar. Have the trusts and the housing side considered short-term, temporary tenancies so that there will be mutual benefit for tenants who are in unsuitable accommodation and Fold, which is having to suffer loss because there are no tenants whatsoever in their brand new housing? Have you considered the flexibility of a temporary arrangement?

Mr O'Kane: Your point is well made, and I think that we need to be mindful, particularly of the experience of Fold in Enniskillen, as, generally, most of the other Fold schemes are sitting at over 95% occupancy. There is a particular set of issues around one project in Enniskillen.

We are exploring all options, and a number of Committee members have made the point that we need to find a solution to letting the housing in Enniskillen.

On the short-term let, I would say that asking someone to move in for six months is not necessarily always a good thing for the longer term to have older people move a number of times, but we are doing some hard work to try to resolve and recover the position for Fold and the trust. It is in none of our interests — by "our", I mean the board, the Western Trust, the Housing Executive and Fold — to have a property in Enniskillen that does not work. We are looking at that. Whether there are short-term options, I am not too sure, but we are looking at making better use of the project.

Mrs McAndrew: It is fair to say that we have not done it as yet, but it is certainly an issue that we can take away and look at.

Mr Beggs: I am conscious that, if it were a private sector operation, you would not have the property sitting vacant for the long term. That would not happen. Choices and decisions would have to be made quickly.

Mrs McAndrew: I refer Committee members to the paper, in which you will see that many of our supported housing arrangements have full or 99% occupancy. I just want to draw your attention to the fact that we are talking about two of the 18 facilities. By and large, the others are well used, and there are not significant occupancy problems.

The Chairperson: Thank you. We will move to the issue of long-term planning. Seán, bluntly, is the Department taking a strategic approach to the need for supported living?

Mr Holland: The Department is taking a strategic approach to the care of older people by identifying a general shift in how we provide services. That is in response to what older people have told us when they have been consulted, which is, primarily, that they want to live in their own home and remain as independent as possible. That is the strategic direction that we have set. I think that there is a difference between setting a strategic direction and having a detailed plan as to how many units of what particular kind of accommodation you will deliver in any specific year. That has to be a much more short-term activity.

Fionnuala has described the current planning cycle as following a three- to five-year pattern. The discussion that we have had around voids in particular schemes and the fact that we do not generally have significant waiting lists or voids around supported housing as a whole suggests that having a three- to five-year cycle is probably working quite effectively. I think that there would be significant risks if we were to try to extend a planning frame linked to specific units much beyond that.

The Chairperson: What you are telling me is that you have a strategic approach to general care for the elderly, but you do not have a strategic approach to supported living?

Mr Holland: No, I did not say that. I said that we have a strategic approach to the care of the elderly, and that includes a range of options that we recognise need to be developed, including supported living. I think that there is a difference between strategically identifying the direction in which you need to go and then making operational plans for how you deliver on that direction. The time frames are different. Strategically, we are looking 20 years hence, saying that we need to have a shift in direction, whereas operationally, we are looking at three to five years hence.

The Chairperson: If the general strategic approach in supported living is seen within the general care of the elderly, have we done work to forecast how many older people in the North would be suitable for supported living or actually want or need it?

Mr Holland: That is the work that is done on a three- to five-year framework. Fionnuala took you through how that work is done currently and the plans that there are to improve it, but that is done on a three- to five-year framework. I do not think that it is very wise to try to make those kinds of projections beyond that kind of time frame. There have been a number of experiences in sectors where, for example, people have tried to do very long-term planning based on demographics. Unfortunately, it has gone badly. I remember being involved in a planning exercise about 10 or 12 years ago that looked at the future healthcare needs of the population in Northern Ireland. At that stage, we anticipated a decline in the number of children based on demographic projections. It turned out to be completely wrong. Things happened — and this has happened across the UK — and actual

demographic projections turned out to be very misleading. The further you go out, the greater risk there is. In the case of children, we had significant inward migration. That population of inward migrants turned out to be far more fertile than the regular population. So, we have significant pressure on maternity and birth services. If we had planned purely on demographic projections, you would have committed resources in a way that would not have actually reflected the change in the population.

The Chairperson: Seán, a few minutes ago, we heard about a GIS that will be brought into health and social care, which will take it down by ward.

Mr Holland: Yes, but the time frame that that will operate on is not 10 or 15 years to the future.

The Chairperson: Whilst I accept that forecasting in terms of population and even per location may not be 100% foolproof, we know the statistics for the ageing population. We know that there will be an additional 344,000 over-65s by 2020. We know that. A lot of the evidence that the Committee has heard to date is that there does not seem to be that strategic approach not only to the operational side of it but to setting policy. That is the key question. What I am hearing from you today is that, as it stands even for that forecast, if we have supported living as a concept in the general care of the elderly, you have not, as a Department, even forecast in your calculation the need that would exist for supported living.

Mr Holland: While people talk often about the demographic time bomb, you need to be cautious. To continue the analogy: it is a bomb that goes off very slowly. If you look at the changes in population year on year, you see that they are not significant. Given the time frame to plan for supported housing, making adjustments to meet demand is better done on a three- to five-year basis.

If we are looking at the population of older people — I am not quite sure that I recognise the figure that you quoted for the increase in the number of older people — I would have thought that —

The Chairperson: Well, it is a figure that has been identified and has been given directly by trusts, Age NI and the Older People's Commissioner. I hope that you are not saying now that we do not have an ageing infrastructure and ageing population.

Mr Holland: No, we definitely have an ageing population. However, the expectancy that I am looking at is that, over the next 50 years, the population of over-65s will increase from 244,000 to just under half a million. I do not think that that is the figure that you quoted.

The Chairperson: Well, look, there is a sizeable shift in the population of over-65s. That is a fact. What I am trying to ask here is this: what strategic approach is the Department using in setting policy to address that need?

Mr Holland: I think that the approach is to plan on a three- to five-year cycle to respond to that need. If we tried to plan on a much longer basis, there would be a risk of greatly exaggerating the kinds of problems that we currently have a very small reflection of, for example, the voids situation.

The Chairperson: I accept the three- to five-year cycle. Has that strategic planning started?

Mr Holland: Yes, that is an ongoing rolling process.

The Chairperson: Can we have sight of it at some point?

Mr Holland: You do have sight of it, in that the current plan is for seven new schemes to come online. That is on a base of rolling planning for demand. The assessment is ongoing. Schemes are identified as being possibilities. Business cases are prepared. They are taken forward. That is being done on a rolling basis.

The Chairperson: Again, we are talking about seven schemes in the overall calculation of whatever the figures are by 2020, which we accept is a huge increase in the population of over-65s, but even seven schemes seems very few.

Mrs McAndrew: Of course, there will be other things that will have to be developed to respond to the overall population increase, so it is not just relying on supported living. What I described earlier was a progression from our planning arrangements around Supporting People, which was very local, to looking at the need for supporting people much more broadly. I am just describing a mapping system — a visual representation of what is available, what the population is in a locality and what the population growth might be — so that we can then make some assumptions about the percentage of the population that might need more domiciliary care, more supported housing and more or less nursing home beds.

Mr Holland: To put the number in context: over the past 10 years, the elderly population — those aged between 60 and 84 — has risen by 20%, while the number of those aged over 85 has risen by 38%. In that time, we have developed the supported living schemes. We have no evidence to suggest that we got that significantly wrong, with the exception of one or two schemes where there are voids, and I do not think that that is down to us miscalculating the population projection. We seem to be getting it right. So, you say that seven schemes does not sound like very many, but based on the increases that we have had in the past 10 years, the schemes have responded to the demand.

The Chairperson: OK. I am going to go back to the point about forecasting, and Fearghal wants in on this as well. You are saying that there is a three- to five-year cycle in strategic planning, and that is accepted. Did that start when the concept of Transforming Your Care was initiated?

Mr Martin: The comprehensive spending review period mirrors the Assembly period. In formulating the bid, officials from my Department and the Health Department worked jointly with the Housing Executive and the board. The numbers that you have in the briefing were our joint assessment of what was needed, and a bid went forward for capital and revenue funding on that basis. We will do the same for the next comprehensive spending review period, which is from 2016 on.

The Chairperson: I appreciate that, Stephen. The point I am putting specifically, Seán, is that a major plank of Transforming Your Care was the shift left, obviously, the £83 million shift, a big focus on reablement and recognition of the ageing population. Did that strategic planning, in the context of supported living, align itself with the origins of TYC, because the CSR was before that?

Mr Holland: The planning process has been evolving since the introduction of Supporting People, so it predates TYC significantly.

The Chairperson: But is there not a planning piece attached to TYC stating where we will be in x number of years and where the need will be?

Mr Holland: We have a planning process. TYC has identified overall the policy direction, which is, as you said, the shift left. If we have a planning process within that that is fit for purpose to deliver TYC, why would we change it?

The Chairperson: We are not sure that there is a planning process there.

Mr Sweeney: Chair, maybe I can help. I think that you are looking for something solid about the planning process and modelling for the provision of services. During Seán's introduction, he talked about three particular little projects that are getting under way at the minute. One of them is to look at alternative models to see whether there are shortcomings in the way that we work and whether we can learn lessons. That is what we meant by modelling in that framework. We are not being complacent about the three to five years, but, given the difficulties that you have acknowledged in long-term planning demographics, we think, first, that what we have is not perfect but it works, and, secondly, we are not so complacent that we would not look at alternative models. That is what we are looking to do in conjunction with our colleagues over the next month.

The Chairperson: So, we are only starting to look at those alternative modelling processes now.

Mr Holland: No. I think it would be fair to say that the model of joint commissioning has been evolving continuously.

The Chairperson: I think —

Mr Holland: We have some specific proposals that we shared with you today.

The Chairperson: Sorry for interrupting you, Seán.

Mrs McAndrew: I think it would be fair — sorry.

The Chairperson: Go ahead, and then I am going to bring in Fearghal.

Mrs McAndrew: I think it would be fair to say that it is a bit of chicken-and-egg situation, to be perfectly honest. I think that TYC was informed by the joint work that we had been doing around Supporting People. I think also that TYC is driving us to do more modelling and more predictions over the next three- to five-year period. It is a bit of chicken-and-egg situation. TYC was informed by some of the work that had already happened and sets out a vision and direction that needs to be supported by some further work that needs to be done.

The Chairperson: But it is almost three years into the process. However, I will hand over to Fearghal.

Mr McKinney: You might call it a chicken-and-egg situation, but it sounds to me, on the basis of what I am hearing today, that it is make it up as you go along.

Where are the figures that show that 155 places are needed? What figures have you predicted? How far short of 155 are you or how far beyond? What is the figure? Where is the work on projections?

Mr Martin: Those figures come from the board and the trusts.

Mr McKinney: Where are they?

Mrs McAndrew: It would have been done in the context of that three-year planning to inform the plan that we already have, which is 18 already developed and seven now in the plan for further development.

Mr McKinney: Yes, but how near is that to your projections for what is needed? Where are the projections?

Mrs McAndrew: They would have been done at local trust level.

Mr McKinney: And who collates those?

Mrs McAndrew: The trusts in terms of assessing the needs that are quite localised.

Mr McKinney: Have you got them collated here?

Mr Holland: The collation is the 155.

Mr McKinney: No, the 155 is what you are building. How is that consistent with your projections? Is it consistent with your projections?

Mr Holland: We build with a view to what we believe will be filled.

Mr McKinney: How does that give people the choice if they are filled?

Mr Holland: There is obviously a degree of churn in each of the facilities. That is a projection based on what we believe people will choose. These are not built all to individual people.

Mr McKinney: But can you point to the body of work that has been done? You are talking about another research project. Was there another research project consistent with that one that you are planning now? Where is that body of work?

Mrs McAndrew: It would have been done at local level by trusts and it would have amounted to a definition of the 155, the 18 and the seven that are now projected. That would be the extent of the modelling done thus far.

Mr McKinney: I hate to bounce this one on you, because it is literally just out — all of this is going towards homes and people living in homes — but the Older People's Commissioner said today that 70% of older carers are not receiving the carers' assessment. Do you have anything to say about that?

Mr Holland: I would really like to have the chance to look at the statement. We do recognise that older people who are entitled to a care assessment are not always taking it up. We have a target to —

Mr Sweeney: Yes, there is a target within the Department to increase the number of carers' assessments out there by 10%, I think. I will have to check that and go back to the figures, but that is the strategic direction of travel as far as carers' assessments are concerned. We have to look over detail of that.

Mr McKinney: I think it is wise to remind ourselves of the second objective of the review, which is about assessing the capacity of supported living options to meet the policy objective of Transforming Your Care in terms of reducing the need for residential home places. The Older People's Commissioner's evidence to us before was that she could not find any departmental planning or modelling data for the future demand for supported living.

Mr Holland: The modelling is not done at the Department. The modelling is an aggregate of local work, which gives us a regional picture in relation to supported housing.

Mr McKinney: Who takes the lead here?

Mr Holland: There is a joint commissioning arrangement between housing and health, which leads on modelling the demand for supported housing.

Mr McKinney: I think some assumptions are made. I refer to what you said earlier: the majority of older people are fit, well and active, and others are able to deal with little help. I am not quoting you exactly. So, is that the working assumption that you are going on?

Mr Holland: That?

Mr McKinney: That most people are fit, well and active, because TYC is based on the premise that older people are getting older and there is a greater demand for hospital and other services. Which is it to be?

Mr Holland: Both statements are correct. The older population is expanding, and, within the older population, people are remaining active to an older age, but the "old old" are also expanding. That group is much more likely to require significant levels of service.

A number of years ago, people entered into residential care and nursing home care at a significantly younger age. People now maintain their independence to a much older age, but the number of people who are in the "old old" category is also growing in actual terms and as a proportion.

Mr McKinney: I hear what you are saying about the three- to five-year plan, but is there not a need for further interrogation, given the decisions made today? You talked about the failings, and I think that you said that the assessment of need was inaccurate in the past. Is there not a need then for good work to be done to try to establish beyond a three- to five-year plan because you are in danger of making it up as you go along or falling shy of what would be reasonable expectations for the older population?

Mrs McAndrew: Just to clarify: I think that we were talking about the assessment of need in Gnangara at the time.

Mr McKinney: Yes, but you also said that those things are being developed by trusts.

Mrs McAndrew: I think we are developing and we are getting more sophisticated.

Mr McKinney: Where is the evidence that you are?

Mrs McAndrew: It is in the work that we are doing around the mapping system etc. If you are asking me whether the board has a 25-year or 20-year plan for the shift in services for older people, my answer would be that it does not at this point.

Mr McKinney: Does it have a 15-year plan?

Mrs McAndrew: No, it does not have a 15-year plan.

Mr McKinney: Does it have a 10-year plan?

Mrs McAndrew: We have Transforming Your Care as a direction of travel. The work is going on at the moment to look at what that means at local level. Committee members know that LCGs and the trusts are working very closely to translate the TYC vision into local plans for the direction of travel.

For Supporting People, we have the joint commissioning arrangement and the plan for the 18 and seven schemes. The work that I described on the mapping system gives us a level of sophistication so that we can put forward our projections of demographic shifts to make a more sophisticated needs assessment. That work is progressing as well.

Mr McKinney: What is the research project called that you referred to in your opening statement?

Mr Holland: At the moment, it is a proposal. I am not aware of the exact wording of the title of the proposal, but it is a proposal that we are seeking funding for.

Mr McKinney: What is the cost of the proposal?

Mr Martin: The proposal for all three projects is around half a million pounds over the next two to three years. We have some indications of support from an independent trust, and we have some early indications of potential government support. We are also collectively committing money to that. So, we are putting the final pieces of the jigsaw in place, but it is around half a million pounds.

Mr McKinney: How long will it take to get the proposal to some stage of maturity?

Mr Martin: The independent trust is taking it to its management board in July, and we expect the proposals for the government element of that to be signed off, hopefully, shortly thereafter, with a view to being able to start to put in place the elements that we need to procure those services by September. That is all with a view to having the researchers in place the next calendar year to begin the work.

Mr McKinney: How long will the proposal take?

Mr Martin: We anticipate the funding for the three projects to run for around two years. Not all the projects will take two years. The supported living champion element would be run as a pilot for around two years. We need to bottom out the detail of the tender for the other two projects. Once we have the funding in place and the tender bottomed out, we will have a clear idea of timescales.
From research of this type that we have been involved in before, we know that these projects typically take up to a year, from the appointment of a consultant or researcher to final report.

Mr McKinney: The timeline between the start of TYC and the conclusion of both a proposal and a pilot or project is five to six years. On one estimate, that is twice the lifetime of TYC.

Mr Holland: I think that you are linking this to TYC in a way that is not how I would have envisaged it. TYC is happening. We have a planning process that TYC was cognisant of and informed by. So, TYC was informed by the developments in supported living, which were generated by the planning arrangements that Fionnuala described. That process has evolved since 2003; it has evolved and changed over that time. Fionnuala referenced a particular change that is happening to that that is not connected to the research. So, it changed during the period in which we wrote and published TYC,

and it is changing as we work towards implementing TYC. Hopefully, it is also being further refined by these projects.

Mr McKinney: That would be OK if decisions were not being made elsewhere vis-à-vis the policy objectives in TYC, which is why I read those out at the start. For example, the Northern Trust simply shut down residential homes, believing that that was consistent with TYC, yet nothing was done. So, you can see the gap and the public concern that is there. TYC says something, and the Northern Trust goes, "Well, that's OK. We will do that", but there is nothing there to support it.

Now we are hearing that there is a project that may or may not get the moneys. I know that you are saying that you are hopeful, but I have not heard you saying that it is happening. You are now beginning to try to assess this, but decisions that have been made had to be reversed.

I still do not know whether we will soon get an admissions policy announcement on this very issue and whether people will be able to remain in homes or have some vehicle for getting assisted living in the absence of alternatives. We highlighted today the absence of some of those alternatives. For example, you said that there is 99% occupancy in most of the 18 schemes that are available. So, a lot of older people do not have a choice right now, despite the churn that you say is in the system. So, you can see where our concern is. I think that I am reflecting the Committee's concern here when I say that, although the policy has started off and people have made decisions, you are only starting to write the first page on how some of this might change.

Mrs McAndrew: Chair, can I make a comment about supported living, which is really important? It might not be as sophisticated as everybody would have wanted. We have been involved in a process of needs assessment and planning for supported living for a number of years, hence the 18 and the seven. That was incorporated into the Northern Trust's thinking about the future of its residential homes. I do not want to be drawn into a discussion about residential homes, but that planning was available, and the Northern Trust was involved in that. I think that Mr Beggs referenced the fact that there are already plans for new supported living facilities in the Northern Trust area, and those have been progressed. The only point I am making is that there was a planning process. We have acknowledged that that might not have been as sophisticated as we would have hoped, but it was there, and it informed TYC and trust decisions.

Mr McKinney: Or informed by TYC. You said that local trusts were making the decisions. Of course they were going to make a decision, because they thought that they had cover to do so. Yet, they did not have a system to replace that. We are being reminded of a number of homes that were already closed.

Mrs McAndrew: There are a number —

Mr Beggs: Just for information, there was replacement supported living accommodation for the ones that were announced for closure, but there were no plans to replace others that were announced for closure.

Mr McKinney: In other words, you can see our concern. A plan, with a policy objective, exists. Things happened within that framework, but we are only now learning of frail plans, let us say, to move the situation forward, notwithstanding the fact that there has been other activity. I am not saying that nothing is happening, but we are dealing with it on a strategic and policy level, and we are only now seeing some things beginning to happen. Some of them are ideas that came to the Committee first.

Mr Holland: It is important to recognise that the planning mechanism that has been in place has been responding to a growing elderly population and has been meeting that demand fairly well.

There is a difficulty in getting the balance between creating excess capacity that would allow for immediate exercise of choice and a financially sustainable model. We have to plan for near full occupancy for these schemes and recognise that, if someone wishes to move into them, you will have some availability, but that they may also wait a short time before availability is there.

If we were to create spare capacity, say 20%, that would not be financially sustainable for the housing associations. Our planning to date has delivered that. With the exception of one or two schemes, which I do not think were failures of the planning process overall, the system that we have been using since 2003, broadly speaking, has responded to a very significant increase in the elderly population during that time. There were specific schemes where there were particular difficulties that, hands up,

we want to learn from and find out exactly why that happened. We want to get better and continually refine the system, but I think that the arrangement in place is currently delivering on the shift that TYC signals.

Mr McKinney: One of the things that we have been looking for throughout is measurement. We can feel the pain of it and hear the narrative of it, but at least things can be defensible with measurement. We are not seeing sufficient measurement on assessment. For example, you have indicators of performance around the direction for 2014, but we have no idea what would be a good number or a bad number. There is a number, and you are saying 155 is good, but how do we know whether that is good or bad.

Mr Holland: I go back to the plans that we made. If it were a bad number, we would have significant voids or significant waiting lists.

Mr McKinney: Yes, but we are encouraging people to go back to their own homes; that is the third part of the choice. Before this, people lived in their own home and the choices were external to the home. You have injected a new bit into the equation, which is people living in their own homes. Of course, other people make an assessment around whether that is appropriate, and you will say that they are doing that consistent with a plan, but we are seeing from this evidence that people are not necessarily getting the care assessment. People are being encouraged to stay in their homes, but are they getting the best there? We do not know that.

So, there are a lot of things that we do not know, and there are a lot of assessments. If I were hearing it, I would be able to say that I was glad to hear it. Sometimes, what you do not hear in a meeting is as important as what you hear, and I am simply not hearing an assessment. I hear things, and judgements made on what you are saying, that it is about both, those people and older people, and the value judgements that you are making around that, but I think that we need to see some kind of measurements, research and understanding. You accept what I am saying, because you are now starting to do it, but we have to ask, within the context of what you are doing now, whether you are doing the right things, given that you have not done it.

Mr Holland: Again, I come back to the activity that has been happening since 2003, which has given us a situation where we do not have significant numbers of voids nor significant waiting lists. That would indicate that it has been a reasonably accurate way of assessing the need at 115. I think that we want to improve it, and that is what we are aiming to do, but I am not sure that the evidence is there to say that it is a bad number.

Mr McKinney: I did not say that it was a bad number. I said that we do not know whether it is a good number or a bad number.

Mr Holland: I suggest that there is evidence to say that it is not a bad number, in that we do not have large numbers of voids and we do not have large waiting lists.

Mr McKinney: Yes, but if they are not built, you will not have large voids.

Mr Holland: If they were not built and demand was exceeding capacity, we would have significant pressure for places and waiting lists. We would have trusts saying that they did not have the capacity to meet the demand that they are seeing as they assess the needs of older people, and that is not what they are saying to us.

Mr McKinney: But, if you are 99% occupied now, you cannot offer people a choice.

Mr Holland: As I said, there is some churn, and people will wait. You will sustain people in their own homes and plan for them to move into one of those dwellings or settings.

Mr McKinney: So, are you measuring how many people are being sustained in their own homes now —

Mr Holland: We know how many people are being sustained in their own homes.

Mr McKinney: — and who might otherwise need something else?

Mr Holland: I could not give you that figure.

Mr McKinney: I suggest to you that that is a very important figure. In fact, it is the most important figure.

Mrs McAndrew: Well, we will certainly have a look at it. I am not sure that there are people who are in their own homes. They may have elements of their care package that they are not receiving, but if you are saying that they are maintaining their own home because they cannot access Supporting People —

Mr McKinney: Is that a reasonable request?

Mrs McAndrew: We will certainly have a look at it. I am not sure that there is anybody in that position. We will take it away and have a look at it. It has not been drawn to my attention that we are offering the wrong sort of care to somebody in their own home because they cannot access supported living, but I am happy, Mr McKinney, to take it away and have a look at it.

The Chairperson: I think it is about suitability, and I asked about people who are currently suitable for a supported living facility and what kind of assessment has been done there.

I am moving on. What I am hearing, Seán, is the word "evolving", and that does not give me a sense that the forecasting, modelling, measurement of outcomes and planning are in place. It seems to be very much an evolving process from trusts. What more could or should the Department do in relation to this? What is the "fit"? Is the Department currently doing enough? If not, what needs to happen?

Mr Holland: My answer is that the evidence shows that, broadly, we are getting it right with the plan. The evidence in relation to the development of supported living schemes, based on the planning model that we are using, is broadly getting it right, but we are looking at ways of improving it.

The Chairperson: OK. I am going to move it on to the issue of the link between supported living places and statutory residential home places.

Mr Brady: Claire Keatinge, the Older People's Commissioner, told us that the availability of supported living will not necessarily reduce the need for residential places, because, obviously, the older population is increasing. We have been told that by the 2020s it will have doubled. There is an assertion in Transforming Your Care that the provision of supported living accommodation will reduce the need for statutory residentials.

The difficulty I have is that there was a residential home in my constituency in which Southern Cross was involved. Obviously, Southern Cross went down the Swanee at some stage, and the trust had to step in in the interim. So, there is always going to be that requirement. They are two separate issues, in a way, yet the Department has linked them. In other words, because you are going to have supported living places ergo you do not need statutory residentials.

The waiting list and the non-admissions policy is a big issue because, in my constituency, there is really only one statutory residential home left. That is working, near enough, at full capacity and there are people waiting to get in but cannot do so because of the non-admissions policy at the moment. That happens. I am really just pointing out that one does not necessarily preclude the other. If you look back to last April or May, the trusts were queuing to see which of them could close their statutory residential homes first. The Northern Trust got in, and then the Southern Trust and the rest. They all sort of jumped in to see which of them could get in first. Maybe that is a cynical view, but I am usually not that cynical. It just seemed to be the —

Mr Dunne: You must have changed.

Mr Brady: Yes, I have. It is the company that I am in *[Laughter.]* Seriously, it seems that that is really what happened. There was a public reaction, a public outcry, and rightly so. That is why it was changed, but the non-admissions policy is still an issue. That is something that needs to be addressed. I am really asking why is there that linkage when, in a sense, they are two different issues.

Mrs McAndrew: I suppose that what we are talking about in TYC is not just supported living, but a range of ways in which people can be supported in the future. We know that we have had a 5% decrease in demand for residential care across all sectors, whether statutory or independent. You have heard us quote the number of vacancies that we have in residential care over a period.

I have been involved in this area of work for a long time, maybe 10 or 15 years even, and the statutory side of the house, because of provision elsewhere, has started to diversify. That happened long before TYC and long before this recent debate and discussion. Other services were introduced on the statutory residential side. We will be planning for the needs of our population for the future in the context of residential care overall. As I said, there has been a significant decrease in demand for residential care as we know it and as we provide it. It is very much communal living; if you have seen the supported living arrangement, it is very different in how it meets the accommodation expectations of the population for the future.

Seán referenced our ability through intermediate care and intensive domiciliary support to maintain people at home for a lot longer; so, in itself, it is not supported living that is making that shift, it is a range of things that has meant that the demand for residential care overall has gone down. I take your point about the independent sector market and, nationally, there is work going on to get better at market predictions and forecasting. That is a national piece of work, because, at the end of the day, we do not want to be moved into a crisis situation where a home decides to close. At the moment, the capacity in the residential sector is significant. You are looking at probably 800 vacant beds in residential care. So, we have a lot of capacity in the system and it is that situation that we have to have regard for as we are planning for the future.

Mr Brady: I accept that there are a lot of diverse issues, but, if I were a cynic, I might think that the reason that there has been a decrease in the applications for statutory residential care is because people are being steered towards the independent sector. Let us be honest; nobody will convince me at this point in time that Transforming Your Care is not a shift towards privatisation, to a greater or lesser extent, but certainly that would be part of the deal.

Mrs McAndrew: We do not believe that, in itself, it is a driver towards privatisation. There are two important things to remember: the first is that we do not have statutory residential homes in all areas across Northern Ireland, certainly, even in the Western Trust area, they are still admitting permanent residents; and secondly, there is a decrease in demand over all. It is not just in the statutory sector, it is in the private and voluntary sector as well. We have the figures to demonstrate that over a period.

As you know, I visited every one of the homes in the last consultation period and I understand that people are committed to those homes, and that the quality of care in them is highly regarded. A lot of them are vibrant hubs of service delivery. They provide a range of services that people need: step-down; step-up; intermediate care; and rehabilitation. Those are things that we are going to need in the future. I am saying that the only bit of this jigsaw is that the demand for permanent living in residential care has fallen significantly.

Mr Brady: I will finish off by saying that in my area the statutory residential care that is left is very much an integral part of the community. It provides very good care. When you say that some areas do not have them, the Belfast Trust closed its statutory residential homes, but did so in a very measured way; it did not put out statements to Stephen Nolan's show to satisfy his demand for what was happening. Again, without being too facetious about it, that is basically what happened in the Southern Trust.

Mrs McAndrew: I think the key in the movement in Belfast is that the alternatives were being developed and people were reassured that if there was a reduction in residential beds it would be consistent with demand and need and that needs could still be met in other ways. Making sure that happens is the biggest communication issue that we have moving forward.

The Chairperson: Finally, the theme that we wanted to pick up was learning from other countries and the use of the private sector. I think Fearghal wanted to raise that issue.

Mr McKinney: Has any work been done on assessing best practice elsewhere?

Mr Martin: On the housing side, a number of the schemes that have been developed have been national and international award winners. Brian can touch on that. There has been a suite of research commissioned by the Housing Executive on housing for older people, which looks at

international experiences, so there has been work there. As Seán said, it is always evolving and we continue to learn, but a lot of work has already been done.

Mr O'Kane: Just to take the point that the Committee has made a number of times, over the last three to four years we have commissioned a suite of research on older people's issues. That is available and I can make it available to you. That has ranged from taking the individual senior citizens' and older peoples' views about what they want in the future to commissioned research about what is best practice across America, Australia and Europe to inform design issues around design standards, space standards and use of technology to help inform the evolving process that we have referred to a number of times in terms of the journey we have been on, together with the health and social care trusts, since 10 years ago, 2003, when the programme was introduced.

I think it is testament that, in the projects you may have seen, be it Cedar Court or Sydenham Court in east Belfast, if you talk to the staff they will say that they have had delegations from across western Europe and America looking at design and at how they have integrated into communities. In many cases, I think we fail to promote and recognise the quality of the accommodation we provide.

Part of it is also to inform some of the learning that we want to take forward in design, the role of technology and scale, so that we learn from it. It is important for us to get feedback, get the customer experience, and listen to the tenants and older people themselves about what they want for the future. This is part of that informing. There is a range of information too, from the evaluation of individual projects, to see what works and that will help us inform the process.

Some of it is about trying to speed up the process. I think that a number of Committee members made the point about how long it takes from thinking of a project to people being able to walk into it. We are looking at ways of doing that as well.

We also recognise that we have not done enough around promotion, education and information. One of the projects here is to do that increasingly at local level with trusts. At the South Eastern Trust, we have done some DVDs on Cedar Court to get the message out and promote it, but also to share good practice, because we have seen huge interest from a number of international design competitions. Cedar Court was nominated for an award. Hemsworth Court is likely to put in for the dementia gold standard. People from the dementia centre in Stirling came over and recognised that what we do here is best practice. I think that sometimes in Northern Ireland we are not very good at saying that we do things well.

I know that the Committee has characterised some of the process as evolving, and I understand why that may be a concern, because "evolving" suggests that we do not have game plan, but it is evolving in the sense of using research evaluation to inform what we do and to do it better. At a local level — to feed on what Fionnuala said earlier — in recent years we have tended to bring all five trusts and ourselves, with the associations, together in a framework. Maybe that did not happen enough in previous years. The structures we have in place now bring everybody together to share best practice and say how we learnt from things. It is still a big challenge for us. We really have not got a good handle on the role of assistive technology *[Inaudible.]* dementia services. We have commissioned research, but that is to help us do a lot better. I think there is a lesson for us in getting that research and that market intelligence back out to you to see that we are trying to improve what we do and to listen to what the older people want.

Mr McKinney: The last time the board was before the Committee — I think it was the last time — it talked about alternatives for assisted living. The view was that that sort of model tended to exist in affluent areas in the south of England. Has there been any more study of that, given, for example, that there are other models in the north of England? Have any more projections been done?

Mr Holland: I would need to check. I thought that the reference to the kind of provision that was popular in the south of England was actually about campus/retirement villages, as opposed to assisted living.

Mr McKinney: Sorry. Yes, I did not describe it, but I was talking about alternatives.

Mr Martin: I can come in on that. The Housing Executive commissioned research in 2007 on retirement villages, which is published as part of the suite and, if the Committee is interested, we can certainly let you have it.

At that time, the view was that while the concept was good, Northern Ireland was not quite ready for it. The concept was there; it was explored and discussed with people. I mentioned to the Committee that we did a piece of research latterly, a survey of the baby-boom generation. It was a fairly small survey, just to get a sense of what people were interested in. Retirement villages and park homes were two things that people in that age cohort said that they were interested in, so there may be a change starting to happen. Certainly, there is some research already there.

Mr O'Kane: Could I just add that, as a result of that research, we have had discussions — conversations may be a better way to put it — with some private sector developers and some voluntary sector organisations that are looking to explore this concept. A major organisation is talking to us about how it had done some quite detailed planning and conceptual work around a retirement village, one that fits and works here in Northern Ireland, rather than on the south coast or north coast. So, there is some interest from the larger private sector developers in the "For Sale" market, because some of that baby boom generation will be homeowners with equity and will want to remain homeowners.

Mr McKinney: Yes. It is 70% of older people.

Mr O'Kane: Absolutely, in that age group.

Mr Holland: Although, not all homeowners would probably be in the market for that kind of development.

Mr O'Kane: Private let is a very niche market.

Mr Holland: It is expensive.

Mr McKinney: Yes.

Mr O'Kane: From a housing perspective, we have done some research and evaluation to look at the concept and applicability of the model to here, locally, to see if it would work. One or two of the key providers are private sector developers, and some voluntary organisations have land banks. We are talking to them to see if that is a way to maybe create a niche market going forward. You will have seen that, in some parts of Belfast, some of the private developers are marketing some of their new apartment developments for people aged 55-plus, and trying to tap into that market.

One of the things that we probably have not got across to you is that, when we look at what we are doing in the Western Trust or Northern Trust areas, we try to take account of what else is happening in the marketplace, whether there is private sector development or things being done by somebody else, to inform us, because it would be imprudent of us to ignore what else is going on. Those pieces of research are a good example of showing some leadership to the sector and what is OK. It has not matured into actual happening, but one or two organisations are at the point where I think they may be testing out planning applications in the near future.

Mr Holland: Going back to your original question about international comparisons and what have you, I think that it is important that both Brian and Stephen referenced the Dementia Services Development Centre in Stirling, which is an international centre of excellence which provides advice on appropriate design and how the built environment can be adapted to meet the needs of people with dementia. That is a centre that we provide financial support to, so that Northern Ireland can access a service from the dementia centre.

The other thing is that, benchmarking internationally, there is a survey that is a few years out of date that estimated that only 1% of homes across Europe were barrier-free for older people, but countries that were in the 2% to 5% band were identified as being progressive in regard to having a good provision, and the UK is within that context. My understanding is that Northern Ireland stands well in overall UK provision. By that benchmark, we would be identified as doing quite well. There are always going to be very innovative, individual schemes in other countries which take very different approaches, and it is always worth looking at those and staying abreast of them. However, as a national benchmark, the UK is seen as doing well across Europe and Northern Ireland is doing well within the UK.

Mr McKinney: I have just one final point. Obviously, if the private sector is looking in on that, it would suggest that your figures are out. I do not want to over-labour the point, but it shows that there is some extra market there that shows a differential. That is all I will say.

Mr Holland: It is worth pointing out that, when you look at what the private sector is interested in, you find that, quite often, it is a different kind of client. They will talk about concierge services and assistive technology, and they are often targeting not only a very affluent group but actually quite an able group, that wants to live with people of similar age, but does not necessarily have the care needs that we are looking at in our 115 figures.

The Chairperson: Folks, I thank you for your time. The Committee will reflect on all this before we make any recommendations. I thank you for your robust responses today, and hopefully, our robust line of questioning too.

Mr Holland: Thank you very much. I particularly thank our colleagues from DSD for coming along with us today. I think that their contribution added value, compared with our previous appearance, which I certainly regretted because I do not like leaving here without giving you answers. I am quite happy that, sometimes, we will not give you the answers that you want, but I hate not giving you answers, and that certainly was your experience of us last time we appeared. It has been very helpful to have our colleagues from DSD here today.

The Chairperson: I appreciate that, and I appreciate your attendance. Thank you all.

Appendix 2

Presentations and additional information provided by witnesses

Belfast Health & Social Care Trust

Supported Living and Services for Older People (including Dementia)
Position at February 2014
Briefing Paper to support meeting with Health Committee 13 March 2014

1. Introduction

The Belfast Health and Social Care Trust was established in April 2007. The Trust provides a wide spectrum of integrated health and social care services across acute hospital, community health and personal social services to the population of the greater Belfast area. The Trust discharges the full range of statutory functions on behalf of the commissioner (Regional HSC Board) It also provides regional services in its specialist hospital facilities The Trust serves a population of 335,000 people resident within the greater Belfast area

Demography

The 2011 Census indicates that 19% (53,530) of the usually resident population of Belfast was aged 60+. Population projections estimate an increase in the older population over the next twenty years, estimating that in 2031 almost 22% of the Northern Ireland population will be aged 65+. In forty years the 65+ proportion of the population is expected to rise to 26.6% in 2051.

It is estimated that there are 19,000 in NI living with dementia and numbers are predicted to rise to 23,000 by 2017 and 60,000 by 2051.

Year	Total Population	Dementia Population*

2014	68,910	5,762
2020	74,644	6,243
2023	78,520	6,569

*based on 1:20 over 60 and 1:5 over 80
Source census 2011

Local Government Reform in 2015 will see an increase of an estimated 72,000 people who will become residents of Belfast. The increase in the population aged 60+ will be 14,074, bringing the total to 67,604, which represents a 26% increase on the current 60+ resident population.

In 2011 42% (22,672) of the 60+ population were male and 58% (30,858) were female. Women outnumber men in all age groups over 60 and the proportionate difference increases with age, with twice as many women as men aged 80 to 89 and three times as many women as men aged 90+.

In 2011 12% (14,555) of all households were one person households where the resident was aged 65 and over

In 2013 there were 3,120 older carers in Belfast aged 65+.

2. Supported Living

What is Supported Living?
Supporting People is a UK wide government programme helping vulnerable people across a number of programmes of care, including older people to live as independently as possible, enabling them to take up tenancies in supported living schemes or to keep their social housing tenancies. The Supported People programme is administered by the Northern Ireland Housing Executive, with personal care and housing support within schemes provided by both health trusts and the voluntary/community sector. It was launched on 1 April 2003.

Supporting People provides funding for housing related support and may also be complemented with funding for personal care (health); the package of support/care designed to meet individual assessed need.

The type of support available via supported living can take various forms, such as:

- Offer of a tenancy in an accommodation based supported living scheme, with staff on site to provide support and care. The level of this support and care can range from moderate to intensive.
- Peripatetic support; provided to clients in their own homes to help them maintain their tenancies, addressing their ongoing support needs and helping them to live as independently as possible.
- Floating Support schemes, similar to Peripatetic schemes in that the support is provided to clients in their own homes, however floating support is time limited (a maximum of two years) and therefore requires empowerment of the client to self-manage after withdrawal of support.
- Warden schemes; such as those provided in sheltered dwelling schemes.
- Community alarm service, providing access to emergency response and allowing the client to seek help if required.

Roles and Responsibilities of bodies involved
(In relation to those programmes of care where a substantial amount of personal care funding may be required)

Body	**Description**
Trust	Responsible for population level needs assessment for local area.
NIHE SP Unit	Administers housing related support revenue process for schemes, carries out validation visits to schemes under contract management process.
SP Commissioning Body	Administering the Support People programme. This body includes representation from the HSCB. Approves business cases.
DSD/DPG	Approval of the Capital Development programme which provides funding for accommodation.
RQIA	Provides validation and inspection of schemes under Domiciliary Care regulations.

The Process for determining the need for a supported living scheme

1. Assessment of need within target group (population) is made.
2. Review of current provision of services for the client group.
3. Identification of the benefits that specific types of SL would provide for the client group is undertaken.
4. Selection of most appropriate model of supported living for client group, i.e. accommodation based, peripatetic, floating support etc.
5. Identification of proportion of client group who could potentially benefit from SL scheme is undertaken.
6. Analysis of best location, size of service, model of service for client group made.
7. Calculation of total costs to establish service made.
8. Estimate of percentage Housing Related Support/Personal Care input required for client group, to inform funding application in OBC based on sample task analyses.

9. Business case development and submission to Supporting People Commissioning Group.

Other services provided for older people by the Belfast Health and Social Care Trust

Within the BHSCT services for older people are provided through Integrated Teams across the Trust with access to the use of:

- Domiciliary care provision (within the persons own home)
- Reablement Services which is a occupational therapy and social care service designed to support older people regain confidence and maximum independence in the activities of daily living. Links are also being developed with the community sector to help address needs related to isolation loneliness support with shopping home maintenance etc.
- Day care options
- Direct payments
- Respite provision
- Residential and Nursing Home care
- Community rehabilitation services.
- Community Mental Health Services, including a range of services for people with dementia.
- Consultant led acute services for older people in hospital.

The nature and balance of the provision of these services is changing with an increased emphasis on enabling the individual to live independently in their own homes, with appropriate care and support as needed.

3. 'Supported Living' Accommodation Based Schemes in the Belfast Trust

Current Supported Living Schemes

Programme of Care	Type of Scheme	Name/Address of scheme	No of places in scheme	Year Opened	Housing Association	Personal Care/ Housing Related Support Provider
Dementia	Accommodation Based	Sydenham Court Sydenham Gardens	25 supported living tenancies	2002	Clanmil	BHSCT

		Belfast				
Dementia	Accommodation Based	Mullan Mews 6 – 16 Willowfield Ave Belfast	30 tenancies	2005	Clanmil	BHSCT
Dementia	Accommodation Based	Hemsworth Court 29 Malvern Way Belfast	35 tenancies	July 2012	Helm Housing	BHSCT
Older People	Accommodation Based	Fairholme Annadale Ave Belfast	40 tenancies	1995	Helm Housing	BHSCT

Proposed Supported Living Schemes (subject to approvals)

Programme of Care	Type of Scheme	Name/Address of scheme	No of places in scheme	Planned commencement Year	Housing Association	Personal Care/ Housing Related Support Provider
Dementia	Accommodation Based Scheme	Grovetree	30 tenancies	2014/15	Clanmil	BHSCT

Notes:

'Supported Living' accommodation based schemes are funded through the DSD Capital Programme with a Housing Association providing the accommodation , and a number of options for the provision of personal care and housing support including the Trust and Independent Providers, or a combination of the two.

4. Peripatetic and Floating Support Schemes (Services Provided in Individual Own Home) in Belfast Trust

Funded by Supported Living Unit NI Housing Executive

Current Peripatetic/Floating Support Schemes

Programme of Care	Type of Scheme	Location/Area	No of places in scheme	Year Commenced	Personal Care/ Housing Related Support Provider
Older people	Floating Support	Belfast	150	2008	BCM (Belfast Central Mission)
Older People	Peripatetic	Belfast	50	2013	BCM (Belfast Central Mission)

Proposed Peripatetic/Floating Support Schemes (subject to approvals)

Programme of Care	Type of Scheme	Location/Area	No of places in scheme	Planned commencement Year	Personal Care/ Housing Related Support Provider

Definitions:

Peripatetic*: A model of housing related support and possibly personal care offered to a client in their own home, following a support/care planning process. Not time limited.*

Floating Support*: more intensive than Peripatetic support, typically offering an outcome focused programme of support for a time limited period; max 2 years in the client's own home.*

5. A Profile of other services supporting older people to live independently in the Belfast Trust

Service	Brief Description	Annual Spend 2012/13	Annual Spend 2013/14	Number of people receiving the service	Comments /Other?
Domiciliary Care Service	The aim of the Trust's Domiciliary services is provide individualised packages of care over a seven day period based on an assessment of need, to enable service users to remain in their own homes and to offer support to carers.	29.4m	24.5 YTD	3301 Stat plus 111(Intensive home care) 3275 Independent Sector	There will be some shared packages between sectors
Reablement	Reablement is the timely and focused therapy-led care support service	346,219	758,646	1067 client received service April 13 - 31Jan 14 Estimate 1600 per year Sept 13 to Feb 14 269 people accessed service	
Assistive Technology	Assistive technology's installed into the clients homes in partnership with Fold Housing to support clients to live independently, to support non intrusive monitoring and management of identified risks		55	175	

Day Care	Day care services provide day support for those people over 65 with varying degrees of physical and cognitive impairment. The centres operate over a five day week providing support to enable service users remain within their own homes in their community.	2,297,450	1,858,600	555 service users supported at Day care.	Service users attend Day care based on assessed needs and this can vary from one day to requiring 5 days support.
Community Rehabilitation and non urgent care	Range of inpatient and community rehab services .	£8m	Not available	Approx 1500 users pa	

6. Other Accommodation Based Schemes/Services that Provide for Older People in the Belfast Trust over and above Trust Statutory Residential Homes

Accommodation/Service	***Description /Comments***
Independent Sector Residential/Nursing Care Homes)	The Independent sector includes community and voluntary organisations as well as private sector organisations. In the Northern Trust areas there are **42** residential and **49** nursing homes with dual registration
Sheltered Housing schemes	Generally refers to grouped housing such as a block or "scheme" of flats or bungalows with a scheme manager . Offers self contained accommodation, suited to needs of older people, disability for example, scheme brings sense of security and proximity to neighbours with similar needs.
Community Alarm e.g. Aid Call provided by Age Concern, or Telecare provided by Fold	Personal Alarm with contact to a call centre and if no response to a next ok kin or emergency services

TRANSFORMING YOUR CARE AND OLDER PEOPLE

Belfast Health & Social Care Trust response to the invitation to give evidence on the Trust approach and provision for assisted living in the context of the Transforming Your Care (TYC) Strategic Implementation Plan

Prior to the publication of Transforming Your Care from Vision to Action the Belfast Health & Social Care Trust, in its strategy for older people, Excellence and Choice (2009), had identified the need to develop a wider range of services to support older people to live in their own homes for as long as possible.

The services that have been developed or enhanced over the last 5-10 years have included:

- Community Rehabilitation Teams
- Reablement services
- Integrated Stroke Services
- Use of assistive technology in peoples own homes
- 24 Hour District Nursing
- Specialist Nursing teams
- Development of stronger links with the community and voluntary sector
- Specialist impatient and outreach dementia forum
- Improved support to carers
- Supported Housing

However, the predominant wish of older people is to remain in their own homes and therefore Trusts plans in the area of supported living schemes is proportionate to meet the needs of a more dependent rather than the full spectrum of older people.

In the letter of invitation to give evidence to the committee reference was made to Section 4.5.1 of the TYC Strategic Implementation Plan (October 2013) and a brief outline of the actions listed over the 3 year period is as follows:

Year 1

Target –Develop a reablement gateway service which provides an intensive period of assessment and support to maximise independence**.**

The Trust commenced the development of a reablement service in September 2012. This service has now been rolled out across the Trust's eight integrated care teams and is available to all eligible clients from February 2014.

Target – 20% of people going into reablement will leave with no service required.

Achievement – at Feb 14' this target has been exceeded.

Year 2

Target – further develop supported housing schemes jointly with NIHE and housing associations and avoid the need for residential care.

Achievement – The Trust have submitted a Business Plan to the Supporting People Commissioning Group for the development of Supported Housing Development in west Belfast. This Business Case is likely to be supported and we have recently had confirmation of a potential suitable site.

Target - Support the natural cessation of use of the 2 remaining statutory residential care homes. The future of these homes is now subject to the Health and Social Care Board led regional process in relation to statutory homes.

Year 3

Reduction in nursing home and residential places - The usage of residential care continues to decline slowly as alternative options develop. Nursing home usage has increased slightly.

Increased in home-base respite – Usage of home-base respite is increasing as new investment is directed towards community alternatives.

Northern Health and Social Care Trust

Senior Directors Office

Ms Kathryn Aiken
Clerk
Committee for Health, Social Service & Public Safety
Room 412
Parliament Buildings
Stormont
Belfast
BT4 3XX

5 March 2014 **Our Ref:** **Your Ref:**

Dear Ms Aiken

Re: Review of Transforming Your Care and Older People – Role of Assisted Housing

I refer to your letter of 18th February 2014 and would confirm that the Northern Health & Social Care Trust will be represented by Mrs Una Cunning, Director of Primary & Community Services for Older People.

I have attached for your information two papers.

1. Supported Living and Associated Services for Older People – Position Paper. This provides demographic context, a brief description of Supported Living, with roles and responsibilities, the range of Supported Living schemes already in place or planned for the NHSCT area and a selection of other services which assist people to live in their own homes.

2. A paper which provides an update on the NHSCT progress towards the objectives outlined in the TYC Strategic Implementation Plan referred to in your letter of invitation.

I trust both papers will be informative for the Committee.

Yours sincerely

Paul Cummings

_____
Mr Paul Cummings
Senior Director

Northern Health & Social Care Trust

Supported Living and Associated Services for Older People (including Dementia)
Position at February 2014
Briefing Paper to support meeting with Health Committee 12 March 2014

1. Introduction

The Northern Health and Social Care Trust (the Trust) was established on 1 April 2007 under the Northern Health and Social Services (Establishment) Order (Northern Ireland) 2006. The Trust is geographically the largest health and social care trust in Northern Ireland; it covers the ten local government districts of Antrim, Ballymena, Ballymoney, Carrickfergus, Coleraine, Cookstown, Larne, Magherafelt, Moyle and Newtownabbey at present; operating from approximately 150 locations and providing services to a population of over 469,000 people. The annual budget for the NHSCT is approximately £619m and the trust employs approximately 12,000 staff.

Within the NHSCT area there were almost 76,000 (75,912) people aged 65 or more reported in the 2013 NISRA mid year estimate, with a projected 27% increase in this age group by 2023 (96,386). A subset of the older population; the numbers of those aged 80 or more at present is estimated at 19,494 people in the NHSCT area, however by 2023 this age group is predicted to have increased to 28,845; a 48% increase.

The Alzheimer's Society estimate that within N. Ireland in 2012 there were almost 19,000 (18,862) people with dementia, they also estimate that one in 14 people over 65 years of age and one in six people over 80 years of age has a form of dementia. Applying these figures to the estimated levels of older people in the NHSCT population in 2023 suggests approximately 6,885 NHSCT residents aged 65 or more will have dementia at that time.

Meanwhile the overall population in the NHSCT catchment area is projected to increase by 5.2% between 2013 and 2023; with the population for those aged 15-64 increasing by only 1%.

Services for older people are provided throughout the NHSCT via integrated Teams of staff with access to the use of domiciliary care provision (within the persons own home), day care options, respite, some supported living schemes, residential care and nursing home care.

2. Supported Living

What is Supported Living?
Supporting People is a UK government programme helping vulnerable people across numerous programmes of care, including Elderly POC to live as independently as possible, enabling them to take up tenancies in supported living schemes or to keep their social housing tenancies. The Supporting People programme in N.I. is administered by the NIHE, with personal care and housing support within schemes provided by both health and social care trusts and the voluntary/community sector. It was launched on 1 April 2003.

Supporting People provides funding for housing related support and may also be complemented with funding for personal care; the package of support/care designed to meet individual assessed need.

The type of support available via supported living can take various forms, such as:

- Offer of a tenancy in an accommodation based supported living scheme, with staff on site to provide support and care. The level of this support and care can range from moderate to intensive.
- Peripatetic support; provided to clients in their own homes to help them maintain their tenancies, addressing their ongoing support needs and helping them to live as independently as possible.
- Floating Support schemes, similar to Peripatetic schemes in that the support is provided to clients in their own homes, however floating support is time limited (a maximum of two years) and therefore requires empowerment of the client to self manage after withdrawal of support.
- Warden schemes; such as those provided in sheltered dwelling schemes.
- Community alarm service, providing access to emergency response and allowing the client to seek help if required.

Roles and Responsibilities of bodies involved
(In relation to those programmes of care where an element of personal care funding may be required)

Body	Description
Trust	Indentifies need, identification of suitable clients for schemes (see needs assessment process below).
NIHE SP Unit	Administers housing related support revenue process for schemes, carries out validation visits to schemes under contract management process.
SP Commissioning Body	Administering the Support People programme. This body includes representation from the HSCB, NIHE, Supporting People, RQIA and Probation Board.
DSD/Development Programme Group	Approval of the Capital Development programme which provides funding for accommodation.

RQIA	Provides validation and inspection of schemes under Domiciliary Care regulations.

The Process for determining the need for a supported living scheme

1. Assessment of current size of client group (population) is made.
2. Review of current provision of services for the identified client group.
3. Identification of the benefits that specific types of SL would provide for the client group is undertaken.
4. Selection of most appropriate model of supported living for client group, i.e. accommodation based, peripatetic, floating support etc.
5. Identification of proportion of client group who could potentially benefit from Supported Living scheme is undertaken.
6. Analysis of best location, size of service, model of service for client group made.
7. Calculation of total costs to establish service made.
8. Estimate of percentage Housing Related Support/Personal Care input required for client group, to inform funding application in Outline Business Case based on sample task analyses.

Cost to the individual in a Supported Living Scheme

The amount someone pays in a Supported Living Scheme depends on their individual circumstances.

If a person is assessed as being entitled to Housing Benefit then they may have their rent paid for them fully or partially depending on their financial situation.

The vast majority of people who reside in Supported Living accommodation receive Housing Benefit which also means that their Housing Support costs are covered too, so they do not pay this charge.

Other services provided for Older People by the NHSCT

Within the NHSCT services for older people are provided through integrated Teams of staff working across the Trust with access to the use of:

- Domiciliary care provision (within the persons own home)
- Reablement programme for clients coming out of Acute hospital care
- Day care options
- Direct payments

- Respite provision
- Residential and Nursing Home care
- Intermediate care

The nature and balance of the provision of these services is changing with an increased emphasis on enabling the individual to live independently in their own homes, with appropriate care and support as needed.

3. 'Supported Living' Accommodation Based Schemes in the Northern Trust Area

Current Supported Living Schemes

Programme of Care	Type of Scheme	Name/Address of scheme	No of places in scheme	Year Opened	Housing Association	Personal Care/ Housing Related Support Provider
Dementia	Accommodation Based	The Brook Brook Green Coleraine	55 supported living tenancies and 6 residential care beds	2005	Fold HA	NHSCT
Older People	Accommodation Based	Barn Halt Cottages Taylors Avenue Carrickfergus	26 supported living units with capacity for 40 people comprising of 14 single bedded, 8 two bedded, 2 with capacity for 3 tenants and 2 one bedded units with capacity for 2 people	2007	Fold HA	Fold

Proposed Supported Living Schemes (subject to approvals)

Programme of Care	Type of Scheme	Name/Address of scheme	No of places in scheme	Planned commencement Year	Housing Association	Personal Care/ Housing Related Support Provider
Dementia	Accommodation Based Scheme	Abbots Cross Newtownabbey	24	2014/15FY	Trinity HA	NHSCT
Older People	Accommodation Based Scheme	Greenisland Shore Road, Newtownabbey	36	2015/16 FY	Trinity HA	NHSCT
Older People	Accommodation Based Scheme	Rathmoyle Ballycastle	28	2015/16 FY	Clanmill HA	NHSCT

Notes:

'Supported Living' accommodation based schemes are funded through the DSD Capital Programme with a Housing Association providing the accommodation , and a number of options for the provision of personal care and housing support including the Trust and Independent Providers, or a combination of the two.

4. Peripatetic and Floating Support Schemes (Services Provided in Individual Own Home) in Northern Trust

Funded by Supported Living Unit NI Housing Executive

Current Peripatetic/Floating Support Schemes

Programme of Care	Type of Scheme	Location/Area	No of places in scheme	Year Commenced	Personal Care/ Housing Related Support Provider
Dementia	Floating support Service	Coleraine	15 floating support places		Praxis Care Group
Dementia	Floating support Service	Cookstown /Magherafelt Dementia Floating Support	25 floating support places	2006	NHSCT
Older People	Peripatetic and Telecare	Newtownabbey Wardens Scheme Covers local government district of Newtownabbey, Carrickfergus, Larne	50 – peripatetic places and 125 Telecare places	2008	Fold
Older People	Floating Support Service	Rathlin Island Floating Support Scheme Rathlin Island Ballycastle Moyle LGD	10 places	2005	NHSCT

Proposed Peripatetic/Floating Support Schemes (subject to approvals)

Programme of Care	Type of Scheme	Location/Area	No of places in scheme	Planned commencement Year	Personal Care/ Housing Related Support Provider
Older People	Peripatetic Scheme	Antrim /Ballymena Peripatetic Service Covering Antrim and Ballymena – proposed scheme as with Fold's Newtownabbey Wardens scheme	140	2014/15 FY	Fold
Older People	Peripatetic Scheme	Moyle Peripatetic Service Covering Moyle Local Government District	TBC	2014/15 FY	Fold

Definitions:

Peripatetic*: A model of housing related support and possibly personal care offered to a client in their own home, following a support/care planning process. Not time limited.*

Floating Support*: more intensive than Peripatetic support, typically offering an outcome focused programme of support for a time limited period; max 2 years in the client's own home.*

5. A Profile of other services supporting older people to live independently in the Northern Trust Area

Service	Brief Description	Annual Spend 2012/13	Annual Spend 2013/14	Number of people receiving the service	Comments /Other?
Domiciliary Care Service	This covers the range of, mainly, personal care services provided to people in their own homes by either Trust or contracted home care services	£36,158,916	£37,129,221 (projected)	As at the end of January 2014 there were 4,700 people receiving home care services	The spend on domiciliary care in the NHSCT has increased by £6.5m between 2010/11 and 2013/14. This is the equivalent of an additional 450,000 hours per year and a 16% growth during that time period.
Domiciliary Care Reablement	The purpose of this service is to provide individually tailored home care support to people in order to promote maximisation of independence and reduce dependence on long-term domiciliary care support.	£1.763M (based on 92 wte staff at mid-point of scale)	£1.767m (based on 92 wte staff at mid-point of scale)	At the end of January 2014 there were 211 people in receipt of domiciliary care reablement, with 1529 receiving reablement since April 2013	The Trust developed its domiciliary care reablement service in September 2014 and it currently extends across the entire Trust area. Further developments in 2014/15 will include the appointment of Occupational Therapy staff to further maximise client independence and support front-line domiciliary care staff.

Assistive Technology - Tele-care	**Tele-care uses a combination of alarms, sensors and other equipment, usually in the home environment, to help people live more independently by monitoring for changes and warning the people themselves or raising an alert at a control centre. Examples of telecare devices include personal alarms, fall detectors, temperature extremes sensors, carbon monoxide detectors, flood detectors and gas detectors.**	**The expenditure quoted is combined for Tele-care and Tele-health –** **£425,808**	**The expenditure quoted is combined for Tele-care and Tele-health –** **£641,380 (fye)**	**339 in 2012/13** **451 in 2013/14**	

Assistive technology – Tele-health	**Tele-health (also referred to as tele-medicine) covers the remote monitoring of physiological data e.g. temperature and blood pressure that can be used by health professionals for diagnosis or disease management. Examples of tele-health devices include blood pressure monitors, pulse oximeters, spirometers, weighing scales and blood glucometers. Tele-health also covers the use of information and communication technology for remote consultation between health professionals or between a health professional and a patient e.g. providing health advice by telephone, videoconferencing to discuss a**	**The expenditure quoted is combined for Tele-care and Tele-health –** **£425,808**	**The expenditure quoted is combined for Tele-care and Tele-health –** **£641,380 (fye)**	**196 in 2012/13** **340 at Jan 2014**	

	diagnosis or capturing and sending images for diagnosis.				
Assistive technology	**Environmental Control Systems. Systems that assist service users with complex needs to operate doors, lighting, television/radio etc. within the home environment.**	**£23,375**	**£30,739 potentially rising to £40,000 with a pending system awaiting installation.**	**21 in 2012/13** **26 in Feb 2014**	**These systems provide users with a degree of independence in carrying out certain tasks in the home.** **They can be expensive to install and do require maintenance and repair post installation.** **Further evaluation of their effectiveness is required but users report positively on their impact on independence and quality of life.**
Direct Payments	**These are payments made directly to an individual who has been assessed as requiring a service and which can be used by that individual to make their own care arrangements independent of the Trust.**	**£749,464**	**£846,463 (projected)**	**148 older people availing of Direct Payments at end of January 2014.**	

Respite Care	**In the context of this submission respite is defined as bed-based services, providing relief to carers through provision of respite for service users in nursing or residential home beds.**	**£699,743 (12,317 days)**	**£729,481 projected to end March 2014 (12,920 respite days projected to end March 2014)**	**12,920 respite days projected to end March 2014.**	**These figures relate only to those provided in independent sector homes.**
Intermediate Care	**This service encompasses a range of bed-based services including Hospital Diversion, Rehabilitation & Stroke Services Teams. There are strong links between these services and acute-based teams to ensure that people are given the maximum opportunity to return to live in their own homes on hospital discharge.**	**£9,368,346**	**£9,203,077 projected to end March 2014**	**From April 2013 until the end of January 2014 1,468 people had used bed-based services and 1,255 had used services within their own homes. (There would be an overlap of these individuals).**	

REVIEW OF TRANSFORMING YOUR CARE AND OLDER PEOPLE – ROLE OF ASSISTED HOUSING

Northern Health & Social Care Trust response to the invitation to give evidence on the Trust approach and provision for assisted living in the context of the Transforming Your Care (TYC) Strategic Implementation Plan

Prior to the publication of TYC and TYC From Vision to Action the Northern Health & Social Care Trust, in its strategy for older people, had identified the need to develop a wider range of services to support older people to live in their own homes for as long as possible. This was and remains the preference of older people.

The services that have been developed or enhanced over the last 5-10 years have included:

- Significant increased investment in domiciliary care
- Use of assistive technology in peoples own homes
- Promotion of self-care/telehealth initiatives
- Day care programmes targeted on reablement, rehabilitation and promotion of integration into the local community
- Wide range of intermediate care and rapid response services
- Development of stronger links with the community and voluntary sector; and
- Provision of a wider range of nursing, occupational therapy and social care services, all aimed at supporting people to live in their own homes

In addition the Trust has developed relationships with the Northern Ireland Housing Executive and Housing Associations to plan for and deliver a range of supported living schemes and to maximise the use of available sheltered housing.

However, the predominant wish of older people is to remain in their own homes and therefore Trusts plans in the area of supported living schemes must be proportionate to meet the needs of a more dependent rather than the full spectrum of older people.

Transforming Your Care provided a new impetus to Trusts to continue on the path of enhancing existing services and developing new initiatives to support older people, supported living being one potential solution.

In the letter of invitation to give evidence to the committee reference was made to Section 4.5.1 of the TYC Strategic Implementation Plan (October 2013) and a brief outline of the actions listed over the 3 year period is as follows:

Year 1

Target – 90% of new referrals to domiciliary care to be admitted to reablement.

Achievement – at 27.02.14 74% of new referrals to domiciliary care were admitted to the NHSCT reablement service. The Trust is proceeding with plans to develop its reablement service as an Occupational Therapy led service which will further enhance the service. The NHSCT is currently reviewing its reablement service to ensure that the service is targeted on those people who will derive the greatest benefit.

Target – 20% of people going into reablement will leave with no service required.

Achievement – at 27.02.14 41% of people discharged from the reablement service left with no package.

Year 2

Target – Increase occupancy rates from 85% to 90% and reduce length of stay from 31 days to 28 days across all Intermediate care beds.

Achievement – Occupancy of the available intermediate care beds was 92% at the end of February 2014 and the average length of stay was 26 days. The improvements in the length of stay have enabled the Trust to achieve the following reduction in the number on intermediate care beds.

Target – Implement reduced number of specialised intermediate care units (to 6 in phase 1) – reduce the number of beds from 143 to 111.

Achievement – The Trust by February 2014 has reduced the number of sites on which it provides intermediate care beds from over 50 to 11. Options are being considered to further reduce the number of sites. The current number of beds across the 11 sites is 119.

Year 3

Target – Develop a range of Housing Support services, including Sheltered Accommodation, Supported Living, Floating Support and Peripatetic Housing Support Services

Achievement – in 2014/15 a supported living scheme for 24 places for people with dementia in the Newtownabbey area will begin development.

In 2015/16 2 supported living schemes, 1 in Greenisland and 1 in Ballycastle, will be progressed for frail older people, providing approximately 60 places.

Target – Increase by 250, the number of service users using alternative housing support services

Achievement – a further 140 places within a peripatetic floating support scheme for the Antrim/Ballymena area are planned for 2014/15 with a further scheme planned for the Moyle Council area within the same year.

The attached paper provided further demographic context and details services under the umbrella of assisted living.

The South Eastern Trust's approach and provision for assisted living in the context of the Transforming Your Care (TYC) Strategic Implementation Plan

Briefing Paper to support meeting with Health Committee 12 March 2014

1. Introduction

The South Eastern Health and Social Care Trust (the Trust) was established on 1 April 2007 under the Health and Social Services (Establishment) Order (Northern Ireland) 2006. The Trust covers the Local Government Districts of Ards, North Down, Down and Lisburn. In addition to its geographical spread, there is also a noticeable diversity in its population characteristics, with areas of relative wealth and prosperity as well as pockets of considerable deprivation and need. There are 6 Wards across the Trust which are considered to be in the top 10% of the most deprived Wards in Northern Ireland.

The South Eastern Trust population of older people is rising year on year. This is something to be celebrated and it requires us to deliver services in new and innovative ways to meet the increasing need in a challenging financial context. . By 2019 it is anticipated that the population of older people aged 65-84 in the Trust area will have grown by 32% amounting to around 60,792 people. The over 85's age group is anticipated to grow by around 45% amounting to around 9,494 people. In addition to the projected levels of population growth, the numbers of people living with dementia is projected to increase rapidly. It is estimated by the Royal College of Physicians that dementia is present in 5-10% in those aged 65 to 70 and over 25% in those over age 85. So by 2019, it could be estimated that in the Trust area around 8,454 people may be living with dementia, a 15% growth from 2014.

The Trust delivers, in partnership with key stakeholders, a wide range of health and social care services that make demonstrable improvements in the health and wellbeing of the population including its older people. In doing so, the Trust constantly reviews its services to ensure that they are modern and fit for purpose. In delivering services, the Trust endeavours to ensure that it provides person centred, safe and effective care that offers value for money.

Transforming Your Care, A Review of Health and Social Care in Northern Ireland, follows the key principle that home should be the hub of care and that steps should be taken to support greater provision of services for older people at home and in the community. This review supports the trend towards independent living, at home or in supported living accommodation, and expects to see a significant reduction in the provision of long-term residential places over the coming years.

Supported living is but one of a wide range of options which are available to older people depending on their level of need and the choices they wish to make. Section 5 of this paper outlines the range of services which are in place to support older people to live independently and in their own home for as long as possible.

2. Supported Living

The Supporting People Programme aims to help vulnerable people live as independently as possible in the community. The programme established the means to manage accommodation on a partnership basis and to strategically commission housing related support services that aim to tackle social exclusion by preventing crisis and more costly service interventions. It plays an important role in the continuum of care by providing an environment for people who cannot live independently in their own home but who may not yet require 24 hour nursing care.

Any new scheme is developed through the outline business case (OBC) process, which provides a strategic context, assesses current and future demand, particular requirements of a programme of care/client group, a non-financial benefit analysis, risk matrix and an option appraisal, including financial information, to identify a preferred option. The OBC process is a collaborative effort with the Housing Association, and the care and support provider (if not the Trust), which is then endorsed by the Trust's Executive Management Team.

Capital for schemes is provided by the Department for Social Development through the Development Programme Group of the Northern Ireland Housing Executive. The Trust assesses the level of need for a particular service, provide care and support services and help refer clients. Housing Associations lead on the design and build/refurbishment of properties and are the landlord for schemes. The Northern Ireland Housing Executive assesses tenants through the Common Selection Scheme where an offer of tenancy is managed through an Admissions Panel, which includes Housing Association, Complex Needs Officer (NIHE) and Trust Staff.

3. 'Supported Living' Accommodation Based Schemes in the South Eastern Trust Area

Current Supported Living Schemes

Programme of Care	Type of Scheme	Name/Address of scheme	No of places in scheme	Year Opened	Housing Association	Personal Care/ Housing Related Support Provider	Scheme Voids March 2014	Weekly Charges
Older People	Accommodation Based	St Paul's Court, Lisburn Phase 1 Phase 2	15 8	2004 2009	Trinity Housing Association	Praxis	Full Occupancy	Rent £90.96 - £101.60 Support Costs- Supporting People £257.31 Care Cost - Health £227.75
Older People	Accommodation Based	Cedar Court, Downpatrick	24	2012	Trinity Housing Association	South Eastern Trust	8 24 Admissions since opening	Rent £104.99 - £115.56 Support Costs – Supporting People £257.76 Care Costs – Health £277.87

All Tenants are means tested and those in receipt of Housing Benefit will get rental charges paid by NIHE and support charges paid by Supporting People otherwise they are required to fund the tenancy privately. There is no means testing for any care provision.

Planned/Proposed Supported Living Schemes

Programme of Care	Type of Scheme	Name/Address of scheme	No of places in scheme	Planned commencement Year	Housing Association	Personal Care/ Housing Related Support Provider
Older People	Accommodation Based	Cuan Court	24	Due to open March 2014	Apex Housing Association	South Eastern Trust
Older People	Accommodation Based	North Down - Ravara	24	2015/16	Ark Housing Association	South Eastern Trust

Notes:

'Supported Living' accommodation based schemes are funded through the DSD Capital Programme with a Housing Association providing the accommodation , and a number of options for the provision of personal care and housing support including the Trust and Independent Providers, or a combination of the two.

4. Peripatetic and Floating Support Schemes (Services Provided in Individual Own Home) in South Eastern Trust

Funded by Supported Living Unit NI Housing Executive

Current Peripatetic/Floating Support Schemes

Programme of Care	Type of Scheme	Location/Area	No of places in scheme	Year Commenced	Personal Care/ Housing Related Support Provider	Cost
Older People	Floating Support	Savoy and Imperial Scheme (North Down)	26	2005	South Eastern Trust	£32.58 per week per place
Older People	Floating Support	Housing Support Service Ards and Peninsula	26 (Average number of 35 clients per year)	2008	Age North Down and Ards	£22.32 per week per place

Proposed Peripatetic/Floating Support Schemes (subject to approvals)

Programme of Care	Type of Scheme	Location/Area	No of places in scheme	Planned commencement Year	Personal Care/ Housing Related Support Provider
*See note below					

*** The Trust plans to undertake a review of sheltered accommodation with a view to further applications for floating support, dependent on identification of need.**

Definitions:

Peripatetic*: A model of housing related support and possibly personal care offered to a client in their own home, following a support/care planning process. Not time limited.*

Floating Support*: more intensive than Peripatetic support, typically offering an outcome focused programme of support for a time limited period; max 2 years in the client's own home.*

5. A Profile of other services supporting older people to live independently in the South Eastern Trust Area

Service	Brief Description	Annual Spend 2012/13	Annual Spend 2013/14	Number of people receiving the service	Comments /Other?
Domiciliary Care Service	A range of personal care services provided in an individual's home.	£23,937,242	£24,492,308	At the end of January 2014 4525 clients were in receipt of domiciliary care.	
Reablement	Reablement is a patient centred therapy led service that focuses on maximising independence with an emphasis on daily living skills. The service is delivered in a person's home with the aim of minimising the reliance on long term domiciliary care and preventing unnecessary hospital attendance.	£210,922 £392,000 non-recurrent	£1,057,599	At the end of January 2014 there were 166 people in receipt of a reablement service, with 1060 people having received a reablement since April 2013.	Recurrent Allocation £1,392,344
Assistive Technology Telecare	This service provides Service Users with 24-hour home safety cover to augment community care packages and enable them to remain as independent as possible for an extended period.	£8,400	Circa £36,000	In April 2013 there were 27 Service Users and by the end of January 2014 there were 97.	The numbers of Service Users are funded to increase to 184.
Day Care	Day care centres offer older people a range of activities, helping	£1,048,992	£1,051,315	The Trust provides 900 daycare places per week,	

	them to remain independent and to continue to live in their own homes.			500 provided in the Statutory Sector and 400 through the voluntary sector.	
Direct Payments	Direct Payments are cash payments, made in lieu of social service provisions, to individuals who have been assessed as needing services.	£727,970	£736,754	At the end of January 2014 there were 82 people in receipt of a direct payment.	
Respite Care	Respite services look after a dependent person temporarily so that their carer can have a break.	Costs not available at the time of the report without further financial analysis.	£2,165,772 to December 2013	From April 2013 to December 2013 379,746 respite care hours were delivered.	Costs are estimated based on activity however; costs couldn't be validated without further detailed financial input.
Intermediate Care	A short term intervention to promote and preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or inappropriate admission to hospital or residential care. The care is person centred and focused on rehabilitation and is delivered by a combination of professional groups.	£2,194,552	£2,963,550	There were 979 admissions to intermediate care from April 2013 to January 2014.	

Southern Health and Social Care Trust
Quality Care - for you, with you

Supported Living and Associated Services for Older People

Briefing Paper to Health Committee 13 March 2014

1. Executive Summary

This paper outlines the Southern Health and Social Care Trust (SHSCT) area and demographic profile and seeks to describe the range of services in place to support older people. Particular emphasis is placed on detailing the range of Supported Living schemes already in place, both "accommodation based" and "Floating Support" and the plans for development over the next 2-3 years.

These plans have been informed by the strategic direction within Transforming Your Care, the expressed needs and wishes of older people, evidence of capacity and demand within southern area and the opportunities that arise from the Supporting People programme.

There are currently 3 "supported living" accommodation based schemes in the Southern Trust area and these are all located in the Craigavon and Banbridge locality area, offering support to 41 older people (see section 4). In addition there are two "Floating support" schemes in Newry/Mourne (Mourne) and Armagh/Dungannon council areas, with a target of offering support to approximately 90 older people (section 5). 43 "Sheltered Living" facilities are spread across the southern area, provided by a range of Housing Associations. These support approximately 510 older people (section 3).

Based on demographic trend analysis including prevalence of long term conditions such as Dementia, plans for 3 further accommodation based schemes are detailed, all of which are at different stages of development (section 4). These will offer 48 additional Supported Living homes, an increase of over 100%. There is also a planned evaluation of the Armagh and Dungannon based Floating Support scheme, with the intent of rolling this programme across the entire southern Trust area, again increasing the capacity to meet the growing needs of older people. These developments will offer a continuum of support and care options to older people.

This paper also summarises a range of services that support older people as evidence of the holistic approach to meeting the broad needs of older people within a choice based model of person centred care (section 6 and section 7).

2. Introduction

The Southern Health and Social Care Trust was founded in April 2007 following the amalgamation of Craigavon Area Hospital Group, Craigavon and Banbridge Community, Newry and Mourne and Armagh and Dungannon Health and Social Services Trusts. The Southern Trust covers in the region of 3,200 square kilometers and is estimated to encompass a population of 358,991. (NISRA 2010)

In the Southern area, 5% of the population is between 60 and 64 and 13% aged 65 years and over. With 18% of the population in the Southern Trust aged 60 and over, and continuing rapid growth in this age bracket the demands on health and social services continue to increase. The table below highlights how the growth in our older population is set to continue. It is anticipated that our 75+ population will have increased by 28% and our 85+ population by 40% by 2023.

AGE BAND	2012	2023		Actual Increase	% Increase
65-69	16000	19000		3000	15.8%
70-74	12000	16000		4000	25.0%
75-79	10000	13000		3000	23.1%
80-84	7000	9000		2000	22.2%
85+	6000	10000		4000	40.0%
65+	**53012**	**69023**		**16011**	**23.2%**
75+	**23000**	**32000**		**9000**	**28.1%**

Source: NISRA Mid-Year Estimates (2008 based)

While more people are living longer fuller lives and are able to maintain their independence, increasing numbers of older people have more complex needs. Considering that as people age they are more likely to experience disability or illness, there continues to be increased demands placed on the provision of care for older people.

The range of health and social care services available to support older people to remain independent at home for as long as possible include Integrated Care Teams comprising Nursing, Social Work and Occupational Therapy, Memory Services, Reablement, Intermediate Care Services (Rehabilitation), Domiciliary Care Services, Rapid Response services, Day Care, Residential and Nursing Care, Floating support / Supported Living options, technological support and a range of social support services provided by community and Voluntary partners. These are detailed more fully in sections 6 and 7 of this paper.

Dementia

The Southern Trust holds a dementia register per locality and details information relating to people with Dementia including personal details, date of diagnosis, current care setting and severity of condition. There are approximately 2,268 people listed on the register who are

known to the service and that it is believed that there are many who may have dementia that are not known to the service. .

Of the 2,268 on the live Dementia register, the Craigavon and Banbridge area have the largest number of people with Dementia with 50% and the other two areas Armagh and Dungannon and Newry and Mourne are both equal in having 25%. This split may be due to the fact that the Craigavon and Banbridge area have in general higher population figures compared to the other two localities.

3. Supported Living

Roles and Responsibilities of bodies involved

Body	Description
Trust	Identifies need, identification of suitable clients for schemes.
NIHE SP Unit	Administers housing related support revenue process for schemes, carries out validation visits to schemes under contract management process.
SP Commissioning Body	Administering the Support People programme. This body includes representation from the HSCB.
DSD/DPG	Approval of the Capital Development programme which provides funding for accommodation.
RQIA	Provides validation and inspection of schemes under Domiciliary Care regulations.

Supported Living Schemes provide innovative living solutions to assist older people with different levels of care needs with appropriate housing support. This can provide an alternative solution to nursing and residential homes, for older people who wish to remain living in their local community. Supported living options ensure a fit for purpose residence for older people that provide greater housing support, promote social inclusion and further enhance independence and quality of life.

Typically an older person living in a supported living project receives assistance in maintaining their tenancy as well as their personal and social care. The benefits of a supported living scheme include;

- Provide a personalised assessment of housing support needs and care support needs;
- Create an individual support plan detailing the expectations and responsibilities of all involved in the process;
- Deliver a person-centred housing support and care service to enhance independent living skills;
- Enable older people to have more control of their lives.

Currently there are 3 supported living schemes in the Southern Trust area and these are all located in the Craigavon and Banbridge locality area (see section 4).

The Trust has been working to further develop Supported Living Options. In July 2010 the Trust was granted approval by the Southern Area Supporting People Partnership (SASSP) to progress the development of a supported living scheme in the Kilkeel area to provide 12 self-contained units of accommodation. This scheme has been subject to a series of delays and Trinity housing are currently undertaking a Planning Appeals process (date 19th March) with regard to Roads Access.

In addition The Trust has outline business cases approved for 2 additional supported living accommodation based schemes (one for Dromore/Banbridge and one for Armagh/Dungannon). Both of these schemes are currently undergoing financial costings and are to be considered for inclusion in the 14/15 Capital Expenditure programme. Sites are still to be identified. The target group will be frail older people and low to level levels of Dementia.

This will provide a further 48 Supported living units thus more than doubling the current capacity.

Floating Support

SHSCT operates a “floating support” service in the Kilkeel area providing a service to approximately 40 older people**.** This has enabled older people to remain independent in their own homes until other accommodation based options are available (see section 5). There is turnover within this scheme which enables ongoing referral and support.

The Trust has also developed a partnership project with Belfast Central Mission for a Floating Support scheme in the Armagh /Dungannon area targeting 50 older people. This launched in November 2013 and has currently achieved 50% of the target for Year 1. This will be evaluated at the end of Year 1 with a view to securing funding to roll the scheme out across all of southern area and to offer a “peripatetic” aspect (not time limited).

Sheltered Accommodation

The southern area has a number of sheltered accommodation schemes offering lower level housing support from a range of Housing association including Alpha Housing, Clanmil, Fold, Oaklee and Trinity. This type of accommodation generally refers to grouped housing such as a block or "scheme" of flats or bungalows with a scheme manager. It offers self-contained accommodation, suited to needs of older people. It provides a sense of security and proximity to neighbors with similar needs and is available within local communities.

There are 21 schemes in the Craigavon and Banbridge area, 12 in the Armagh and Dungannon area and 10 within the Newry and Mourne locality. There are limited vacancies available across the year in these schemes.

4. 'Supported Living' Accommodation Based Schemes in the Southern Trust Area

Current Supported Living Schemes

Programme of Care	Type of Scheme	Name/Address of scheme	No of places in scheme	Housing Association	Personal Care/ Housing Related Support Provider
Dementia	Accommodation Based	Spelga Mews Banbridge	24	Fold HA	Fold HA SHSCT contribute personal care costs
Older People	Accommodation Based	Scarva Street Banbridge	7	Abbeyfield UK (NI) ltd	Abbeyfield UK (NI) + SHSCT Care support
Older People	Accommodation Based	Sloan Street Craigavon	10	Abbeyfield UK (NI) ltd	Abbeyfield UK (NI) + SHSCT Care support

Proposed Supported Living Schemes (subject to approvals)

Programme of Care	Type of Scheme	Name/Address of scheme	No of places in scheme	Planned commencement Year	Housing Association	Personal Care/ Housing Related Support Provider
Older People	Accommodation Based Scheme	Kilkeel _Mourne Hospital	12	13/14	Trinity housing	Trinity – housing support SHSCT – Care support
Older People/ Low – moderate Dementia	Accommodation Based Scheme	Armagh/Dungannon – site to be identified	18	14/15	Not yet identified	Housing Provider to be identified SHSCT – Care support
Older People/ Low – moderate Dementia	Accommodation Based Scheme	Craigavon/Banbridge – site to be identified	18	14/15	Not yet identified	Housing Provider to be identified SHSCT – Care support

Notes:

'Supported Living' accommodation based schemes are funded through the DSD Capital Programme with a Housing Association providing the accommodation. SHSCT will undertake to provide the personal care element.

5. Peripatetic and Floating Support Schemes (Services Provided in Individual Own Home) in Southern Trust

Funded by Supported Living Unit NI Housing Executive

Current Peripatetic/Floating Support Schemes

Programme of Care	Type of Scheme	Location/Area	No of places in scheme	Year Commenced	Personal Care/ Housing Related Support Provider
Older People	Floating support	Kilkeel	Up to 40	2008	SHSCT
Older People	Floating Support Service	Armagh/ Dungannon	50 in Year 1	2013	Belfast Central Mission (BCM) SHSCT – Care support

Proposed Peripatetic/Floating Support Schemes (subject to approvals)

Programme of Care	Type of Scheme	Location/Area	No of places in scheme	Planned commencement Year	Personal Care/ Housing Related Support Provider
Older People	Floating support and Peripatetic Scheme	Southern Trust Area wide	To be confirmed	2014/15	Belfast Central Mission (BCM) SHSCT – Care support (Roll out of above scheme)

Definitions:

Peripatetic*: A model of housing related support offered to a client in their own home, following a support/care planning process. Not time limited.*

Floating Support*: Typically offering an outcome focused programme of housing support for a time limited period; max 2 years in the client's own home.*

6. A Profile of other services supporting older people to live independently in the Southern Trust Area

Service	Brief Description	Annual Spend 2012/13	Annual Spend 2013/14	Number of people receiving the service	Comments
Domiciliary Care Service	Dom Care Packages supporting individuals to remain at home through the provision of support with personal and practical tasks.	£31Million	Projected to year end = increased expenditure of 2.2 million compared to 12/13 - Includes direct payments (1.6 m)	3870	Increasing demands on service including increasing complexity of client need places greater demands on available budgets.
Reablement	Providing therapeutic input to ensure	£666,038	£1.18 Million	Between 01 Jan 2013 & 31 Dec 2013, there	This service is in in place in 5 out of 7

	individuals are rehabilitated and their skills and abilities maximised, so ensuring they can remain as independent at home for as long as possible, with minimal support of others in respect of activities of daily living.			were 1098 patients commenced on the Reablement Scheme.	areas.
Assistive Technology	Telecare – an assistive technology to support individuals to remain independent at home. This includes personal alarms (lifelines), falls sensors, heat/water and personal safety sensors, Telehealth – includes a range of products that enable proactive health monitoring of specific conditions and active involvement with professional staff teams	£165,070 £471,748	£263,400 projected £478,586	The Southern Trust is supporting approximately 600 individuals with telecare, through Trust scheme and CAWT (Cooperating and Working Together) – cross border programme funded from Interreg 1V). Funding for CAWT now discontinued 240 clients currently supported with Telehealth	
Day Care Reablement Programmes	Regulated Day care services offering care and support in line with assessed need.	£1,887,633	£1,864,946	8 Statutory Day Centres providing support to approx. 400 older people with a range of needs.	Service Improvement approach underway in line with TYC. Dedicated memory services

Social centres	Lower level support within the community offering support to older people.	£55,870	£52,665	16 community based groups offering social support within local areas providing support to approx. 180 older people.	
Intermediate Care, Integrated Care Teams, Memory Services, Day Hospital and Rapid Response Services	Range of primary care services to support older people to remain in their own home and ensure timely discharge from hospital with a focus on reablement and rehabilitation				
Community / Voluntary Sector	A range of contracts to support older people across a wide spectrum of services including befriending, volunteering, luncheon clubs, day care, good morning / good neighbour schemes	2.4 million			

7. Other Accommodation Based Schemes/Services that Provide for Older People in the Southern Trust Area

Accommodation/Service	***Description /Comments***
Independent Sector - Residential/Nursing Care Homes	In the Southern Trust area there are a range of Independent Sector residential and nursing homes offering care for older people and older people with dementia. This equates to 7 Residential homes, 44 Nursing Homes and 21 dual registered as both Nursing and Residential homes. These are commissioned from Independent sector on a spot purchase basis. There is capacity within the Care Homes for older people with varying needs.

Statutory Residential Homes	In addition there are 5 statutory Residential Homes with capacity for 121 residents – one (Skeagh House Dromore) is currently evacuated due to a land slide. Occupancy ranges from 60-80% currently. Stage 1 Regional consultation is underway to agree criteria for consideration with regard to future plans for these statutory homes Currently SHSCT supports 1341 clients in Independent Sector Nursing beds and a further 381 clients in Residential accommodation (across both statutory and independent sector). These figures include approximately 100 older people placed in Independent Sector Homes outside the Trust boundaries.

The Western Health and Social Care Trust – Key Facts

- **Government Districts** – the Western Trust covers 5 local council districts – Derry; Fermanagh; Omagh, Strabane and Limavady
- **Population** – 2013 NISRA population projections indicate that the Western Trust's current population figures stand at **306,118**
- **Population Projections** - The population of Northern Ireland is growing older and the Western area is no exception to this demographic trend. By 2020, the Western Trust's population will rise by 5.8%, with the number of people aged 65 years and over estimated to increase from approximately 38,000 persons (Mid-Year Estimates 2010) to 52,000 persons (Projected Population 2020), ie, 72.7% increase within a decade.
- **Population Density/Rurality** – the Western Trust covers the largest geographical area (466,945 hectares) of all 5 Trusts, which is diverse in nature, from the densely populated areas of Derry/Londonderry to the very rural areas in Omagh and Fermanagh. This is challenging in the provision of equality of service delivery. Census 2011 figures identify the Western Trust as the least densely populated Trust with an average of **0.63 persons per hectare**, compared to the NI average of 1.34 persons per hectare and the Belfast Trust's figures of 17.91 persons per hectare.
- **Budget** – the Western Trust spends approximately **£600 million** per year on the delivery of its services
- **Workforce** – the Western Trust employs in the region of **12,000 staff**
- **Dementia** – the Alzheimer's Society estimates that within Northern Ireland in 2012 there were almost 19,000 (18,862) people with dementia, with 1 in 14 people over 65 years of age and one in 6 people over 80 years of age having a form of dementia. In the **WHSCT in 2012**, there were **2,717 people** estimated to have **dementia** - 1830 (67.4%) of these had a diagnosis. Population projections indicate that there will be more than **3 times this amount by 2051**.
- **Key Services** – our older people have told us again and again that they want to remain in their own homes for as long as possible. Subsequently, the Trust has designed its services to reflect this demand, with community care and support for older people provided throughout via multi-disciplinary teams of staff with access to the use of domiciliary care provision (within the person's own home), rehabilitation care; older people's mental health services, Reablement, intermediate care, Flexicare, day care, respite care, community meals, sitting services; carer support. As dependency levels increase, residential care and nursing home care is provided.

Supported Living

What is Supported Living?

Supporting People is a UK government programme helping vulnerable people across numerous programmes of care, including Elderly POC to live as independently as possible, enabling them to take up tenancies in supported living schemes or to keep their social housing tenancies. The SP programme in N.I. is administered by the NIHE, with personal care and housing support within schemes provided by both health trusts and the voluntary/community sector. It was launched on 1 April 2003.

Supporting People provides funding for housing related support and may also be complemented with funding for personal care (health); the package of support/care designed to meet individual assessed need.

The type of support available via supported living can take various forms, such as:

- Offer of a tenancy in an accommodation based supported living scheme, with staff on site to provide support and care. The level of this support and care can range from moderate to intensive.
- Peripatetic support; provided to clients in their own homes to help them maintain their tenancies, addressing their ongoing support needs and helping them to live as independently as possible.
- Floating Support schemes, similar to Peripatetic schemes in that the support is provided to clients in their own homes, however floating support is time limited (a maximum of two years) and therefore requires empowerment of the client to self-manage after withdrawal of support.
- Warden schemes; such as those provided in sheltered dwelling schemes.
- Community alarm service, providing access to emergency response and allowing the client to seek help if required.

Roles and Responsibilities of bodies involved

(In relation to those programmes of care where an element of personal care funding may be required)

Body	Description
Trust	Identifies need, identification of suitable clients for schemes (see needs assessment process below).
NIHE SP Unit	Administers housing related support revenue process for schemes, carries out validation visits to schemes under contract management process.

SP Commissioning Body	Administering the Support People programme. This body includes representation from the HSCB.
DSD/DPG	Approval of the Capital Development programme which provides funding for accommodation.
RQIA	Provides validation and inspection of schemes under Domiciliary Care regulations.

The Process for determining the need for a supported living scheme

1) Assessment of current size of client group (population) is made.
2) Review of current provision of services for the identified client group.
3) Identification of the benefits that specific types of SL would provide for the client group is undertaken.
4) Selection of most appropriate model of supported living for client group, i.e. accommodation based, peripatetic, floating support etc.
5) Identification of proportion of client group who could potentially benefit from SL scheme is undertaken.
6) Analysis of best location, size of service, model of service for client group made.
7) Calculation of total costs to establish service made.
8) Estimate of percentage Housing Related Support/Personal Care input required for client group, to inform funding application in OBC based on sample task analyses.

'Supported Living' Accommodation Based Schemes in the Western Trust Area

Current Supported Living Schemes

Schemes	Number of places at each development	Housing Provider	Personal Care/ Housing Related Support Provider
Sevenoaks Londonderry	16 Residential 14 Housing with Care	Fold	Fold
Gnangara Enniskillen	15 Residential 15 Supported Housing	Fold	Fold
Daleview Londonderry	18	Apex Housing Association	Apex
Various Apex Housing Association Facilities: Abbey House, Derry Beechwood Court, Derry Father Mulvey Park, Derry Glenbrook House, Derry Mulvey House, Strabane	Abbey = 30 Beechwood =37 Mulvey Park = 29 Glenbrook = 39 Mulvey House = 31	Apex Housing Association	Apex
St Julian's House Omagh	44	Apex Housing Association	Apex

Proposed Supported Living Schemes (subject to approvals)

The Western Trust is currently exploring the development of an accommodation based scheme in partnership with Supporting People for EMI clients in the Strabane area.

Notes:

'Supported Living' accommodation based schemes are funded through the DSD Capital Programme with a Housing Association providing the accommodation and a number of options for the provision of personal care and housing support including the Trust and Independent Providers, or a combination of the two.

Peripatetic and Floating Support Schemes (Services Provided in Individual Own Home) in the Western Trust

Current Peripatetic/Floating Support Schemes

Programme of Care	Type of Scheme	Location/Area	Personal Care/ Housing Related Support Provider
POC4	Floating Support – Frail Elderly	Cityside, Derry	Praxis
POC4	Floating Support – Older People's Mental Health	Lisnaskea	Praxis
POC4	Floating Support - Addictions	Derry/Limavady/Strabane	Praxis

Proposed Peripatetic/Floating Support Schemes (subject to approvals)

Programme of Care	Type of Scheme	Location/Area	Personal Care/ Housing Related Support Provider
POC4	Floating Support – Older People's Mental Health	Extension of Praxis scheme in Cityside for people with dementia	Praxis

Definitions:

- ***Peripatetic****: A model of housing related support and possibly personal care offered to a client in their own home, following a support/care planning process. Not time limited.*
- ***Floating Support****: more intensive than Peripatetic support, typically offering an outcome focused programme of support for a time limited period; max 2 years in the client's own home.*

Supported Living

The Trust has implemented a number of significant strategic drivers to maintain people in their own home and services such as Flexicare and assistive technology (assisted living), which have enabled people to remain in their own home for longer. As a consequence, people who require accommodation-based services appear to have higher dependency levels that can only be met in either residential or nursing home care, resulting in reduced lengths of stay in supported living type facilities.

The Trust's current experiences with supported living models has indicated that location, demand and deprivation levels require detailed joint analysis and consideration when planning any proposed supported living models.

Accommodation Information

Whilst the Western Trust is committed to supporting older people to remain in their own home for as long as possible, the Trust offers a range of accommodation options (some in partnership with the independent sector and other statutory agencies), when this is no longer possible. The table below provides an overview of the range of alternative accommodation options available to older people in the Western Trust.

Statutory Residential Care Places	Independent Sector Residential/ Nursing Places
154	**1,643**

Statutory Residential Care

The Western Trust has 5 statutory residential care homes offering a total of 154 places. At 24th February 2014 the occupancy status was as follows:

- **22% vacancy rate**
- **58%** of total places available occupied by residents with **permanent status**
- **20%** of places occupied by residents on a **temporary or respite status**

Independent Sector Nursing/Residential Care

There are approximately 1,643 independent sector nursing/residential places available for older people in the Western Trust's area, with **66%** of total places located in the **Strabane/Omagh/Fermanagh** areas.

Occupancy rates vary across the Trust, but there is a shortage of nursing homes places in the Derry City Council area, particularly in the Cityside area. There is also a significant shortage of EMI nursing homes places in the Derry/Limavady areas, but it is hopeful that the development of a new nursing home in the Cityside area of Derry later in 2014 will help to alleviate this shortage.

Community Services for Older People

The nature and balance of the provision of these services is changing with an increased emphasis on enabling the individual to live independently in their own homes, with appropriate care and support as needed. The table below indicates a number of key community services available to older people in the Western Trust area.

Service	Brief Description	Annual Spend 2012/13	Annual Spend 2013/14 (April 2013 – January 2014)
Domiciliary Care Service and Reablement	Domiciliary Care: Mainly personal care services provided to people in their own homes by either Trust or independent sector Reablement: Individually tailored home care support to people in order to promote independence and reduce long-term care on domiciliary care support.	£20,313,918	£18,047,605
Assistive Technology - Telecare and Telehealth	Telecare uses a combination of alarms, sensors and other equipment, usually in the home environment, to help people live more independently by monitoring for changes and warning the people themselves or raising an alert at a control centre. Examples of telecare devices include personal alarms, fall detectors, temperature extremes sensors, carbon monoxide detectors, flood detectors and gas detectors. Telehealth (also referred to as tele-medicine) covers the remote monitoring of physiological data e.g. temperature and blood pressure that can be used by health professionals for diagnosis or disease management. Examples of tele-health devices include blood pressure monitors, pulse oximeters, spirometers, weighing scales and blood glucometers. Tele-health also covers the use of information and communication technology for remote consultation between health professionals or between a health professional and a patient e.g. providing health advice by telephone, videoconferencing to discuss a diagnosis or capturing and sending images for diagnosis.	£501,991	£529,842
Direct Payments	The Western Trust offers Direct Payments to clients to enable them to arrange care that meets their individual needs.	£898,332	£828,256

Service	Brief Description	Annual Spend 2012/13	Annual Spend 2013/14 (April 2013 – January 2014)
Community Meals	The Western Trust's Community Meals Service is an important component of a range of community services the Trust has in place to support older people to maintain their independence for as long as possible in the community.	£494,764	£400,978
Day Care	The Western Trust provides a range of day care options for older people to enable them to maintain their independence. Day care is provided by both the Trust and the independent sector.	£1,748,807	£1,518,744
Flexicare	The Western Trust's Flexicare service focuses on supporting older people to remain at home within their own community by offering services such as befriending, respite, repair jobs, shopping and sitting services. The service also aims to facilitate access to established health promotion programmes for older people in rural communities and to develop solutions that will include signposting to services, creation of new networks and promotion of the social economy.	£327,229	£330,344

COPNI Commissioner for Older People for Northern Ireland

Supported Living options for older people, within the context of *Transforming Your Care* (TYC).

Brief: Committee for Health, Social Services and Public Safety

from the Commissioner for Older People for Northern Ireland

April 2014

Contents

1. Executive Summary

The following is a summary of the Commissioner's views on ***Supported Living options for older people*****,** as described in the Terms of Reference for this evidence session. The other sections of the document set out her views in greater detail.

Commissioner's Summary

1.1. The Commissioner has followed the debate about the need for Supported Living, both in this Committee and more widely.

1.2. The absence of a clear, agreed definition, has led to confusion during hearings of this Committee with regard to conflicting information being presented about Supported Living projects, and the exact numbers of Supported Living projects which will be financed and implemented, both now and in the future.

1.3. The Commissioner supports the aim of providing older people with more choice over where to live. The needs and choices of today's and tomorrow's older people should drive service design and planning. We need accurate projections based on evidence of the need and likely choices of older people, which must be made available. The planning must include staff, resources, physical buildings and qualitative evidence of the preferences of today's and tomorrow's older people.

1.4. Modeling of the additional service and support needs for older people living in Supported Living is also required. That modeling should include nursing, Domiciliary Care, Physiotherapy, meals, befriending, social activities, advocacy and palliative care.

1.5. Planning should include older people and implementation should respect their needs. Supported Living will meet the needs of some older people, and every effort must be made to ensure it is available to meet the needs of these individuals. Supported Living will not be the most appropriate choice for all and each individual older person must be provided with appropriate options that meet their care and support needs.

1.6. Care assessments must offer a range of options that people can choose from, and that are suitable to meet their assessed needs. They must not be vehicles for one option to be publicised or to steer an individual's decision towards one particular choice.

1.7. Supported Living options and their development will not necessarily reduce the need for either residential or nursing care. The overall older population and demand for health and social care support will rise, with the increasing numbers in our ageing population. A wide variety of Supported Living options will help provide choice to older people and will help older people live more independently for longer. Some older people will require domiciliary residential or nursing care and this must continue to be available on the basis of fully meeting assessed need.

Terms of Reference

1. Consider the structure and availability of Supported Living options for older people in Northern Ireland.

Commissioner's Comments:

1.8. There are many differences in definitions of the term Supported Living, as highlighted in the separate hearings of the Committee. This creates difficulty for the Committee in getting clear detailed mapping of the structure and availability of Supported Living options for older people. This is a picture further complicated by the fact that Supported Living may include specialist facilities for those with specialised needs, that include older and younger people.

1.9. The difficulties in defining the scope of Supported Living have been evidenced in the previous Assembly hearings, where the Health and Social Care Trusts and the DHSSPS evidence appears to be conflicted on the number of Supported Living places available in Northern Ireland.

1.10. The variability of definitions, combined with a lack of statistics for either present or future Supported Living options, makes it impossible to formulate an accurate picture of the structure and availability of Supported Living options for older people in Northern Ireland. This applies to current and future provision.

2. Assess the capacity of Supported Living options to meet the policy objective of Transforming Your Care in terms of reducing the need for residential home places.

1.11. *Transforming Your Care* (TYC) has some inconsistencies between the original documents and the implementation plan, with the initial publication talking of supported accommodation and the implementation plan talking of assisted housing, two terms which can be interpreted very differently.

1.12. TYC clearly sets out an overarching policy objective of more older people in homes they call their own, benefiting from support to enable them to be able to continue to live there independently.

1.13. TYC states that if health and social care was continued to be provided on the current model, there would need to be a commitment of an additional billion pounds over the next 3 years.

1.14. The Commissioner recognises the challenging budgetary environment facing the Northern Ireland Executive. The needs of older people for high quality housing support and health and social care services must be met.

1.15. Lack of detailed future projections, especially beyond the 3 year funding cycle, make it impossible to evaluate whether Supported Living will meet the needs of today's and tomorrow's older people and the TYC objectives in the longer term.

3. Identify examples of best practice in relation to Supported Living options in other countries/regions which could be applied in Northern Ireland.

1.16. The Committee has been advised of a range of Supported Living options in Northern Ireland and elsewhere. A comprehensive list of best practice is available in the Northern Ireland Assembly Research and Information Service Briefing Paper, 'Specialised Grouped Housing for Older People'. [1]

[1] Dr Janice Thompson, Northern Ireland Assembly Research and Information Service Briefing Paper, 'Specialised Grouped Housing for Older People – Introductory Briefing', 14th February 2014.

2. The Commissioner for Older People

2.1. The office of the Commissioner for Older People for Northern Ireland (COPNI) is an independent public body established under the Commissioner for Older People Act (Northern Ireland) 2011. The Commissioner has an extensive range of general powers and duties which will provide the statutory remit for the exercise of her functions. In addition, the Commissioner may provide advice or information on any matter concerning the interests of older people. Her wide ranging legal powers and duties include amongst others:

- To promote and safeguard the interests of older people (defined as being those aged over 60 years and in exceptional cases, those aged over 50 years);
- To keep under review the adequacy and effectiveness of law and practice relating to the interests of older people;
- To keep under review the adequacy and effectiveness of services provided for older persons by relevant authorities (defined as being local authorities and organisations including health and social care trusts, education boards and private and public residential care homes);
- To promote the provision of opportunities for and the elimination of discrimination against older persons;
- To review and where appropriate, investigate advocacy, complaint, inspection and whistle-blowing arrangements of relevant authorities;
- To assist with complaints to and against relevant authorities;
- The power to bring, intervene in or assist in legal proceedings in respect of relevant authorities;
- To issue guidance and make representations about any matter concerning the interests of older people.

2.2. The Commissioner's powers and duties are underpinned by the United Nations Principles for Older Persons (1991) which include Independence, Participation, Care, Self- fulfillment and Dignity.

2.3. The Commissioner welcomes the opportunity to provide comments or assistance to the Committee on this issue.

3. Background

3.1. *Transforming Your Care, A review of Health and Social Care in Northern Ireland (TYC)*, published in December 2011, acknowledged a changing trend in care for older people. It proposed to make a person's home the *"hub of care"* for older people, with more services being delivered at home or in the community. *Amongst other recommendations to support the aim of enabling older people to live at home for longer, was a proposal to make "a major reduction in residential accommodation for older people, over the next five years."* [2]

3.2. Supported Living is a flexible and sometimes disputed term. This makes analysis of the role of Supported Living in Northern Ireland and the extent to which it can meet the objectives set out in TYC more difficult. This has been seen in the previous two Committee hearings where there were differences of opinion over which types of accommodation would be included in Supported Living and what statistics applied. There were particular differences between the DHSSPS and the Trusts about whether sheltered housing was part of Supported Living. [3] In some definitions sheltered housing and extra care housing are defined as parts of Supported Living, but in other instances they are not.

3.3. The Commissioner supports the right of all older people to have their assessed housing and health and social care needs fully met. The Commissioner supports the provision of high quality domiciliary, residential and nursing care at levels that will meet current and future needs, together with a move towards a more independent type of living for those people who wish to live in this way. Supported Living options can be a valuable and appropriate option for individual older people. It must be made as easy as possible for older people to make the choice to participate in a Supported Living development where it is appropriate. Supported Living at its best can bring specialised staff and communal facilities to support independent living, in creating an environment that is supportive for older people. But it is important that individual older peoples' needs and preferences are taken into account when considering what sort of living arrangements would

[2] Transforming Your Care: A Review of Health and Social Care in Northern Ireland', December 2011, p.135.
[3] Committee for Health, Social Services and Public Safety, 'Official Report (Hansard) Review of Transforming Your Care and Older People: DHSSPS and Health and Social Care Board', 26th February 2014.
Committee for Health, Social Services and Public Safety, 'Official Report (Hansard) Review of Transforming Your Care and Older People: Health and Social Care Trusts', 12th March.

be most appropriate for them, and they have the freedom to make the choice that is right for them. This choice must not be primarily dictated by overall policy considerations, but by individual needs.

3.4. Consistent with the policy direction set out in TYC, it is projected that demand for statutory residential homes will decrease, and it is proposed that at least 50% of statutory residential homes will close over the next 3 to 5 years. Subsequent to the initial publication of TYC, a discussion paper was jointly published by DHSSPS and DSD. It said that residential care and nursing homes would "continue to play an important role in supporting the most vulnerable in our communities." But the paper also maintained that there needed to be a range of alternative options like *"supported housing, which provides people with that little bit of extra help and security, while at the same time enabling people to remain in as domestic an environment as possible."* [4] This emphasis on extra living options is welcome as long as it can be related to individual need and preferences and is based on reliable statistical projections. The projections must show how Northern Ireland is providing the best possible services and support for today's and tomorrow's older people.

[4] DHSSPS, DSD, 'Who Cares? The Future of Adult Care and Support in Northern Ireland, A Discussion Document'.

4. Commissioner/COPNI Engagement Re TYC with Relevant Authorities, 2013-2014:

4.1. Over the past 12 months either one or more members of the COPNI team have had a number of meetings with staff from the Department, the Boards, Trusts, NISCC, RQIA and a number of other stakeholders. Some of these are summarised in the table below. All of these enquiries have been by the Commissioner or the COPNI office seeking answers. None of the responses received so far are sufficient to give the Commissioner confidence that there is adequate modeling of current and future demand and the need for services and support for older people.

WHO	PURPOSE
Minister of Health, Social Services and Public Safety	Re: Resettlement of older long stay patients from learning disability hospitals, clarification of figures Re: Domiciliary care workforce regulation, request for information on targets and timeline of work Re: Domiciliary care for older people, request for information on present domiciliary care clients, complaints statistics and future planning
DEPARTMENT OF HEALTH SOCIAL SERVICES AND PUBLIC SAFETY Head of Governance & Planning Office of Social Services, DHSSPS Elderly & Community Care Unit, DHSSPS	Re: Roll out of registration - domiciliary care workers, timelines for progress and TYC planning, timelines for progress and TUYC planning Via e mail Re : figures relating to older carers and domiciliary care funding projections

Community Information Branch, DHSSPS	General queries on the telephone or via e mail Re : Carer stats and domiciliary care packages
Reform of Adult Care and Support Team, DHSSPS	Information on the ongoing process re: Reform Adult Care and Support.
Office of Social Services, DHSSPS	Meeting in February 2014 Re: workforce planning
HEALTH & SOCIAL CARE BOARD	
Information Manager, Performance Management and Service Improvement Directorate, Health and Social Care Board	Re: annual statistics on all domiciliary care packages
Assistant Director of Mental Health and Learning Disability, Health and Social Care Board	Re: The resettlement of older long stay patients from learning disability hospitals
Director of Social Care and Children's Services, Health and Social Care Board	Re: 'Making Choices – meeting the current and future accommodation needs of older people' feedback
Two Assistant Directors, TYC Team Health and Social Care Board	Meeting arranged in February 2014 – TYC and workforce planning, attended by COPNI CEO and Head of Legal and Policy Advice
Assistant Director of Older People and Adults, TYC; the TYC Asst Director and the Commissioning Lead for social care.	General queries on the telephone or via e mail Re :TYC, Domiciliary care and carers implications
Department of Social Development, Housing Division	Re: The 'Supporting People' Programme

5. Individual Needs

5.1. There are many different uses of Supported Living as a term, which creates difficulty for analysis. Supported Living can encompass facilities that enable older people to live independently in flats or individual houses, but with communal facilities and practical support. It can also encompass more specialised support for individuals with particular needs, where more extensive support is required. [5]

5.2. The difference between the types of Supported Living facilities available in Northern Ireland highlights the flexibility of Supported Living arrangements, and has given Supported Living projects considerable scope to fulfill individual needs.

5.3. When an individual makes the choice to live in a Supported Living facility it must, as far as possible, be the most suitable option that meets that older person's individual needs. If there is another appropriate option that meets individual needs then the individual must have an appropriate level of freedom to make that choice as well. Future planning must be driven by transparent assessment of future individual needs based on reliable projections of numbers. This has so far been unavailable to the Commissioner, especially beyond short term planning.

5.4. Individual older people also need more information about Supported Living options if they are to make an informed choice about the matter. Concerns were raised in the Committee hearing with the DHSSPS that not enough promotion and information was being produced about Supported Living and this is a matter of concern. [6] Research has additionally noted that there is often limited awareness among older people living in poor housing conditions of what level and range of assistance is available. Much of the information needed by older people about housing related issues can be disparate and difficult to find. In some cases increased awareness of where to find assistance to improve housing conditions may allow older people to remain in their own homes for longer, without need for Supported Living or residential care, and this is something that needs to be assessed.

[5] Dr Lesley Ann Black, Northern Ireland Assembly Research and Information Service Research Paper, 'Caring for an Ageing Population TYC Proposals', March 2014.

[6] Committee for Health, Social Services and Public Safety, 'Official Report (Hansard) Review of Transforming Your Care and Older People: DHSSPS and Health and Social Care Board', 26th February 2014.

5.5. There are a range of positive and negative 'pull' factors that encourage older people to remain living in their homes, as well as negative 'push' factors that encourage them to move to other types of accommodation. We have to recognise there are a variety of 'push' factors for older people that either need to be rectified, or in cases where they cannot, more appropriate accommodation must be found. These factors include substandard or unsuitable accommodation combined with an inability to access funds for repairs, loneliness or isolation, security concerns, ill health, a need to be nearer facilities, fuel poverty, and the costs of repairs and maintenance. Health related frailty has been found to be a major reason for older people choosing to move, and as people get older the links between their housing situation and their health and care get closer. [7]

5.6. The numbers of older people are increasing, with the numbers of those aged 85 increasing most rapidly. Incidences of dementia increase from 1.3% among 65-69s to 32.5% among people aged over 95.[8] NISRA population projections show that the future increases in numbers of the 90+ outstrip the rises in people over 60 as a whole. To 2062, numbers of people aged 60 and over will increase by 87%, but there will be huge proportional increases in the numbers of people aged 90-94 (501%) and 95-99 (1406%). [9] While many in these age groups will want to live independently, many others may find it is not practical to. They must be given appropriate choices, and these demographics must be a part of future planning.

[7] Professor Chris Paris, Report to the Northern Ireland Housing Executive, 'The Future Housing and Support Needs of Older People in Northern Ireland: Analysis of the Future Need and Demand for Appropriate Models of Accommodation and Associated Services for Older People'.
[8] Professor Chris Paris, 'The Future Housing and Support Needs of Older People in Northern Ireland'.
[9] NISRA, 'Northern Ireland Home Population by Sex and Five Year Age Bands 2012 to 2062', http://www.nisra.gov.uk/demography/default.asp20.htm

6. Objective One: Consider the Structure and availability of Supported Living options for older people in Northern Ireland

6.1. The difficulty when answering this question was demonstrated in the previous Committee hearings when it was clear that there were different definitions in use by the DHSSPS and the Trusts collectively and individually. The DHSSPS defined Supported Living to the Committee as providing an "environment for people who cannot live independently in their own home but who may not yet require the additional support of residential nursing home care." The Belfast Health and Social Care Trust defined Supported Living before the Committee as a partnership between health and social care Trusts, and housing associations, where they *"pool their expertise in housing and care to provide a model of support that allows people to have their individual home and front door while receiving, as an option, 24-hour support, instead of, for example, domiciliary care, residential care or even nursing care."* This support may be available all the time, but it is support for independent living, not support that precludes it. The Northern Trust also defined Supported Living as including "floating support and peripatetic services" that could be provided either in people's homes or in sheltered housing. [10]

6.2. The number of definitions of Supported Living which are in use across Northern Ireland alone are evidence of the difficulty in defining the structure of Supported Living options in Northern Ireland. There has also been difficulty in defining the definitive number of Supported Living facilities in Northern Ireland, with the DHSSPS stating there were 414 and the Trusts claiming there were between two and five Supported Living facilities in each Health and Social Care trust. [11]

6.3. When seeking this information from the DHSSPS, many of the figures about Supported Living options were not available, and the Commissioner has been unable to ascertain, with any certainty exactly what level of Supported Living facilities actually exist in Northern Ireland, amongst the different definitions and statistics used. The Commissioner has also encountered difficulty finding any

[10] Committee for Health, Social Services and Public Safety, 'Official Report (Hansard) Review of Transforming Your Care and Older People: Health and Social Care Trusts', 12th March.
[11] Committee for Health, Social Services and Public Safety, 'Official Report (Hansard) Review of Transforming Your Care and Older People: DHSSPS and Health and Social Care Board', 26th February 2014.

substantive amount of information on the planning for Supported Living in the future.

7. Objective Two: Assess the capacity of Supported Living options to meet the policy objective of Transforming Your Care in terms of reducing the need for residential home places

7.1. Supported Living options have some potential to meet the needs of older people. By providing an environment where, with the help of high quality care and support, and with access to communal facilities, older people are able to live in individual accommodation for longer, Supported Living can reduce the proportion of older people who need residential care, by acting as a space between totally independent living and residential care.

7.2. But it also must be recognised that, especially with the individuals 85 and over projected to make up a larger part of our society, there must be a mix of living options available, and Supported Living will not be appropriate to meet the needs of all older people.

7.3. The lack of forward planning information available to the Commissioner to date has made it much more difficult to assess the capacity of current and planned Supported Living options. There must be more planning and modeling that is accessible, transparent, and based on evidence of projected current and future needs and choices of older people.

7.4. Models have been developed that establish a basis for assessing future need for supported housing. The National Housing Federation, Housing Corporation, Mayor of London and London Supported Housing Forum have published a toolkit which uses key concepts that feed into a predictive model to estimate the need for supported housing. These include:

- Population at risk (Numerical estimates of people that share characteristics that are often related to a requirement for supported housing).
- People in need (Sub set of the ‘at risk’ population likely to need housing related support).

- Service balance (Strategic decision about the balance between supported housing and non accommodation support services).
- Duration (Planned usage patterns of existing stock).
- Demand adjustments (where local authorities can adjust apparent demand to take account of specific local factors).
- Repurposing capacity (Degree to which any supported accommodation for which there is not sufficient demand can be recycled for use by other client groups). [12]

7.5. Determining need and demand can be difficult, as people may only consider options like supported housing when the need arises, and could be partially influenced by the options available. But this makes it even more of an imperative that what planning **can** be conducted **is** undertaken comprehensively and transparently.

7.6. Finance and projected future costs play a part in the thinking behind TYC. TYC states that if health and social care was continued to be provided on the current model, there would need to be a commitment of an additional billion pounds over the next 3 years. [13] The Commissioner recognises the challenging budgetary environment facing the Northern Ireland Executive. The best value for the public purse is delivered when older people receive excellence in housing, health and social care and support that meets their needs.

7.7. There are also some differences between the different editions of TYC that cause confusion over the precise nature of objectives relating to Supported Living. The initial 2011 publication stated that the aim was for people to be supported to live independently "at home or in supported accommodation." [14] But in the implementation document it talks of older people living independently "at home or in assisted housing."[15] If assisted housing is taken to mean services in the home, instead of specialist facilities, then we can see the difference in definitions which sometimes causes confusion. It is also said in TYC that "there is an over reliance on buildings to provide care rather than support its delivery." [16] This raises questions over the place of Supported Living options and where they fit into the TYC direction.

[12] London Housing Federation, Housing Corporation, 'Building for All: Identifying the Need for Supported Housing in London'.
[13] Transforming Your Care: A Review of Health and Social Care in Northern Ireland', December 2011.
[14] 'Transforming Your Care: A Review of Health and Social Care in Northern Ireland', December 2011.
[15] 'Transforming Your Care: Draft Strategic Implementation Plan', October 2012.
[16] 'Transforming Your Care: A Review of Health and Social Care in Northern Ireland', December 2011.

7.8. Demographic changes and the numbers of older people owning homes are significant factors in considering to what extent Supported Living options can help meet the needs of older people.

7.9. The numbers of older people who own their own homes is forecast to rise in the near future before declining again.[17] Over 70% of older people own their own homes.[18] People who own their own homes may be more reluctant to sell and move to different accommodation, so the fluctuating numbers of older people who own homes must be an additional consideration for policy planners. Older home owners, now in receipt of pension, have less available for adaptations and building work to accommodate changing needs.

8. Objective Three: Identify examples of best practice in relation to Supported Living options in other countries/regions which could be applied to Northern Ireland

8.1. Housing our Ageing Population: Panel for Innovation (HAPPI) was established to analyse the question of 'What further reform is needed to ensure that new build specialised housing meets the needs and aspirations of the older people of the future?' [19] HAPPI have recommended ten essential points for the design of retirement housing for older people:

- Generous internal space standards.
- Plenty of natural light.
- Maximise light and ventilation and have balconies/patios.
- Easily allow new technology to be installed.
- Circulation areas promoted as shared spaces.
- Multi purpose space for group activities.
- Preservation and expansion of greenery.
- Should be energy efficient, and well insulated and ventilated.
- Adequate storage.
- Shared external surfaces.[20]

[17] Professor Chris Paris, 'The Future Housing and Support Needs of Older People in Northern Ireland'.
[18] NISRA, 2011 Census.
[19] Homes and Communities Agency, 'HAPPI', https://www.homesandcommunities.co.uk/ourwork/happi
[20] HAPPI, 'The HAPPI Report', 2009.

8.2. Examples of best practice from the Assembly Research Paper, 'Specialised Grouped Housing for Older People':

- Darwin Court, London: Residents have choice whether to enter through social main entrance or privately by lift or stairs. Has resource centre with pool, café, IT, fitness facilities. Care needs of residents range from none to 24 hours.
- Hartigg Oaks, York: Has central community building with 152 bungalows around it. There is a pool, gym, restaurant and other facilities.
- Broad Meadow, Dudley: 132 apartments, with many additional amenities and facilities, staffed full time by Midland Heart Limited, offering person centred care and support.
- Barn Halt Cottages, Carrickfergus: 26 bungalows, with visiting management staff, active facilities and activities and assistive technology.
- Fold Loughview Holywood: Housing and 24 hour care and support to frail elderly and dementia clients. [21]

April 2014

[21] Dr Janice Thompson, Northern Ireland Assembly Research and Information Service Briefing Paper, 'Specialised Grouped Housing for Older People – Introductory Briefing', 14th February 2014.

Review of Transforming Your Care and Older People – Role of Supported Living

Introduction

The Northern Ireland Federation of Housing Associations (NIFHA) represents 26 registered housing associations in Northern Ireland. Collectively our members provide 44,000 homes comprising general needs, specialist and supported accommodation, as well as shared ownership.

Housing associations are charitable social businesses. Our movement is investing increasing private finance to deliver public benefit in meeting housing need, supporting tenants and transforming communities. Further information on NIFHA and housing associations is available at www.nifha.org

Key recommendations

To maximize supported living's role in delivering *Transforming Your Care*, the following are needed:

- **Retention of Supporting People and Special Needs Management Allowance** as dedicated housing budgets to help older people live as independently as possible in their own homes, with annual index-linked uplifts following a seven year funding freeze.

- **Review regional care rate for domiciliary care in supported living schemes** to recognise additional costs and complexities of caring for people with dementia.

- **Review DSD Social Housing Development Programme capital funding** to ensure the Total Cost Indicators (TCIs) support the required standard of schemes, and set aside a small pot to allow re-modelling of sheltered housing and general needs homes as supported living.

- **A regional approach on some risk-sharing on voids** to encourage Trusts to make full use of schemes and avoid the accumulation of unsustainable deficits by housing providers.

- **Joint commitment to new schemes and specific levels of revenue funding** from all partners including Trusts, NIHE Supporting People team, RQIA, housing associations and managing partners, before business cases are signed off.

- **Commitment by statutory funders to revenue funding for first ten years of new schemes** to help safeguard significant capital investment by government and housing associations.

- **Appointment of Supported Living 'Champions'** in the HSCB and each Trust to promote the model and help unblock barriers to proposed schemes, as well as an overall champion hosted within the housing sector to promote the model (see appendix for proposal).

- **Earlier and more formal involvement of RQIA in commissioning of schemes**, along with consistent and realistic views on safeguards needed to protect vulnerable people in their own homes, especially people with dementia.

Background on types of housing association accommodation for older people

Housing associations are major providers of housing, care and support to older people in Northern Ireland. Although some of this provision is through **registered residential and nursing homes**, most such provision for people with high needs is delivered through the private and statutory sectors.

Housing association housing options for older people include **sheltered housing** and **supported housing** including 'supported living'.

Sheltered housing 'is a term used to describe a group of dwellings built in accordance with specific guidelines set by DSD, designed for older or disabled people and with support provided on site.'[1] The agreed aim of sheltered housing is to enable older people to continue to live independently for as long as possible in the community, through providing support at the level and timing required. Residents of sheltered accommodation are independent, free to come and go and have visitors as they wish.[2] There are around 300 sheltered housing schemes in Northern Ireland providing around 9,000 homes.

Eligibility for sheltered housing has traditionally been viewed as solely for couples or single people aged over 60, although some housing associations advertise sheltered housing as an option for people aged 55-plus. Category 2 sheltered housing (the majority of the sheltered stock) is accessed via the Common Selection Scheme, although sheltered housing is increasingly being offered to younger people and those with additional needs.

Overall sheltered housing residents are satisfied with their accommodation and associated services. Sheltered housing is relatively affordable accommodation providing safety and security in a community setting.

However sheltered housing faces a number of challenges:

- Younger people (50+) accessing services
- The wide age range of residents (aged 50 to 100+)
- The complexity of needs
- The varying levels of support required
- Issues over the desirability and suitability of physical design
- Providing services to older people in the local neighbourhood[3]

Some residents find that the much more varied population of sheltered housing residents and increasing prevalence of people with complex needs has significantly altered the nature of the accommodation they expected. Housing associations are concerned that many residents now have significant care packages on entering sheltered housing, and that this may not be appropriate or sustainable. However a number of sheltered housing developments may be suitable for re-modelling as supported living schemes.

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[1] *The role of sheltered housing in Northern Ireland and future issues*, Fiona Boyle for the Northern Ireland Housing Executive, September 2012, page 15
[2] Ibid.
[3] *Housing Related Support Strategy 2012-2015*, Northern Ireland Housing Executive, page 25

Supported housing is an umbrella term which is applied to a whole range of housing based options for vulnerable people. It has been defined in many different ways depending on who regulates, commissions, provides or uses the services.

Supported housing can be described as any housing scheme where housing, support and often care services are provided as an integrated package. The following elements best describe its essence:

- The purpose of support is to enable service users to live as independently as possible within their community;
- Service users are empowered to become socially included in the wider sense of community participation;
- The care and support provided varies and relates to the nature of the accommodation; and
- It is a finite and an increasingly limited resource which is not generally available (unlike sheltered housing) but limited to those who are vulnerable.[4]

Supported living, and other types of supported housing, are distinct from general needs social housing because there are higher staff levels than other forms of social housing because support and care services are provided in addition to housing management. It is commonly arranged through partnerships between different organisations, including Health Trusts and Area Supporting People Partnerships that commission services, housing associations providing the accommodation (and sometimes care and support too), and other care and support providers, both Health Trusts and a wide range of charities that enter in to management agreements with housing associations.

Supported housing includes both accommodation-based services where vulnerable people live in a specifically designed property to receive support services; and non-accommodation based services where vulnerable people can receive the necessary support services irrespective of where they are living. For the purposes of this paper, supported housing is used to refer to specifically designed accommodation rather than non-accommodation based services such as floating support.

Currently there is much less supported housing for older people than sheltered housing – approximately 1,500 units compared to 9,000 units. Although people accessing both sheltered and supported living have to apply through the Housing Executive, unlike sheltered housing supported living is not allocated through the Common Selection Scheme but through a separate process.

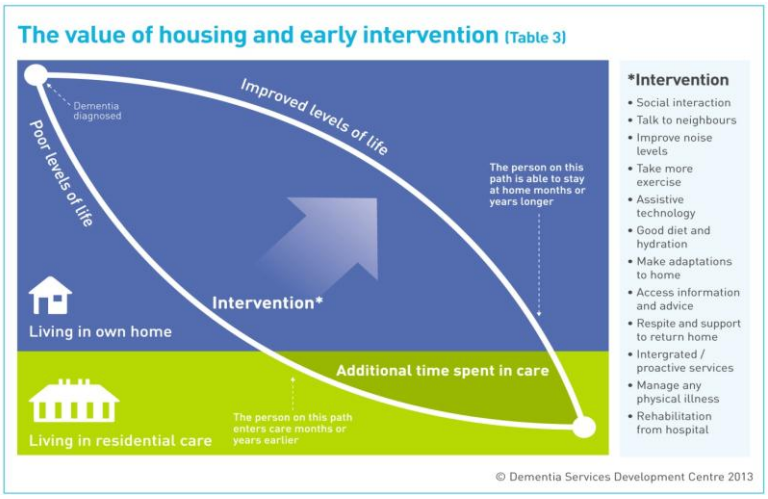
Advantages of the supported living model

Housing associations are big supporters of the supported living model. Among excellent supported living developments for older people in Northern Ireland are Hemsworth Court, Belfast (Helm/Belfast Trust); Cedar Court, Downpatrick (Trinity/South Eastern Trust); and Barn Halt, Carrickfergus (Fold/Northern Trust).

Our movement therefore believes supported living has a major potential role to play in fulfilling the vision of *Transforming Your Care*. Among its advantages for frail elderly people and older people with early dementia are that it can help:

[4] Explanation from Sitra - http://www.sitra.org/about-us/vic-rayner-explains-supported-housing/

- Maximize independence
- Reduce mental health deterioration and overall deterioration in health and wellbeing
- Avoid or delay the need for more expensive residential or nursing care
- Reduce health emergencies
- Reduce admittances to hospital
- Enable palliative care in a community setting



The graphic above from the Dementia Services Development Centre[5] demonstrates that appropriate housing interventions, whether in a person's family home or sheltered housing or supported living, can greatly improve quality of life and significantly reduce the need for expensive registered care in an institutionalised environment.

Obviously supported living is no panacea. It is unlikely to be suitable for residents currently in statutory residential care homes who are unlikely to be able to regain the necessary degree of independence. Also the majority of older people will continue to wish to 'age in place' in their own family home. With appropriate care and support this should be possible. However supported living can be a great option for people who feel unable to manage in the current home but do not need the more intensive care and support in registered homes.

Funding for supported living for older people

Supported living schemes depend on a fairly complex mix of capital and revenue funding.

The capital costs are met primarily by statutory funders. Most of this funding is from the Department for Social Development in the form of housing association grant (HAG) administered by the Housing Executive in its management of the Social Housing Development Programme (SHDP). In exceptional circumstances Health Trusts may top-up this funding, perhaps to achieve their desired specification for the development. Housing associations still contribute a significant proportion of the capital costs for new schemes – typically between 20-30%. Most of the housing association investment will be money borrowed at competitive rates from banks or, increasingly, the capital debt [bond] markets, secured against the associations' assets.

[5] *Dementia: Finding Housing Solutions*, National Housing Federation & Dementia Services Development Centre, 2013, page 14

On the revenue side, supported living tenants are responsible for paying their rent. A majority will receive full support from Housing Benefit to pay their rent and service charge. Additionally they are likely to receive domiciliary care paid for by their Health Trust, and housing-related support paid for by Supporting People (SP). Supporting People funds are variety of services to help older people in supported living live as independently as possible and sustain their tenancy. This can include help to run a household including budgeting, initiatives to reduce social isolation and assistance with repairs.

Challenges to the delivery of new supported living for older people

As charities, housing associations are committed to providing high quality housing, care and support for older people. However as social businesses they have to ensure that any new development is viable and sustainable. There have been issues with supported living schemes such as Fold's Gnangara development in Enniskillen and Helm's Hemsworth Court development off the lower Shankill. The residents expected to be allocated to these by Trusts have either not materialised or not at the rate required for the schemes to break even. As a result the housing associations concerned are facing significant and unsustainable deficits on these schemes that understandably diminishes the appetite of the sector to take forward further such schemes at considerable risk.

Housing associations are particularly concerned about the revenue funding that underpins the viability of Supported Living schemes. For seven years Supporting People funding has been frozen in cash terms, a cut in real terms of at least 15%. No provision has been made for fast increasing energy costs, or allowances for pay increments to which employees are contractually entitled. This has been compromising the viability of many care and support schemes, not just for housing associations but their charitable managing partners too. It is noticeable that as Health spending continues to increase, and our population is ageing fast,[6] spending is being squeezed on a key 'invest to save' budget that helps people live as independently as possible and reduces the need for acute services.

Currently DSD is leading a review of Supporting People that our sector fears could lead to fundamental changes in the Programme. Our sector is keen to work with government to reform the Programme to make it even more effective and efficient. However some of the potential changes, including the transfer of much of the budget to Health, the removal of the ring-fence and the introduction of competitive tendering could harm service delivery. If and when the future of Supporting People is confirmed as a properly funded, dedicated housing programme, housing associations will be much more likely to invest in new supported living schemes for older people.

On the first page we outline a number of key recommendations that can help maximize supported living's role in fulfilling the vision of *Transforming Your Care* for older people. These include funding, commissioning, regulatory and education matters.

Departmental action to unblock barriers to new supported living schemes for older people

Since the start of the year we have participated in several useful meetings including with Ministers Poots and McCausland and their respective departments on unblocking the barriers to new supported living schemes.

[6] By 2021 the number of people aged 85 and over in NI is projected to have increased by 67% to 47,900 from 2010 (NISRA)

The Ministers have asked officials from their Departments to take forward a programme of work. This includes DHSSPS assessing the viability of developing a common approach to the sharing of financial risk associated with voids. As outlined above, it is important this is achieved as quickly as possible to enable the development of the Rathmoyle scheme (Clanmil/Northern Trust) in Ballycastle and other schemes where this is a sticking point.

DSD and DHSSPS are also scoping work to address medium-term and longer-term blockages to delivery of new supported living units for older people and people with dementia including, potentially:

- Commissioning a project to identify and develop appropriate future models of supported living for elderly clients (including those with dementia) and people with physical disabilities. This work would take into account factors such as geography, needs (including care), affordability and assistive technologies. It would also include an assessment on whether existing models, particularly sheltered housing, are being used effectively and for the purposes intended. The study would also highlight situations or client needs for which supported living are not appropriate.

- Commissioning a project to identify lessons learned from 'legacy' supported living schemes. A small number of such schemes have run into financial difficulties due to places being unfilled (voids) over a sustained period of time. The purpose of this project would be to identify and share lessons learned from the commissioning, design, construction and operation of these schemes with a view to both identifying how these schemes can be made sustainable over the medium-term and pinpointing lessons for future developments.

- Promoting the benefits of supported living, potentially through the appointment of a Supported Living champion on a pilot basis.

NIFHA and our members value the work that has been started by the two departments and involving the Board, Trusts, Supporting People and housing associations. Joint meetings have been useful in coming to a shared understanding of the issues and identifying potential solutions, including in policy, assessment of needs, financial aspects, partnership and communications and project management. We hope this will quickly lead to a more streamlined system in which risk is fairly shared.

More broadly, if the huge potential of housing in successfully delivering *Transforming Your Care* is to be fulfilled, it is vital that there is more systematic and ongoing engagement between Health and Housing at a senior level. This could usefully include developing joint bids for related capital and revenue funding for the next spending period.

NIFHA

24 April 2014

Appendix – *Championing Supported Living in NI – An outline proposal*

Championing Supported Living in Northern Ireland

An outline proposal

Introduction

Almost everyone supports the vision of *Transforming Your Care* (TYC) to support people with significant health issues to live more independently in the community. This will require a decisive shift towards a more responsive and preventative approach. Within this, properly joining-up housing and health, care and support will be essential. Although the housing 'family' fully endorses the vision of TYC, there has thus far been little opportunity for us to contribute at a strategic level. To maximise the prospects for success, that needs to change.

Developing a wider range of housing options is central in the TYC Implementation Plan. A key commitment is to

> *Support Older People and those with Long Term Conditions to maintain their own independence and manage the functions of daily living in their own home or assisted housing, as opposed to an acute setting or long-term care.*

It also states that:

> ***Community-based alternatives to residential care are increasing all the time**, and there is a need to ensure that the availability and functioning of these is more widely known so that people can see the different styles of independent living that it is now possible to offer older people, where the traditional response would have been to offer a residential placement. **Due to the improved availability of these types of community-based alternatives, it is expected that the demand for statutory residential homes will further decline.***

Although community-based alternatives to residential care have increased in recent years, this continued growth cannot be taken for granted; it can only be sustained through the creation of a more joined-up and supportive policy and funding. The Health and Social Development ministers are committed to achieving this and NIFHA and our members also want to play a full part.

Joining-up health, housing, care and support

> *A well-funded, fully integrated system of care, support, health, housing and other services is essential, not just to provide high quality support for individuals, carers and families, but also to provide good value to the exchequer and the tax payer.*
>
> House of Commons Health Select Committee 2012

Housing is an essential part of an effective health and social care system. Integrated care, housing and support enables alternative care pathways to be provided that reduce the demand an individual has for acute services, as well as improving their quality of life. Specialist housing and housing-related support help people to live independently in the community, reducing the need for care and preventing poor health. For example, timely home adaptations and re-ablement services get people home from hospital quickly and prevent hospital readmissions, helping them to recover their independence after illness.

Housing associations in Northern Ireland already deliver a wide range of services that promote independence and prevent people needing more intensive and institutional forms of care, including:

- supportive design including new homes built to Lifetime Homes
- adaptations, handyperson and care and repair schemes
- advice and information on housing options
- supported, sheltered and specialist housing
- support services built around individual needs and preferences
- assistive technology, telecare and telehealth, as pioneered by Fold Housing Association
- floating support for owner-occupiers

Furthermore, effective joint working between providers of housing, health and care and support can:

- Avoid or delay a move to residential care;
- Reduce admittance to hospital and avoid readmission;
- Reduce the demand for assessment and treatment centres;
- Prevent the need for domiciliary care;
- Prevent health emergencies and reduce demands on A&E; and
- Prevent mental health deterioration and overall deterioration in health and wellbeing.

In Great Britain there is significant policy development and analysis to help ensure housing's contribution to meeting health outcomes is maximized. Excellent work is undertaken by a range of bodies including Sitra, Housing LIN and Erosh. As outlined below, the NHS in Scotland and England are also investing in specific projects in this area.

Northern Ireland can learn much from work in other jurisdictions, but policy development and strategic planning here suffers from the lack of similar dedicated resources.

England – National Housing Federation Health Partnership Hub

The National Housing Federation (NHF) is one of 21 voluntary sector organisations that is part of the Department of Health's £3.5million Health and Care Voluntary Sector Strategic Partner Programme through which the third sector can contribute their expertise to inform and shape national policy. Through the Partnership, the NHF is further developing housing's offer to health, advising housing associations on how they can engage with health bodies, from research to presenting their case to build strong partnerships.

Scotland – Joint Improvement Team

The Joint Improvement Team (JIT) is a strategic improvement partnership between the Scottish Government, NHS Scotland, COSLA (Convention of Scottish Local Authorities) and the Third, Independent and Housing Sectors. JIT provides a range of practical improvement support and challenge including knowledge exchange, developmental innovation and improvement capacity and direct practical support to local health, housing and social care partnerships across Scotland. It champions the identification, development, evaluation, spread and adoption of good practice to accelerate the pace of improvement towards the Scottish Government's vision for 2020 for each citizen to be able to lead a longer, healthier life at home or in their own choice of setting in an integrated health and social care environment – which includes an increasing focus on prevention, anticipation and supported self-management.

Housing has been an integral part of the work of JIT since it was formed in 2005. JIT's role is to identify the housing 'connections' of local health and social care partnership's work. Housing is one of the 'themes' within JIT's work programme as well as forming part of the intensive support we provide to local partnerships.

Outline proposal for Supported Living Champion

The Health and Social Development Ministers are committed to delivering sufficient new supported living accommodation, which will make a valuable contribution to fulfilling the vision of *Transforming Your Care*. Housing associations and our charitable managing partners are committed to working with statutory partners to deliver more supported living provision, but there are significant challenges. These have been ably captured, along with potential solutions, in meetings led by the DSD and DHSSPS.

NIFHA is committed to maximize our contribution to the success of the supported living model, and accepts the actions recommended for us through the joint DSD/DHSSPS meetings (although these will require some funding). However we believe that a more extensive and ambitions programme may be required. Ideally this could be progressed through the recruitment of a 'Supported Living Champion' who could champion the model in the statutory, housing association and managing partner sectors.

NIFHA would be keen to host such a post, which could be recruited on a consultancy basis, for a 12-24 month programme of work encompassing:

Education, communication and promotion

- Development of a website, range of literature and a short film to promote supported living, including to the general public; carers and potential clients; health and social care professionals; elected representatives and planners. These would set out the success of the model so far in NI including case studies and testimonies from residents and professionals.

- Programme of events across Northern Ireland aimed at the groups listed above to promote the supported living model, explaining its role within the spectrum of housing and care options for people with older needs. 25-30 meetings across NI in a year might be needed to achieve step-change in awareness.

- With support from NIHE, lead an awareness process with Trusts around processes for developing and delivering new supported living units and on the purpose of sheltered housing, perhaps through a seminar. This would also give Trusts the opportunity to raise awareness of their processes and constraints. This could also contribute to promoting the supported living model to practitioners within Trusts.

- Organise a 'Supported Living Week' to provide a focus for awareness raising and education efforts. This could replicate many of the approaches that have been used by the National Housing Federation in their annual supported housing week.

- Run a media campaign to highlight the success of the supported living model. This would target local media which has extensive reach and credibility in communities around NI. There would be an emphasis on using local case studies for feature articles.

- With statutory partners, directly addressing local opposition to supported living schemes by greater promotion of the model at a political level, including through enlisting the Health and Social Development Ministers to actively promote supported living. Again a series of events is likely to be required to get results, including potentially a Long Gallery event at Stormont and meetings with each party group, and meetings with councillors in the eleven new local authorities.

Policy / service model development

- Development of a new supported living website as a hub for information required by policy-makers and professionals in the housing, health and social care fields. This could include detailed sections on the various challenges of establishing and running supported living schemes, with case studies on how these can be overcome. Detailed case studies, similar to those on the Housing LIN website could be developed to consider the strengths, weaknesses and cost-effectiveness of the supported living model in NI to date.

- Contribute significantly to DSD/DHSSPS/NIHE/HSCB commissioned project to identify and develop appropriate future models of supported living for older clients (including those with dementia) and people with physical disabilities.

- Help statutory partners to assess whether existing models, particularly sheltered housing, are being used effectively and for the purposes intended, and highlight situations or client needs for which supported living will not be appropriate.

- With the Dementia Centre, publish a Northern Ireland version of *Dementia: Finding housing solutions*, setting out the role housing associations can play in allowing people with dementia to live independently, and how supported living can help people with dementia meet their aspirations, and reduce hospital stays and care home admissions.

- Contribute to DSD/DHSSPS/NIHE/ HSCB commissioned project to identify lessons learned from 'legacy' supported living schemes. This will identify and share lessons learned from the commissioning, design, construction and operation of these schemes with a view to both identifying how these schemes can be made sustainable over the medium-term and pinpointing lessons for future developments.

- With member housing associations and sector lenders, consider future scope for housing associations to raise private finance for new supported living (and other care and support) schemes. By analysing private financing of this element of provision, confidence of lenders can hopefully be increased and a much more accurate picture can be established of the degree of capital funding required post 2016 to support the necessary provision of new supported living schemes.

NIFHA would be very interested in hosting a Supported Living Champion post, perhaps for an initial period of two years. There is a huge amount of work to be done in achieving the necessary increase in understanding, confidence and capacity in the model. Although ad hoc and individual efforts by the various partners can be helpful, a more co-ordinated and concerted approach is now required.

We hope there will be an early opportunity to discuss this outline proposal with statutory partners.

Cameron Watt
24 February 2014

Evidence to the HSSPS Committee Members

Transforming Your Care: Enabling Older People to Remain at Home

14th May 2014

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Age NI delivers care services, provides advice and advocacy, campaigns, fundraises and lobbies decision-makers to improve later life for us all.

Transforming Your Care: Enabling Older People to Remain at Home 14th May 2014

Introduction

1. This Evidence Paper provides members of the Health, Social Services and Public Safety Committee with an overview of the key issues for older people and Transforming Your Care (TYC), particularly around enabling older people to remain at home – a central plank of TYC.

2. As members of the HSSPS Committee, you will be aware, through our attendances at your party conferences, presentations to your assembly party group and individual meetings over the last number of years that we have been calling for a fundamental review of social care.

3. All political parties gave unanimous support not only for our vision of social care, but also a commitment '***to care enough to get social care right!'***

Working in Partnership – Vision for Social Care

4. Throughout all our work on social care we have worked in partnership with key stakeholders, particularly for the development of our vision on social care, which calls for, ***"quality integrated social care that recognises the rights, aspirations and diversity of us all, and is based on the right to live with dignity, independence, security and choice."***

5. At the heart of our vision is a system that enhances wellbeing and independence, so that older people can continue to engage socially and maintain self-esteem, dignity and purpose. Older people have told us that they want to remain at home for as long as possible, but at the same time recognising that home may not be suitable for a number of reasons and that a move to a care setting or supported living accommodation may be appropriate.

Context

- **Demographics**

6. The evidence on the changing demographics are well rehearsed but worth re-stating. Figures from the 2011 census show that those aged 65 and over represent 15% of

the population in Northern Ireland and the percentage increase in those over 85 since 2001 is 35%[1].

7. The numbers of older people, especially those over 85 who are most likely to need care will increase. By 2025, the number of persons aged 85 and over in Northern Ireland will increase by 25,000 or 83% and women at this age will significantly outnumber men at 62% of this population group[2].

8. In addition, increasing life expectancy is not being matched by parallel increases in healthy life expectancy. Again, Northern Ireland fares worst of all regions in the UK in this regard. While women in the UK can expect to have 63.9 years of disability free life, women from Northern Ireland can expect just 60.3 years[3].

9. Again we know that rates of disability and ill health increase with age. The rates of disability among those ages 85 is 67% compared with only 5% among young adults.[4] In addition the prevalence of the number of long term conditions, namely hypertension, coronary heart disease, stroke and diabetes among adults in Northern Ireland is predicted to increase by 30% by 2020.[5]

- **Poverty/ Fuel Poverty**

10. 23% of pensioners are living in poverty and this figure is increasing[6]. It is a similar story for fuel poverty, as the following statistics show:

    - 61.5% of older people are living in fuel poverty in NI (up from 47% in 2006)
    - 75.8% of people over 75 are in fuel poverty in NI (up from 55%)
    - 83.2% of lone older people are in fuel poverty in NI (up from 62%)[7]

- **Some Housing Statistics**

11. The housing system in Northern Ireland has undergone significant change, especially around tenure from 1981 with major shifts in this area. This has implications for older people, specifically those who may need care and support and for homeowners whose capital resources may impact of any changes to how social care is funded in Northern Ireland.

12. The House Condition Survey in 2011 showed that in relation to tenure in Northern Ireland:

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[1] NISRA (2011) *Statistical Bulletin Census 2011: Population and Household Estimates for Local Government Districts in Northern Ireland*
[2] NISRA (2011) *Statistical Report, Population Projections 2010*
[3] OFMDFM (2009) *A Profile of Older People in Northern Ireland*. Belfast NISRA
[4] DHSSPS (2012) *Transforming Your Care.* DHSSPS. Belfast
[5] Institute of Public Health in Ireland (2010) *Making Chronic Conditions Count.* IPH. Dublin
[6] DSD (2009) Households Below Average Income
[7] NIHE (2009) House Conditions Survey

- 62% are Owner Occupier (67% in 2001)
- 17% are in the Private Rented (8% in 2001)
- 15% are in the Social Sector (29% in 1991) and
- 5% of properties are vacant.

For Sheltered Housing, there are:

- 290 Sheltered Housing Schemes
- 7,930 Units
- The average age is 75 and female
- 48% moved from other rented housing and
- 36% were owner occupiers.

Residential and Nursing Accommodation: at June 2012 there were:

- 230 residential homes and 5, 491 available place in residential accommodation
- 267 nursing homes and 10,876 available places in nursing accommodation[8]
- 12,264 care packages in place in residential and nursing accommodation
- The total Supporting People spend for 2012 to 2013 was £8.93m.[9]

- **Economic and Welfare Reform**

13. The Office for Budget Responsibility has warned that high life expectancy will have serious consequences for public finances and we have seen 53% reduction in house prices across NI since 2007. Age NI's key concerns regarding the introduction of the Welfare Reform Bill and its impact on older people relate to the following;

    - Mixed age couples who will be assessed under Universal Credit
    - Reduced capital limits under Universal Credit in relation to mixed age couples
    - Unsuitable sanctions being applied to older working age claimants and the impact this will have on their older partner
    - Restrictions with regards to occupancy and help with housing costs for mixed age couples
    - The impact of PIP and lack of clarity around DLA reassessment for pensioners

[8] DHSSPS (2012) *Statistics on Community Care for Adults in Northern Ireland, 2011-2012.* DHSSPS. Belfast
[9] NI Assembly (2014), *Specialised Grouped Housing for Older People – Introductory Briefing.* NIAR 108-14

Age NI's Response to TYC

14. Age NI welcomed the chapter on older people in the initial TYC report - the clear recognition that home should be the hub of care; that older people are often in hospital unnecessarily; that there is an over reliance on institutional care; the need for an holistic assessment process using the Northern Ireland Single Assessment

    Tool; and an acknowledgement that prevention was pivotal to maintaining the independence of older people, thus keeping them at home for longer.

15. This gave us a sense of confidence and hope that TYC could begin the process of delivering a health and social care system that addressed the needs and experiences of older people. However, ***The Strategic Implementation Plan***, ***The Population Plans*** and ***Vision to Action***, we believe, did not translate the vision contained in the original TYC report.

16. We accepted and welcomed 'falls prevention', 'cataract and audiology services'; 're-ablement' and 'increasing the use of technology'; 'individualised budgets'; and 'increased respite breaks for carers in '*Vision to Action'*. However we felt that this fell short of the sentiments outlined in the initial TYC report. We got a sense that these were not necessarily new initiatives but on-going work.

Current Situation

17. We know that Health and Social Care Trusts are rationing services by only offering support to people with very high levels of social care needs, e.g. those who need help getting out of bed, going to the toilet, washing and other essential daily tasks. Today people with fewer needs, who might once have received a few hours of 'home help' or a visit to a day centre, usually get nothing. Meanwhile for those who are entitled to help, the level of support on offer is often inadequate as older people living in their own home may only have short visits to help dress and wash. In addition:

    - The system remains baffling with little or no information available to older people and their families who often find now that '*you need to be really bullish to get the care and support you need*'[10]
    - Assessments are inconsistent and only based on a person's suitability for a particular service rather than the outcomes that they value for their wellbeing
    - Prevention is not a priority
    - Older people may have to sell properties and use savings to fund their care and many families are forced to pay top-up fees for residential and nursing care

[10] Age NI / DHSSPS Joint Events

- The status of the social care workforce remains low, with limited investment and pay. There needs to be a strategic attention to workforce planning.

18. In our report, '*Would you Have Sandwiches for Your Tea Every Night? Older people's views of social care in Northern Ireland*[11]*,'* older people told us that they felt that their care needs were reduced to pounds and pence and that in many instances they felt that they were required to justify their need for the service as if they were in some way maximising what they could from the system.

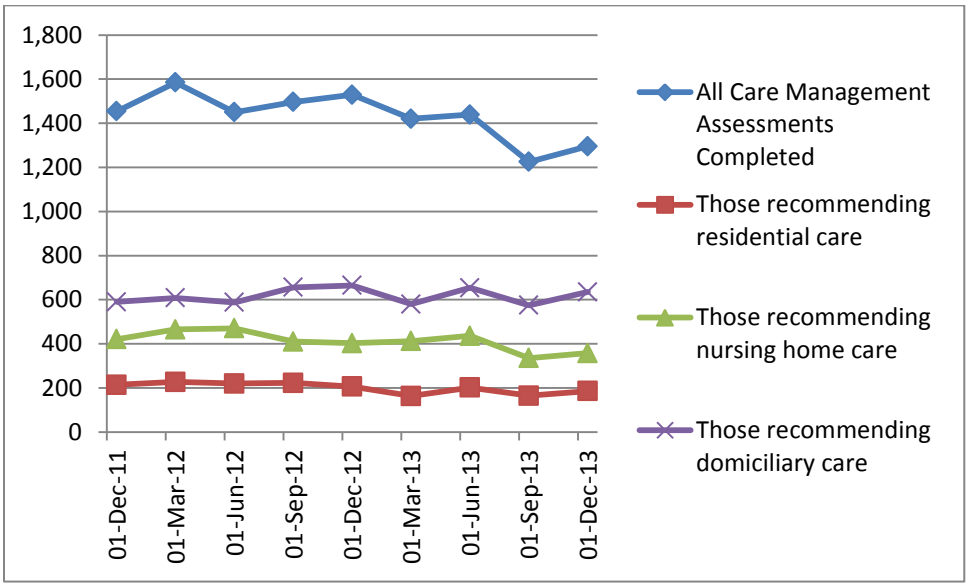
19. United Kingdom Homecare Association[12] in their survey in 2012 highlighted that the time of the visit from a care worker is increasingly being commissioned for thirty minutes or less. A staggering 87% of respondents from Northern Ireland reported that Trusts are commissioning very short visit times for frail older and disabled people (42% in Wales and Scotland; 73% in England). The UKHCA survey also reported that the use of 15 minutes calls are evident and as high as 28% in Northern Ireland. These concerns have been echoed by older people in consultation with Age NI who constantly referred to care workers not having enough time to even, *'bid the time of day*[13]*.'*

20. In addition 87% of providers in Northern Ireland (34% overall) in this survey reported concerns that undertaking personal care tasks in such short visits, risked the dignity of the users, and a number also expressed concern over compromising safety. The UKHCA questioned whether inappropriate commissioning of short visits by Trusts amounts to institutional abuse.

21. Age NI is deeply concerned that the level of assessed eligible care needed can be provided. The chart below highlights that care management assessments have been decreasing despite not only an ageing population but significant increases in the 85+ age group who are more likely to need care and support. In addition, despite an emphasis on enabling older people to remain at home, residential and nursing care remains in the main unchanged.

[11] Age NI (2011) *Would you Have Sandwiches for Your Tea Every Night? Older people's views of social care in Northern Ireland.* Belfast. Age NI
[12] UKHCA (2012) *UKHCA Commissioning Survey 2012: Care is Not a Commodity*. UKHCA. Sutton
[13] Age NI / DHSSPS Joint Events

22. Care Managed Assessments and by Type of Care



Source Community Information CC3 & CC4 Returns

23. The following is a typical case study from Age NI's advice line and reinforces the view that HSC Trusts are rationing services and failing to meet those very needs that prevent older people being admitted to nursing or residential care or requiring more complex and intense care packages later:

Henry is 87 years of age and lives alone. He has complex needs and on reassessment, Henry was informed that his shopping and cleaning services were being removed and to make alternate arrangements himself as,

"the Trust has decided not to provide shopping and cleaning…they are withdrawing it from everyone."[14]

This amounted to one hour per week for this service. Henry has no capacity to undertake these tasks due to his physical disability and the impact on his mental and physical health should not be underestimated. Hovering and ironing may be deemed 'non-essential' but for older people like Henry they are essential to enable them to live with dignity and to remain at home for as long as possible. In addition**, this is an assessed eligible need**, which is governed by the Health and Personal Social Services (NI) Order 1972 and the Chronically Sick and Disabled Persons (NI) Act 1978.

[14] Conversation with a Senior Care Manager, HSC Trust. November 2012

24. Removing essential services, particularly those low-level services, will result in greater reliance on high-level care and could result in Henry entering into residential or nursing care. Age NI therefore fails to see how TYC can deliver if HSC Trusts continue to fail to provide these services and only meet critical and substantial need.

Enabling Older People to Remain at Home: A Regional Prevention Strategy

25. As we have seen, the emphasis in TYC is enabling older people to live independently in their own homes for as long as possible. However living at home for as long as possible requires a decent, suitable home. To date the health and social care sector tends to focus on targets to reduce hospital bed days and increase community care packages to facilitate care in your own home, yet housing standards and suitability are pivotal to achieving these targets but receive little or scant attention.

26. The House of Lords report, *Ready for Ageing*[15]*?* suggested that bad housing has a knock-on effect on the NHS and that many of the chronic health conditions experienced by older people have a causal link to, or are exacerbated by, particular housing conditions. Care and Repair England in their evidence to the Committee stated that,

    "The housing-health link becomes more important with age, as people become more prone to trips and falls and more susceptible to cold or damp related health conditions. Poor thermal standards in the homes of older people are a quantifiable contributor to excess winter deaths[16]*."*

27. The context section above shows that we have a great number of older people living in fuel poverty, increases in owner occupation, increasing numbers of the older old age cohort who are likely to need care and support, increasing levels of ill health and chronic conditions amongst older people, coupled with the restrictions in care packages and the proposed reform of the funding of adult social care *(Who Cares? The Future of Adult Care and Support in Northern Ireland, DHSSPS)* all make for a perfect storm.

28. The Committee will be aware of Age NI's call for a regional prevention strategy as we believe that prevention in many instances is the key to the promotion of good health and a reduction in health inequalities. For older people investment in preventative social care services is cost effective and can increase their quality of life and housing needs and solutions should be part of any regional strategy. Age NI

[15] House of Lords Select Committee on Public Service and Demographic Change, *Ready for Ageing?* March 2013. HL 140.LONDON. TSO

[16] Care and Repair England (2012) *Written Evidence to House of Lords Select Committee on Public Service and Demographic Change, March 2013.* LONDON TSO

believes that a regional prevention strategy can reduce the need for the provision of social care both at home and in a care home setting, reduce attendances and admissions at Emergency Departments and enable older people to remain at home where they want to be. By staying well and feeling good, older people are more likely to play an active role in their communities, contribute to society and live independently.

29. Age NI welcomes the introduction of re-ablement by some HSC Trusts. Re-ablement is an intensive form of support for 6 to 8 weeks to get people '*back on their feet'* usually after a period of illness or a fall. However this by itself will not deliver the reduction and reliance on social care.

30. There is clear evidence that projects which promote early intervention and independence show how this approach, through a strategic shift to prevention and early intervention can produce early outcomes and greater efficiency for health and social care. Care and Repair England, have estimated that the costs to the NHS in England of poor housing is over £600 million per year. In their evidence they showed how avoiding falls through small adaptations and a handyperson service cost in the region of £6,302, potentially preventing the costs of a hip fracture of £24,000 and the on-going costs of care and support. Added to this, is the potential annual costs of £28,000 for admission to residential care[17].

31. In our response to the TYC consultation process, we noted that the initial TYC report referred to *'that little bit of help,'* and the Partnership for Older People's Projects. This was welcome, but has not followed through the subsequent documentation, apart from re-ablement. Re-ablement is just one component of a preventative agenda and on its own will not deliver the *'shift left'* or the reductions in Emergency Department attendances and admissions.

32. Prevention is broadly defined to include a wide range of services that:

- Promote independence
- Prevent or delay the deterioration of wellbeing resulting from ageing, illness or disability
- Delay the need for more costly and intensive services.

33. Preventative services represent a continuum of support ranging from the most intensive services, through to early intervention and finally promotion of wellbeing provided by a range of health and social care professionals. The emphasis is on maximising people's functioning and independence through approaches such as rehabilitation, intermediate care and re-ablement.

[17] Ibid, page 300

34. There is clear evidence that projects which promote early intervention and independence show how this approach, through a strategic shift to prevention and early intervention, can produce early outcomes and greater efficiency for health and social care. Older people themselves acknowledge that '*a little bit of help can go a long way to preventing further ill health if it is something the client themselves feels will help them*[18]*'.* Examples include the Ageing Well Reach in Northern Ireland,[19] First Connect Service[20] and the Partnerships for Older People Projects[21] in Great Britain.

35. The recent evaluation of the Partnerships for Older People's Projects (POPPS) demonstrated that these projects lead to cost reductions in secondary, primary and social care:[22]

    - For every £1 spent, hospitals save £1.20 in emergency beds
    - 47% reduction in overnight hospital stays
    - 29% reduction in A&E departments
    - 11% reductions in outpatient appointments.

36. Overall, low-level practical support initiatives such as simple housing adaptions in relation to safety and security to running older people's active lifestyle programmes can have dramatic outcomes for older people and are of great importance to older people themselves.

37. We held a joint seminar with SCIE in March 2012[23] on prevention and social care. In this seminar our key experts highlighted the spectrum of prevention from wellbeing and maintaining independence through minimising disability and maximising functioning, noting that re-ablement was within this spectrum.

38. The use of technology Telecare has the potential to provide benefits for the target users, their family carers and the health and social care systems as a whole. However, it is not easy to prove the benefits of telecare. Telecare is relatively under-researched and there are associated methodological problems in the existing research. There is very little work done on how telecare works in practice, *i.e.* the impact of telecare implementation on existing roles and responsibilities not just in terms of formal health and social care services, but also informal/family carers and social networks of older people. There are also ethical challenges involved, as telecare can involve surveillance and monitoring of people who are vulnerable, isolated or have diminished capacity[24].

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[18] Age NI / DHSSPS Joint Events
[19] CENI (2009), *Evaluation of Ageing Well Reach.* Belfast CENI
[20] Blake Associates (2009) *Evaluation of First Connect Service: Age Concern Help the Aged NI*
[21] PSSRU, *The National Evaluation of Partnerships for Older People Projects,* London DoH
[22] PSSRU, *The National Evaluation of Partnerships for Older People Projects,* London DoH
[23] http://www.ageuk.org.uk/northern-ireland/for-professionals/policy/health--social-care/age-ni--scie-seminar/
[24] The Role of Telecare in Supporting Carers of Older People, 2011. Dublin. CARDI

Conclusions

39. Age NI has called for a fundamental review of social care with a view to developing a modern and responsive care system that focuses on rights, entitlements and fairness. Any service changes as a result of TYC must promote the dignity, choice and independence of older people.

40. It is important that we identify the appropriate provision of care depending on age ranges. For example for older people aged 65 to 75, provision may need to centre around loss, bereavement and social isolation with the appropriate provision in place such as counselling, advice and opportunities to participate. For those aged 75 to 85 there may be some limited loss of capacity to live independently, therefore technology or re-ablement may be useful strategies to employ. Those over 85 may have severe loss of capacity, both physical and mental and end of life issues. High quality intensive domiciliary and or palliative care may be needed at this stage as well as institutional and hospitalisation if appropriate. Whatever the provision, Age NI recommends that there should be an unrelenting focus on outcomes for individuals – the type of care that they will value and that they need to maintain their independence, dignity, security and choice.

ENDS
Judith Cross, May 2014

Select Committee on Health, Social Services and Public Safety: Northern Ireland Assembly. Notes for discussion May 28th 2014

Professor Anthea Tinker, CBE, PhD, FKC, AcSS, Professor of Social Gerontology, Institute of Gerontology, Department of Social Science Health and Medicine, King's College London

Drawing mainly on research for the Technology Strategy Board (where the research was undertaken by Professor Anthea Tinker, Professor Jay Ginn, Professor Leonie Kellaher and Eloi Ribe) but also other related research.

Institute of Gerontology,
Department of Social Science, Health and Medicine,
King's College London

Review of supported living for older people – Professor Anthea Tinker

1. **Starting from where we are**

Numbers and % of older people will increase but more significant will be the increase in numbers of very old people and more will have dementia.

2. **What do we know?**
    a. That housing is increasingly recognised as a crucial ingredient in wellbeing (and also the link between health and housing).
    b. There is a growth in solitary living, a high degree of under occupation, many homes are in poor condition.
    c. Growing evidence that older people want to remain in a home of their own.
    d. That housing is bound up with the environment.
    e. A shortage of housing for all groups.
3. **Learning from Europe**

    Our research for the Technology Strategy Board- a programme 'Revolutionising Long Term Care' (published 2013 and 2014). The vision was for alternatives to residential care although we conclude that there is a role for it. The context was rising numbers of very old people, increased prevalence of long term conditions, rising expectations, more older people in employment, numbers in institutions and costs, poor care in institutions and at home, financial constraints, the key role of informal carers and the complexity of funding (as in NI). We identified the Netherlands as a country we could learn from.
4. **Findings from the main study and the Netherlands: services**
    a. Putting older people at the heart of provision – not just lip service.
    b. The importance and key role of housing and its role in prevention.
    c. Ways that older people can remain in a home of their own
        - New build – ideally to Lifetime Homes standard (e.g. inclusive design).
        - Home modifications – repairs, aids and adaptations.
        - Sharing a home with family – either the family move in with the older person or vice versa – Granny flats. Fostering – Shared Lives/Adult Placements.
        - Co-housing – where people live independently in their own accommodation in a group and share some communal facilities such as a laundry, hobby room, garden space. Now used for all ages including older people.
        - Home sharing – where an older person provides a home at lower or no cost to another person in return for an assigned amount of help - not personal care.
    d. Moving to specialist grouped housing
        - Assisted/supported living/sheltered housing – from other research difficult to let because of number of rooms, e.g. bedsits, location, unsuitable buildings.
        - Extra care housing - especially valuable for frail older people but some schemes are outdated. Generally thought that the UK leads the way.
        - Retirement villages – Usually a variety of housing and provision – sometimes the whole range.
    e. Radical alternatives such as hotels, cruise ships
    f. The value of technology but ethical issues to do with surveillance

- Telecare – from simple personal alarms (e.g. pendant, /panic/medical/social alarms, PERS, etc.) to smart homes.
- Telehealth – delivery of health care at a distance. The assumption is that there is a health professional either at one or both ends of the communication.
- Greater use of mobile phones.
- Smart homes – integrated provision of assistive technology such as sensors and cameras – originated in the Netherlands but not widespread use there.

g. Importance of the wider environment. Fits in with NI Positive Ageing Strategy April 2013. Now EPSRC study Mobility, Mood and Place 2013 – 2016 explores how places can be designed collaboratively to make mobility easy, enjoyable and meaningful for older people.
h. Dementia – problems of loss of ability to carry out everyday activities, problems with memory and communications. Good examples from the Netherlands.
i. People who are dying – end of life strategies e.g. advice for extra care schemes.
j. Personal budgets (PBs) – the move away from public funding for personal services across Europe towards mixed models of care. Research on PBs not encouraging also potential for abuse.
k. Using institutional care more creatively for non-residents but caution.

5. Wider issues from the main study and the Netherlands

a. Looking for leaders maybe from Public Health?
b. Services working together.
c. Issues of age discrimination – less so in health but is in employment.
d. Encouraging new providers (but need to monitor standards). The role of industry e.g. more use of pharmacies. Opportunities for business e.g. technology.
e. Paying for products and services. Thinking beyond payment in money e.g. time banks.
f. Giving more information
g. Changing practice including new ways of doing things (as is being shown with dementia strategies).
h. Staff – low status/pay/training - changing attitudes and training. Improving status e.g. as in Sweden
i. The future is likely to lie in voluntary organisations working in consortia and with the private sector
j. Measuring outcomes and the need for more research including the need to evaluate some interesting looking schemes e.g. HAPPI report.

6. A note of caution about comparisons with seemingly similar countries in the case of the Netherlands.

In common with the UK e.g. the demographics, sea faring nations, experience of war. But how to explain:

a. Longer life expectancy in the Netherlands – over 4 years
b. Dutch older people are less likely than the British to live with their children
c. Informal care is lower and formal care higher
d. Different funding i.e. contributory social insurance covers home based social care and institutional care for those with chronic conditions.

Appendix 3

Departmental briefing papers and correspondence

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA

Department of
Health, Social Services
and Public Safety
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Ms Maeve McLaughlin MLA
Chair
Committee for Health Social Services and Public Safety
Room 416
Parliament Buildings
Ballymiscaw
Stormont
BELFAST
BT4 3XX

Our Ref: SUB/1120/2013

Date: 19 December 2013

Dear Ms McLaughlin

2014/15 COMMISSIONING PLAN DIRECTION AND INDICATORS OF PERFORMANCE DIRECTION

Further to my letters of 17 October and 12 November which provided the Committee with drafts of the above Directions, I am writing to advise that the Commissioning Plan Direction and Indicators of Performance Direction for 2014/15 have been finalised and have issued formally to the HSC Board and Public Health Agency. Copies of both Directions are enclosed for the Committee's information.

The next stage is for the HSC Board, in consultation with the Public Health Agency, to prepare a Commissioning Plan setting out the health and social care services to be commissioned in the next financial year, as well as the underpinning financial plan and details of how commissioning will serve to deliver the planned reforms arising from *Transforming Your Care*.

It is my intention that the Commissioning Plan should be approved by me and in place by the beginning of April 2014. The Committee will of course have an opportunity to consider the Plan before it is agreed.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

DIRECTION

2013 No. 13

The Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014

The Department of Health, Social Services and Public Safety makes the following Direction in exercise of the powers conferred by sections 6 and 8(3) of the Health and Social Care (Reform) Act (Northern Ireland) 2009(a):

Citation, commencement and interpretation

1.—(1) This Direction may be cited as the Health and Social Care (Commissioning Plan) Direction (Northern Ireland) 2014 and shall come into operation on 13 November 2013.

(2) In this Direction—

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act;

"Commissioning Plan" means a plan to be prepared and published by the Regional Board, in consultation with and approved by the Regional Agency, in accordance with sections 8(3) and 8(4) of the Act.

Requirements of the Commissioning Plan

2.—(1) The Commissioning Plan to be prepared and published by the Regional Board, in consultation with and having due regard to advice or information provided by the Regional Agency, shall provide details of the health and social care services which it will commission for the period 1st April 2014 to 31st March 2015, for consideration and approval by the Minister. In doing so, it shall include the underpinning financial plan, and detail how commissioning will serve to deliver the planned transformation of services, including *Transforming Your Care* (TYC), and meet the standards and targets set out in the Schedule.

(2) The Commissioning Plan shall provide details of indicative commissioning intentions and associated indicative financial commitments for the period 1st April 2015 to 31st March 2016.

(3) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board and the underpinning financial plan align with and support the delivery of the Executive's Programme for Government (PFG) commitments and associated milestones, its Economic Strategy and its Investment Strategy; the Minister's vision and priorities for health and social care; extant statutory obligations, including Equality duties under the Northern Ireland Act 1998(b), the discharge of delegated statutory functions and requirements under Personal and Public Involvement (PPI); the standards, policies and strategies set by the Department; the agreed transformation of health and social care services including TYC; and Departmental guidance and guidelines.

(4) The Commissioning Plan shall provide details of how the services being commissioned by the Regional Board will deliver safe, effective and high quality care in the most appropriate

(a) 2009 c.1 (N.I.)
(b) 1998 c.47

setting, represent an equitable use of the resources made available for health and social care to the Northern Ireland population, based on relative need, and support the implementation of the agreed service delivery changes arising from planned transformation. In doing so the Commissioning Plan must:

(a) include the Strategic Context – the environmental factors and drivers for change influencing commissioning intentions and future service development and design, taking account of the strategic policies and priorities set by the Department;

(b) include the five LCG Commissioning Plans as part of the Commissioning Plan. These should reflect the use of an evidence-based methodology, including the Capitation Formula (subject to approval by the Department), to assess the relative needs of the populations of the LCG areas and hence each LCG's target fair share, and the actual resources deployed for the respective populations;

(c) for all regional services and for each of the five Local Commissioning Groups, set out fully the services to be commissioned with details of specific commissioning intentions designed to deliver on the targets, standards and strategic priorities in this Direction for the year 1st April 2014 to 31st March 2015. This should include the values and volumes of services to be commissioned at LCG level and how they relate directly to meeting the assessed needs of the population and the delivery of standards and targets. The Plan should also provide indicative commissioning intentions for the year 1st April 2015 to 31st March 2016, to include a high level assessment of values and volumes of services to be commissioned;

(d) set out clear timescales and milestones for the delivery of the commissioning plan and underpinning financial plan as appropriate, and for the implementation of agreed service delivery changes arising from TYC;

(e) demonstrate how commissioning intentions take account of existing performance, and detail how performance management of HSC Trusts and other providers is used to ensure that assessed needs are met and targets and standards are being delivered through the effective and efficient use of the available resources. The Plan should explain how the Regional Board, in consultation with the Regional Agency as appropriate, will address significant under-performance against requirements by providers; and

(f) include specific commissioning intentions designed to support the six PFG commitments led by DHSSPS and the achievement of PFG milestones.

3.—(1) The Commissioning Plan shall demonstrate how the commissioning proposals deliver on the following key strategic priorities and statutory obligations:

(a) *To improve and protect health and well-being and reduce inequalities, through a focus on prevention, health promotion, anticipation and earlier intervention*;

The Commissioning Plan must demonstrate how the services to be commissioned support the aims and outcomes of the Public Health Strategic Framework 2013-23 and related population health strategies, and are conducive to the improvement of the health and social well-being of, and the reduction of health inequalities between, people in Northern Ireland to fulfil the requirements of Section 2(3) (g) of the Act. There should be a strong focus in the Plan on how the services to be commissioned will prevent ill-health, anticipate the needs of local populations, and promote health and well-being. The Plan should also detail the early intervention measures being taken by the Regional Board and Regional Agency, where appropriate working in partnership with other organisations, and should demonstrate a commitment to address the wider determinants of health through, for example, the use of social clauses in procurement and service contracts where appropriate, and to maintaining and developing grassroots community and voluntary organisations.

(b) *To improve the quality of services and outcomes for patients, clients and carers through the provision of timely, safe, resilient and sustainable services in the most appropriate setting*;

The Commissioning Plan must demonstrate how the services to be commissioned will fulfil the statutory duty on the Regional Board under Article 34(1)(a) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003(**a**); reflect the principles, values and standards set out in the Quality 2020 Strategy; improve the safety and effectiveness of services to deliver safe, high quality care that meets recognised standards, including those set out in Service Frameworks; and improve the patient and client experience, including implementation of the regional priorities identified in the PHA annual report (2013/14) on the Patient Experience Standards. The Plan must explain the outcomes which will be delivered for patients, clients and carers and outline how the Regional Board will take account of the views of patients, clients and carers in the commissioning of services. The Plan should also demonstrate that the design and delivery of services to be commissioned is based on the best available robust, research-informed evidence, in accordance with the objectives of the Department's strategy for Health and Social Care Research and Development.

(c) *To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions*;

The Commissioning Plan must demonstrate how the services commissioned will improve access to treatment, care and support closer to home, and facilitate people to live as independently as possible in their own community. This should include preventing people unnecessarily entering hospital and enabling them to return home safely as soon as they are fit to do so. The Plan should set out how services being commissioned will meet the requirement for more effective long-term condition management. The Plan should demonstrate how innovation in the delivery of services has been adopted, working with a range of providers to improve patient and client care, including through the use of innovative technologies to support people to manage their conditions at home.

(d) To promote social inclusion, choice, control, support and independence for people living in the community, especially older people, and those individuals and their families living with disabilities;

The Commissioning Plan must detail how the services to be commissioned will promote social inclusion and support people with health and care needs living in the community, particularly older people, and people with disabilities and their families. The Commissioning Plan should demonstrate an emphasis on home as the hub of care, including through the use of personal budgets, access to reablement services, age-appropriate day opportunities, enhanced provision of short breaks and the timely delivery of carers' assessments.

(e) *To improve the design, delivery and evaluation of health and social care services through involvement of individuals, communities and the community, voluntary and independent sector*;

The Commissioning Plan must detail how the Regional Board proposes to take forward the design and delivery of services developed around the local needs of patients, clients and carers through strengthened local commissioning and performance management systems, and working in partnership with other organisations as appropriate.

(f) *To improve productivity, by ensuring effective and efficient allocation and utilisation of all available resources in line with priorities*;

(a) S.I. 2003/431 (N.I. 9)

The Commissioning Plan must act as a driver for improvements in quality, productivity, efficiency, effectiveness and patient and client outcomes. It must demonstrate how the Regional Board and Regional Agency intend to incur expenditure within their budgets, how the Regional Board intends to ensure that HSC Trusts do not exceed budget allocations, and how proposed expenditure makes best use of the resources available to meet its statutory obligations under section 8(2)(b)(iii) of the Act. It must also demonstrate how the Regional Board and Regional Agency will adopt and implement learning from relevant benchmarking studies; the experience of other organisations and how they intend to promulgate and share best practice.

(g) *To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services*;

The Commissioning Plan must demonstrate that the services being commissioned are sufficient to ensure that statutory responsibilities to assess needs, safeguard, protect and support vulnerable groups, including through the discharge of delegated statutory functions, will be met. There should be an emphasis on prevention and early intervention, in particular in connection with those families whose children are on the edge of care. The Plan will demonstrate how all HSC Trusts, as corporate parents, will be expected to meet the specific needs of looked-after children by providing high quality, enduring placements for them and supporting their transition out of care and into adult life.

Commissioning and the use of financial allocations

4.—(1) The Commissioning Plan shall include details of how the total available resources, as specified by the Department in its respective budget allocation letters to the Regional Board and Regional Agency respectively for the financial year from 1st April 2014 to 31st March 2015, have been committed to the HSC Trusts or other persons or bodies, from which the Regional Board commissions health and social care. This should include a breakdown of planned commitments at programme of care level covering both the Regional Board and Regional Agency resources. The Plan shall also provide details of indicative commitments for the financial year from 1st April 2015 to 31st March 2016.

(2) This information shall be provided separately for resources allocated to the Regional Board and resources allocated to the Regional Agency.

(3) This information shall be provided separately for each of the five LCGs, for provider organisations and for services commissioned regionally by the Regional Board in the manner specified by the Department in its budget allocation letters.

(4) This information shall include an analysis of how the Regional Board plans to shift the proportion of spend from hospital services to primary and community services in accordance with the planned transformation of health and social care services.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 13 November 2013.

Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

SCHEDULE

Standards and Targets for 2014/15

Priority	*Standard/ Target*
To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion, anticipation and earlier intervention	**Bowel cancer screening** 1. The HSC will extend the bowel cancer screening programme from April 2014 to invite, by March 2015, 50% of all eligible men and women aged 60-74, with an uptake of at least 55% of those invited. **Family Nurse Partnership** 2. By March 2015, improve long-term outcomes for the children of teenage mothers by establishing a test site of the Family Nurse Partnership Programme within each Trust. **Substance misuse** 3. By March 2015, services should be commissioned and in place that provide seven day integrated and coordinated substance misuse liaison services within all appropriate HSC acute hospital settings undertaking regionally agreed Structured Brief Advice or Intervention programmes. **Tackling obesity** 4. By March 2015, all eligible pregnant women, aged 18 years or over, with a BMI of 40kg/m^2 or more at booking are offered the Weigh to a Healthy Pregnancy programme with an uptake of at least 65% of those invited.
To improve the quality of services and outcomes for patients, clients and carers, through the provision of timely, safe, resilient and sustainable services in the most appropriate setting.	**Hip fractures** 5. From April 2014, 95% of patients, where clinically appropriate, wait no longer than 48 hours for inpatient treatment for hip fractures. **Cancer care services** 6. From April 2014, all urgent breast cancer referrals should be seen within 14 days; at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat; and at least 95% of patients urgently referred with a suspected

	cancer should begin their first definitive treatment within 62 days. **Unscheduled care** 7. From April 2014, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within four hours of their arrival in the Department; and no patient attending any Emergency Department should wait longer than 12 hours. 8. By March 2015, 72.5% of Category A (life threatening) calls responded to within eight minutes, 67.5% in each LCG area. **Hospital readmissions** 9. By March 2015, secure a 5% reduction in the number of emergency readmissions within 30 days (using 2012/13 data as the baseline). **Elective care – outpatients / diagnostics/ inpatients** 10. From April 2014, at least 80% of patients wait no longer than nine weeks for their first outpatient appointment and no patient waits longer than 15 weeks. 11. From April 2014, no patient waits longer than nine weeks for a diagnostic test and all urgent diagnostic tests are reported on within two days of the test being undertaken. 12. From April 2014, at least 80% of inpatients and daycases are treated within 13 weeks and no patient waits longer than 26 weeks **Healthcare acquired infections** 13. By March 2015, secure a further reduction of x% in MRSA and *Clostridium difficile* infections compared to 2013/14.**[x to be available in March 2014]** **Organ transplants** 14. By March 2015, ensure delivery of a minimum of 80 kidney transplants in total, to include live, DCD and DBD donors. **Specialist drugs**

	15. From April 2014, no patient should wait longer than three months to commence NICE approved specialist therapies for rheumatoid arthritis, psoriatric arthritis, ankylosing sponylitis or psoriasis. **Stroke patients** 16. From April 2014, ensure that at least 12% of patients with confirmed ischaemic stroke receive thrombolysis. **Pressure ulcers** 17. By March 2015, secure a 10% reduction in pressure ulcers in all adult inpatient wards. **Medicines Formulary** 18. From April 2014, ensure that all therapeutic areas relevant to primary care are included in the NI Medicines Formulary and 70% prescribing compliance is achieved in each area.
To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions	**Allied Health Professionals (AHP)** 19. From April 2014, no patient waits longer than nine weeks from referral to commencement of AHP treatment. **Telehealth** 20. By March 2015, deliver 500,000 Telehealth Monitored Patient Days (equivalent to approximately 2,800 patients) from the provision of remote telemonitoring services through the Telemonitoring NI contract. **Unplanned admissions** 21. By March 2015, reduce the number of unplanned admissions to hospital by 5% for adults with specified long term conditions (using 2012/13 data as the baseline).
To promote social inclusion, choice, control, support and independence for people living in the community, especially older people and those individuals and their families living with disabilities	**Carers' assessments** 22. By March 2015, secure a 10% increase in the number of carers' assessments offered. **Direct payments**

	23. By March 2015, secure a 5% increase in the number of direct payments across all programmes of care. **Telecare** 24. By March 2015, deliver 800,000 Telecare Monitored Patient Days (equivalent to approximately 2,300 patients) from the provision of remote telecare services including those provided through the Telemonitoring NI contract.
To improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the community, voluntary and independent sector	**Patient experience** 25. The Regional Agency, in liaison with the Regional Board and HSC Trusts, to assist the Department to deliver a regional survey of inpatient and A&E patient experience during 2014/15, in order to baseline the position regarding patient experience and put in place a programme of work to secure improvements. **Integrated Care Partnerships** 26. By March 2015, 95% of patients within the four ICP priority areas [frail elderly, diabetes, stroke, respiratory] will have been identified and will be actively managed on the agreed Care Pathway.
To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities	**Delivering transformation** 27. By March 2015, transfer £83m (excluding transitional funding) from hospital/institutional based care into primary, community and social care services. **Normative staffing** 28. The Regional Agency should continue to lead and monitor the programme of work to develop and implement Normative Nurse Staffing which should be used to commission and deliver services as follows: i. From April 2014, the Normative Nurse Staffing Tool should be applied to all inpatient general and specialist adult hospital medical and surgical care settings; ii. By March 2015 normative staffing

	ranges will be developed and introduced for Health Visiting within a range which secures the delivery of the service model detailed within the Departmental Strategy 'Healthy Futures'. **Unnecessary hospital stays** 29. By March 2015, reduce the number of excess bed days for the acute programme of care by 10% (using 2012/13 data as the baseline). **Cancelled clinics** 30. By March 2015, reduce the number of hospital cancelled consultant-led outpatient appointments by 17%. **Patient discharge** 31. From April 2014, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days; 90% of complex discharges from an acute hospital take place within 48 hours, with no complex discharge taking more than seven days; and all non-complex discharges from an acute hospital take place within six hours.
To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across all our services	**Learning disability and mental health** 32. By March 2015, resettle the remaining long-stay patients in learning disability and psychiatric hospitals to appropriate places in the community. **Mental health services** 33. From April 2014, no patient waits longer than nine weeks to access child and adolescent mental health services; nine weeks to access adult mental health services; nine weeks to access dementia services; and 13 weeks to access psychological therapies (any age). **Children in care** 34. From April 2014, increase the number of children in care for 12 months or longer with no placement change to 85%.

	35. By March 2015, ensure a three year time frame for 90% of children who are to be adopted from care. 36. From April 2014, ensure that all school-age children who have been in care for 12 months or longer have a Personal Educational Plan (PEP).

EXPLANATORY NOTE TO ACCOMPANY THE HEALTH AND SOCIAL CARE (COMMISSIONING PLAN) DIRECTION (NORTHERN IRELAND) 2013

1. The Minister's vision for the integrated health and social care system is to drive up the quality of health and social care for patients, clients and carers, to improve outcomes, to safeguard the vulnerable, and to ensure that patients, clients and carers have the best possible experience in every aspect of their treatment, care and support.

2. The direction sets out the focus for the Regional Board in the commissioning of Health and Social Care services in support of the Minister's vision and priorities during the year 1st April 2014 to 31st March 2015.

3. The direction provides for the development of an integrated Commissioning Plan which must detail how the services to be commissioned in the 2014/15 financial year are resourced through the underpinning financial plan and will serve to deliver on the agreed planned transformation of services, including TYC. The Commissioning Plan shall provide details of indicative commissioning intentions and associated indicative commitments in 2015/16 to reflect the integrated nature of the Plan and the need to plan over the longer term timescale for effective implementation of agreed transformation.

4. The targets and standards included in the Schedule to the Direction do not imply that other services or standards are less important. Rather, they represent particular areas for focus in the coming year and are complemented by identified indicators of performance included in a separate Indicators of Performance Direction to the Regional Board.

5. Effective performance management of the health and social care system requires availability of a range of indicators to help track trends. An Indicators of Performance Direction will be produced alongside the Commissioning Plan Direction to ensure that the HSC has a core set of indicators in place, on common definitions across the sector. The Regional Board, Regional Agency and HSC Trusts are expected to monitor the trends in indicators, and take appropriate and timely action as necessary in light of emerging trends.

PROGRAMME FOR GOVERNMENT (PFG) COMMITMENTS AND MILESTONES

The Department leads on six PFG Commitments each of which has three annual milestones. The Commissioning intentions within the Commissioning Plan must support the continued delivery of milestones set for 2012/13and 2013/14, and the achievement of milestones for 2014/15.

PFG Commitment 22: Allocate an increasing percentage of the overall health budget to public health

2012//13 – Strengthen the cross-sectoral, cross-Departmental drive on improving health and mental wellbeing and reducing health inequalities by setting new policy direction and associated outcomes based on the most recent bodies of evidence available.

2013/14 – The HSC will have in place all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from 1st April 2014

2014/15 – Invest an additional £10m in public health (increase based on 2011/12 spend)

PFG Commitment 44: Enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a dedicated chronic management programme

2012/13 – Identify and evaluate the current baseline of patient education and self management support programmes that are currently in place in each Trust area.

2013/14 – Health and Social Care Board and Public Health Agency should work with key stakeholders to develop and secure a range of quality assured education, information and support programmes to help people manage their long-term conditions effectively, alongside full application of the Remote Telemonitoring contract

2014/15 – People with a long-term condition will be offered access to appropriate education, information and support programmes relevant to their needs, including innovative application of connected health

PFG Commitment 45: Invest £7.2 million in programmes to tackle obesity

2012//13 – Invest £2 million in tackling obesity through support of Obesity Prevention Framework

2013/14 – Invest £2.4m in tackling obesity through support of Obesity Prevention Framework

2014/15 – Invest £2.8m in tackling obesity through support of Obesity Prevention Framework

PFG Commitment 61: Introduce a package of measures aimed at improving safeguarding outcomes for children and vulnerable adults across Northern Ireland

2012/13 - Develop a Strategic Plan for Adult Safeguarding in Northern Ireland and produce a joint Domestic and Sexual Violence and Abuse Strategy

2013/14 - Open new Sexual Assault Referral Centre at Antrim Area Hospital

2014/15 – Develop an updated inter-departmental Child Safeguarding Policy Framework

PFG Commitment 79: Improve Patient and Client outcomes and access to new treatments and services

2012/13 – Enhance access to life-enhancing drugs for conditions such as rheumatoid arthritis, cancer, inflammatory bowel disease and psoriasis and increase to 10% the proportion of patients with confirmed Ischaemic stroke who receive thrombolysis

2013/14 – Improve long-term outcomes relating to health, well-being, education and employment for the children of teenage mothers from disadvantaged backgrounds by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site

2014/15 – Expand cardiac catheterisation capacity to improve access to diagnostic intervention and treatment and further develop the primary percutaneous coronary intervention (PPCI) service to reduce mortality and morbidity arising from myocardial infarction (heart attack)

PFG Commitment 80: Reconfigure, reform and modernise the delivery of Health and Social Care services to improve the quality of patient care

2012/13 – Development of a clear implementation and Population plan to ensure delivery of the new model of care as set out in the Transforming Your Care report

2013/14 – As part of a shift in the delivery of services to primary and community settings reduce by 2013/14, the number of days patients stay in acute hospitals unnecessarily (excess bed days) by 10% compared with 2011/12

2014/15 – Secure a shift from hospital-based services to community-based services together with an appropriate shift in the share of funding in line with the recommendations of Transforming Your Care

DIRECTION

2013 No. 14

The Health and Social Care (Indicators of Performance) Direction (Northern Ireland) 2014

The Department of Health, Social Services and Public Safety makes the following direction in exercise of the powers conferred by sections 6 and 8(2)(a) of, and paragraph 20 of Schedule 1 to the Health and Social Care (Reform) Act (Northern Ireland) 2009(**a**):

Citation, commencement and interpretation

1.—(1) This direction may be cited as the Indicators of Performance Direction (Northern Ireland) 2014 and shall come into operation on 19 December 2013.

(2) In this direction–

"the Act" means the Health and Social Care (Reform) Act (Northern Ireland) 2009;

"LCG" means a Local Commissioning Group appointed as a committee by the Regional Board in accordance with section 9 of the Act.

Performance indicators

2.In exercise of its functions under section 8(2) of the Act, with the aim of improving the performance of the HSC Trusts, the Regional Board shall refer to the indicators of performance set out in the Schedule for the period 1st April 2014 to 31st March 2015.

3.The Regional Board shall record the information against the indicators of performance set out in the Schedule for the period 1st April 2014 to 31st March 2015.

Sealed with the Official Seal of the Department of Health, Social Services and Public Safety on 19 December 2013.

Permanent Secretary
A senior officer of the
Department of Health, Social Services and Public Safety

(a) 2009 c.1 (N.I.)

SCHEDULE

Priority	*Indicators*
To improve and protect health and well-being and reduce inequalities through a focus on prevention, health promotion, anticipation and earlier intervention	**Life expectancy** A1. Average life expectancy for women and men. A2. Life expectancy differential between Northern Ireland average and most disadvantaged areas for women and men. A3. (a) Number of deaths of men aged 65 and over from abdominal aortic aneurysm (AAA), excluding thoracic aortic aneurysm; (b) Rate of uptake of Northern Ireland wide Screening Programme for AAA. A4. Potential years of life lost (PYLL) from causes considered amenable to healthcare. A5. Healthy life expectancy. A6. Self-reported well-being. A7. Infant mortality. **Standardised death rates** A8. Age Standardised Death Rate (SDR) for under 75s for circulatory disease; respiratory disease; cancer; and liver disease in Northern Ireland and its most deprived areas. **Suicide and self-harm** A9. Suicide rates across Northern Ireland and in the most deprived areas.

	A10. Number of A&E presentations due to deliberate self-harm.
	Diabetes
	A11. The prevalence of diabetes.
	Obesity
	A12. Level of overweight and obesity across the life course (2-10 year olds and 16+).
	A13. The proportion of adults meeting the Chief Medical Officer's recommended guidelines on physical activity.
	A14. The proportion of adults (aged 16+) consuming the recommended five portions of fruit and vegetables each day.
	Alcohol consumption
	A15. The proportion of adults who report having reached or exceeded the recommended weekly limit.
	A16. Standardised rate of alcohol-related admissions to hospital within the acute programme of care.
	Drug misuse
	A17. Standardised rate of drug-related admissions to hospital within the acute programme of care.
	Smoking
	A18. Proportion of adults who smoke.
	A19. Numbers of pregnant women, children and young people and adults from deprived areas (lower quintile) who set a quit date through cessation services.

	Teenage pregnancies and sexual health A20. Rate of births to mothers under 17 years of age (with breakdown against most deprived areas). A21. Number of new episodes of selected sexually transmitted infections diagnoses made by genito-urinary medicine clinics. A22. New HIV diagnoses. **General health – flu** A23. Uptake of seasonal flu vaccine by front-line health and social care workers. **Circulatory conditions** A24. Admissions for venous thromboembolism.
	Maternity and young children A25. Activity in maternity and child health programme of care. A26. Percentage of babies born by caesarean section and number of babies born in midwife-led units either freestanding or alongside. A27. Breastfeeding rate at discharge from hospital. A28. Rate of each core contact within the pre-school child health promotion programme offered by health visitors. A29. Percentage reduction in intervention rates (including caesarean sections) benchmarked against comparable units in UK and Ireland.

To improve the quality of services and outcomes for patients, clients and carers through the provision of timely, safe, resilient and sustainable services in the most appropriate setting	**Cancer services** B1. The number of red flag cancer referrals. **Attendances at Emergency Departments** B2. Percentage of patients triaged at levels 1, 2, 3, 4 and 5 of the Manchester Triage Scale at Type 1 or 2 emergency departments. B3. Percentage of new and unplanned review attendances at emergency care departments waiting: less than 30 minutes, 30 minutes to 1 hour, 1 to 2 hours, 2 to 3 hours, 3 to 4 hours, 4 to 6 hours, 6 to 8 hours, 8 to 10 hours, 10 to 12 hours and 12 hours or more, before being treated and discharged or admitted. B4. Patient and ambulance turnaround times by length of time (less than 15 minutes; 15 – 30 minutes; 31 – 60 minutes; 61 – 120 minutes; and more than 120 minutes). B5. Percentage of cardiac arrest patients who suffered an out of hospital cardiac arrest who have return of spontaneous circulation (ROSC) on arrival at hospital. B6. (i) The percentage of Face Arm Speech Test (FAST) positive stroke patients (assessed face to face) potentially eligible for stroke thrombolysis, who arrive at a hospital providing 24/7 stroke lysis within 60 minutes of call; and (ii) the percentage of patients with suspected stroke or unresolved transient ischaemic attack (assessed face to face) who receive an appropriate care bundle. B7. Percentage of unplanned re-attendances at emergency departments within seven days of original attendance. B8. Total time spent in emergency

	departments including the median, 95th percentile and single longest time spent by patients in the A&E department, for admitted and non-admitted patients.
	B9. Percentage of people who leave the emergency department before their treatment is complete.
	B10. Time from (i) arrival to initial assessment and (ii) initial assessment to treatment in emergency departments.
	B11. Number of GP referrals to emergency departments.
	Elective care
	B12. Number of GP referrals to consultant-led outpatient services.
	B13. Number of outpatient appointments with procedures within the specialities of pain management, ophthalmology, gynaecology, general surgery, plastic surgery and dermatology.
	B14. Number of barium enema, computerised tomography, magnetic resonance imaging, non-obstetric ultra sound, positron emission tomography and plain film x-ray tests undertaken.
	B15. Total number of patients admitted for inpatient treatment in the independent sector, by HSC Trust.
	B16. Total number of attendances at consultant-led outpatient services in the independent sector, by HSC Trust.
	Stroke
	B17. Number of patients admitted with stroke.

	Patient safety
	B18. Variation in death rate for emergency admissions (all diagnoses) comparing patients admitted at the weekend and patients admitted during the week.
	B19. Variation in death rate for emergency admissions comparing patients admitted at the weekend and patients admitted during the week for (i) heart attacks; (ii) heart failure; (iii) stroke; and (iv) aortic aneurysm.
	B20. To produce quarterly Summary Hospital-level Mortality Indicator (SHMI) measures for NI by LCG.
	Patient / client experience
	B21. Percentage of all adult inpatient wards in which the Fall Safe bundle has been implemented.
	B22. Number of hearing aids fitted within 13 weeks as a percentage of completed waits.
	B23. Percentage of patients waiting over 13 weeks for any wheelchair (basic and specialised).
	B24. Percentage of patients who have lifts and ceiling track hoists installed within 16 weeks of the OT assessment and options appraisal.
	Prescribing and medicines optimisation
	B25. Level of prescribing compliance with the NI Formulary by HSC Trust.
	B26. (a) Prescribing activity, and the level of compliance of GP practices, by LCG for each Chapter of NI Medicines

	Formulary; (b) prescribing activity by LCG for generic prescribing and dispensing rates.
	B27. Evidence of shared learning outcomes and communications issued arising from medication incidents reported in primary and secondary care.
	B28. The number and proportion of patients admitted to hospital receiving the integrated medicines management service, by HSC Trust.
	Pharmacy
	B29. The number of medicines management and public health pharmaceutical services delivered in the community reported by LCG area. The number and proportion of Health and Care Centres in each HSC Trust with: active pharmaceutical services provision, plans for active pharmaceutical services provision.
	B30. Proportion of people accessing the "Building the Community Pharmacy Partnership" (BCPP) projects residing in the bottom three quintiles of wards / Super Output Areas (SOAs) by deprivation.
	Organ transplants
	B31. Percentage change in overall transplants.
	B32. Total number of deceased organ donors by type.
	B33. Number of organs declined.

	Cardiac catheterisation B34. Percentage increase in access to cardiac catheterisation. **Fracture** B35. Percentage of patients, where clinically appropriate, waiting less than seven days for inpatient fracture treatment. **Hospital re-admissions** B36. The number of emergency admissions for acute conditions that should not usually require hospital admission. B37. The number and proportion of emergency admissions and readmissions for people aged 0-64 years and 65 years and over: (i) with and (ii) without a recorded long term condition, in which medicines were considered to have been the primary or contributing factor, by HSC Trust.
To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long term conditions	**Specialist drug therapies** C1. Number of patients waiting longer than 13 weeks to commence NICE-recommended therapies for multiple sclerosis (MS), or therapies under the UK Risk Sharing Scheme for disease modifying treatments for MS. C2. Number of patients waiting longer than six weeks to commence specialist drug treatment for wet AMD for the first eye, and six weeks for the second eye. **Telemonitoring**

	C3. Number of patients benefiting from remote telemonitoring.
To promote social inclusion, choice, control, support and independence for people living in the community, especially older people and those individuals and their families living with disabilities	**Day opportunities** D1. Number of adults in receipt of day opportunities, by programme of care. **Self-directed support** D2. Number of people eligible for social care services who are accessing self-directed support through a personal budget. **Supported living** D3. Number of older persons living in supported living facilities. **Continuing care needs** D4. (i) Number of people with continuing care needs waiting longer than five weeks for an assessment of need to be completed and (ii) Number of people with continuing care needs waiting longer than eight weeks, from their assessment of need, for the main components of their care needs to be met. **Telecare** D5. Number of patients benefiting from the provision of telecare services.
To improve the design, delivery and evaluation of health and social care services through the involvement of individuals, communities and the community, voluntary and independent sector	**Patient experience** E1. The Regional Agency will take forward recommendations of the 2013/14 report on Patient Experience Standards. In particular, by March 2015 the Regional Agency will have led a process with Trusts to develop and fully implement policies for: (i) protected mealtimes across all acute inpatient areas and (ii)

	name and designation badges for all staff except where deemed inappropriate. **Integrated Care Pathways (ICPs)** E2. Number of care pathways for each of the ICP initial priority areas agreed and being implemented by each ICP. E3. Percentage of risk stratified patients within the ICP initial priority areas, designated as high risk of hospital admission, who are actively managed on a care pathway. E4. Number of ICPs that have agreed to adopt and utilise the regional approach for risk stratification which will include an approach to improving the quality of data across the service.
To improve productivity by ensuring effective and efficient allocation and utilisation of all available resources in line with Ministerial priorities	**Efficiency indicators** F1. Elective average pre-operative stay. F2. Elective average length of stay in acute programme of care. F3. Average length of stay for stroke patients. F4. Day surgery rate for each of a basket of 24 elective procedures. F5. Percentage of operations cancelled for non-clinical reasons. F6. Percentage of patients admitted electively who have their surgery on the same day as admission. F7. Percentage of routine diagnostic tests reported on within two weeks of the test

	being undertaken.
	F8. Percentage of routine diagnostic tests reported within four weeks of the test being undertaken.
	F9. Ratio of new to review outpatient appointments attended, by HSC Trust.
	F10. Rate of new and review outpatient appointments where the patient did not attend, by HSC Trust.
	F11. Rate of new and review outpatient appointments cancelled by the hospital, by HSC Trust.
	F12. Ratio of new to review outpatient appointments cancelled by the hospital, by HSC Trust.
	F13. Number of 30 day emergency readmissions by days after discharge, by HSC Trust.
	F14. Percentage of emergency admissions returning within seven days and within 8-30 days, by HSC Trust.
	F15. Clinical causes of emergency readmissions (as a percentage of all readmissions) by Trust for (i) infections (primarily: pneumonia, bronchitis, urinary tract infection, skin infection); and (ii) long-term conditions (COPD, asthma, diabetes, dementia, epilepsy, CHF).
	Out of hours GP attendance
	F16. Out of Hours GP attendance by timeband (i) 12am to 8.30am; (ii) 8.30am to 6pm; and (iii) 6pm to 12am.

	Prescribing and medicines optimisation F17. Attainment of targets set out in the Regional Board pharmacy efficiency programme. **Expenditure** F18. Balance of expenditure between community and hospital based services. F19. Percentage of funding spent on primary and community care. F20. Percentage of funding invested in tackling obesity.
To ensure the most vulnerable in our society, including children and adults at risk of harm, are looked after effectively across all our services	**Children** G1. Percentage of all foster care placements that are kinship care placements. G2. Number of care leavers in education, training and employment by placement type. G3. Percentage of care leavers at age 18, 19 and 20 years in education, training and employment. G4. The percentage of children with an adoption best-interests decision that are notified to the Adoption Regional Information Service (ARIS) within 4 weeks of the HSC Trust approving the adoption panel's decision that adoption is in the best interest of the child. G5. The number of school age children in care for 12 months or longer who have missed 25 or more school days by placement type. G6. Length of time for best interest decision

	to be reached in the adoption process. G7. Number of children and number of times absconding from residential or foster care has been notified to the police. G8. Activity relating to the development of specialist/ professional foster care places by HSC Trust, in line with TYC recommendation 50. **Autistic spectrum disorders** G9. Number of referrals for ASD (under 18). G10. Number diagnosed with ASD (under 18). **Safeguarding vulnerable adults** G11. Number of Adult Protection Referrals received by HSC Trusts.

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA

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Your Ref:

Our Ref: AGY/85/2014

Date: 17 February 2014

Dear Ms McLaughlin

You have requested an evidence session from Departmental officials on supported living within the context of the Committee's review of Transforming Your Care and its impact on older people.

The meeting is scheduled to take place on 26 February 2014 and I would confirm that the witnesses attending on behalf of the Department and Health and Social Care Board will be:

- Sean Holland Deputy Secretary DHSSPSNI and Dean Looney Elderly and Community Care DHSSPSNI;
- Pamela McCreedy, Director of Transforming Your Care and Kevin Keenan Assistant Director of Social Services, Older People and Adults Health and Social Care Board.

A briefing paper is attached for your information.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

TRANSFORMING YOUR CARE AND OLDER PEOPLE: SUPPORTED LIVING

Introduction

1. This briefing note provides information on Supported Living within the context of the Committee's review of Transforming Your Care and its impact on Older People.

Background

2. The Transforming Your Care – a Review of Health and Social Care in Northern Ireland, published in December 2011, set out strategic aims, in the form of 99 proposals, to place the individual, family and community that use health and social care services at the heart of how things are done. The Review supported the trend towards independent living – at home or in supported accommodation – and expected to see a very significant reduction in provision of long-term residential places in the next five years.

3. It made the case that preventative approaches can deliver better outcomes and set proposals on supporting Older People including:

    - Home as the hub of care for older people, with more services provided at home and in the community.
    - A major reduction in residential accommodation for older people, over the next five years.
    - A focus on promoting healthy ageing, individual resilience and independence.
    - A diverse choice of provision to meet the needs of older people, with appropriate regulation and safeguards to ensure quality and protect the vulnerable.

4. The service change proposals made by the Health and Social Care Board (HSCB) and set out in the consultation document "Transforming Your Care: Vision to Action" gave examples of services that the HSCB could commission to meet the strategic aim of the TYC Review. These included:

    - Falls Prevention Programmes
    - Improvements in access times to cataract surgery and audiology services to support living at home
    - Reablement programmes in order to promote rehabilitation and independence
    - Use of telehealth and telecare programmes for remote health monitoring

5. The TYC Strategic Implementation Plan, revised following the consultation exercise and published in its final form in October 2013, in section 4.3.2 sets out in further detail the strategic programmes the HSCB would provide to support Older People to maintain their own independence and manage the functions of daily living.

Supported Living

6. Supported Living provides an environment for people who cannot live independently in their own home but who may not yet require the additional personal or clinical inputs required in residential and nursing care. In Northern Ireland, the Supporting People programme, led by DSD, funds supported living services. The programme works on a partnership basis between DSD, the NI Housing Executive, DHSSPS, and the HSC.

7. The Housing Executive chairs a Supporting People Commissioning Body that includes representation from the HSC Board, RQIA, and Probation Board alongside officials from both DSD and DHSSPS. The Commissioning Body approves business cases for proposed local schemes put forward by Area Supporting People Partnerships on which each Trust is represented.

8. DSD provides capital funding for new supported living developments together with revenue funding for housing support services, funded by Supporting People, which provides information, advice and help to, for example, someone to support people to manage their money and pay their bills. This can be provided in a person's own home and in supported living accommodation.

9. HSC Trusts provide personal care support to tenants in response to assessed need. In 2012/13, Trusts invested just over £3.7m providing support in supported living settings. In addition, Trusts spent just over £160m on domiciliary care services, a proportion of which would also have been invested in support to supported living tentants.

10. Across NI there 28 different service providers (5 statutory, 14 Housing Associations and 9 voluntary) providing housing support services to older people in over 400 services.

Trust	Number of Supported Living facilities for Older People	Number of tenancies
Belfast	**137**	**3, 444**
Northern	**105**	**2, 372**
South Eastern	**70**	**1, 808**
Southern	**44**	**1, 045**
Western	**58**	**1, 312**
Total	**414**	**9981**

11. In addition, a number of intended developments are being considered across Northern Ireland. While these developments are currently at different stages in

the planning process it is clear that supported living has an important role in supporting people to remain as independent as possible.

Other Community-based services

12. A range of other community-based services also contribute to achieving the aim of home as the hub:
    - Domiciliary Care;
    - Reablement;
    - Self directed support;
    - Assistive Technology; and
    - Housing Adaptations.

13. **Domiciliary care**, the provision of personal care in a person's own home, is the main service used to help people maintain their independence. In the survey week 15-21st September 2013, over 25,000 people were supported by the domiciliary care service, with the HSC investing in the region of £160m per year on domiciliary care services for older people.

14. **Reablement** involves working for a limited period (2-6 weeks) with individuals whose independence is at risk to learn or relearn the skills necessary for daily living, to rebuild their confidence and promote their social inclusion. The goal is a level of independence that either allows discharge requiring no service, or requiring reduced services on an ongoing basis. Reablement services are currently being rolled out across NI, with three of the five HSC Trusts already providing full coverage of their Trust area.

15. **Self directed support** offers service users and carers greater flexibility and independence by enabling individuals to tailor their support package to their individual needs. It is available via direct payments, where an individual receives a cash payment from a HSC Trust, in lieu of social service provision, or via a personal budget where the money identified to meet the needs of the individual is retained by the Trust, but the individual determines the way in which the money will be spent, and what type of services will be purchased. While direct payments have been available to individuals across NI for many years, personal budgets are still at an early stage of roll-out of across the region.

16. **Assistive technology** such as the Telemonitoring NI service helps to support people with chronic conditions, including older people, at home. The Telemonitoring service combines technology and services to enable service users to test their vital signs at home on a daily basis thereby enabling the identification of irregularities, enabling earlier intervention and the prevention of deterioration.

17. **Housing adaptations** can also help people to remain independent in their own home. Following a public consultation last year, DHSSPS and DSD officials are working collaboratively to draft a final review report and associated action plan on housing adaptations built around the theme of home as the hub of care.

Residential Care

18. The HSC Board is currently consulting on the document 'Making Choices: Meeting the Future and Current Accommodation Needs of Older People'. The consultation proposes four criterion to be used later in the process by Trusts to score, at a local level, statutory residential homes with a view to potential proposals for change.

19. The highest weighted criterion is 'Availability and Accessibility of Alternative services'. This criterion proposes that Trusts should consider the extent to which:

    - Existing services, including independent sector residential care and supported living, could meet the needs of existing residents of statutory residential homes;
    - Planned new developments of independent sector residential care and supported living within the next five years could meet the needs of residents; and
    - The length of wait for community based services such as domiciliary care.

20. In addition, the proposed Care Trends criterion includes analysis of changing demand for residential care and domiciliary care over the last three years, together with an analysis of the number of supported housing units in each

locality. It is intended that the criteria will enable full consideration of alternative services within each Trust area before considering any potential changes to statutory residential care.

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA

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Our Ref: AGY/176/2014

Date: 3 April 2014

Dear Ms McLaughlin

Thank you for your letter dated 6 March requesting further information following the evidence session, which took place on February 26, on supported living for older people.

The information you requested is attached at **TAB A**. Please note that, given the cross Departmental nature of supported living, the information given in answers 1-6, inclusive, was supplied by the Department for Social Development while the information for answers 7– 9 was supplied by the Health and Social Care Board.

I hope this information is helpful.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

TAB A

Q.1 Details of the Supporting People budget for older people for 2012/2013, 2013/2014, and projected spend for 2014/2015 and 2015/2016.

A.1 Supporting People is a revenue fund which makes provision for a range of housing support services for older people. Services come in a variety of tenures including sheltered housing, supported accommodation for frail elderly/dementia, floating support services and peripatetic support as well as Home Improvement Agency Services for people with a disability (older people with a disability are the main recipients of this advice and assistance service through the grants application process).

Allocation for older people (60+)

- 2012/13 £12.8ml
- 2013/14 £13.3ml
- 2014/15 £13.7ml (projected budget)
  2015/16 £13.7ml (projected budget)

Q.2 The number of tenancies for supported living for older people which are currently unoccupied; and a breakdown of where these vacancies exist broken down by Trust area;

A.2 As at the end of Quarter 3 (31 Dec 2013) (sheltered and supported) utilisation exception reports by Trust area yield the following underutilisation information for older people services:

Trust Area	No of schemes where occupancy below 90%	Total number of vacancies in these schemes
West	7	30
South East	9	51

South	9	23
North	6	23
Belfast	21	109
Total	52*	236

*out of over 400 schemes

Q.3 The rate of turnover of tenancies for supported living for older people;

A.3 Performance indicators record the level of voids on a scheme by scheme basis as opposed to a particular client group.

Q.4 The Department's projections as to the number of new tenancies for older people required by 2015/2016;

A.4 The allocation of housing is based on identified need, by client group. At December 2013 there were 5,822 people over 60 on the housing waiting list which represents 14.5 per cent of the Common Selection Schemes (waiting list)

Q.5 The number of older people who self-refer themselves to a supported living facility, the number of older people who are referred via a social worker assessment, and the number of older people who are referred via the Housing Executive because they are already living in social housing.

A.5 All applicants who are interested in sheltered housing and supported living schemes are required to apply for and be registered for housing through the NIHE's Common Selection Scheme. However the scheme allows for those requiring supported living to be dealt with separately by the NIHE's local Complex Needs officer (Housing Support Officer), who will then liaise as necessary with social workers and providers.

Older applicants and social workers who make initial enquiries to supported living scheme providers will be referred to the NIHE'S Complex needs officer. Applications are then considered in relation to clear eligibility criteria and may then be placed on a separate waiting list by the provider. Usually if vacancies arise in schemes there is an admissions panel convened comprising the social worker, provider and complex needs officer.

Q.6 Details of the six proposals for supported living facilities for older people currently being considered by the Supporting People commissioning body – where they will be located, the budget required, and when the facilities are expected to open;

A.6 Supporting People 3 Year Programme – Services for Older People

TRUST	DEVELOPMENT	NO. OF TENANCIES	BUSINESS CASE APPROVED & COST	PROGRESS/ISSUES	ESTIMATED COMPLETION DATE
BELFAST	Grovetree	31	Outline Business Case	Site transfer (former care home). Programmed 14/15	unknown
NORTHERN	Greenisland	36	In development – 517k	Business Case at advanced stage. Environmental issues around timing of demolition. Should go on site 14/15	Anticipated 15/16
	Rathmoyle Ballycastle	28	In development	Issue with day care facility on site. Future of this to be determined. programmed 14/15	unknown
SOUTH	Cuan Court	24	Yes	Approved. Due to be	Complete

EASTERN	N'Ards			opertational March/April 2014	March 2014
	Ravarra Bangor	24	In development	Costings to be provided by Trust. Land Transfer process initiated.	Anticipated 15/16
SOUTHERN	Kilkeel	12	Yes	Mourne Hospital site planning was refused, planning appeal wk beginning 17.03.14	unknown

Q.7 Details of the projected spend from the HSC Trusts in relation to the six proposals described above;

A.7

Name of Scheme	Location	Tenancies	Care Revenue	SP Revenue	Completion Date
Grovetree - Ballyowen	Belfast	31	£600,000	£318,000	2014/15
Greenisland	Northern	36	£273,942	£364,023	2015/16
Rathmoyle	Northern	28	£471,000	£425,000	Unknown
Cuan Court	Newtownards (SEHSCT)	24	£144,081	£279,953	2014
Ravarra	Bangor (SEHSCT)	24	OBC outstanding-due end of April 2014		2015/16
Kilkeel	SHSCT	12	£36,000	£17,000	Unknown

Q.8 The spend by Trusts on supported living for older people for 2012/2013 and 2013/2014, and projected spend for 2014/2015 and 2015/2016; (this should include an explanation of any anomalies in terms of how the Trusts record spend in this area)

A.8

Trust Name	Trust domiciliary care package costs for SP facilities 2012-2013	Trust domiciliary care package SP costs for facilities 2013-2014	Projected domiciliary care packages expenditure into SP facilities 2014-2015	Projected domiciliary care packages expenditure into SP facilities 2015-2016	
Belfast	£1,776,082	£1,658,941 (10 mths) Full yr 1,990,729	£1,990,729	£1,990,729	Please note BHSCT are planning a 5th SH scheme in West Belfast. This may be available 15/16 and would require approx 500k recurrent from Trust. However cannot be 100% certain at this point.
South Eastern HSC Trust	£437,000	£503,000	£780,000	£868,000	Please note that projected expenditure for 2014/15 is on the basis of Cuan Court opening in May 14, and for 15/16 Ravara opening in January 16.
Southern HSC Trust	£200k approximately care costs	£200k approximately	216k approximately	332k (which includes 216k dom care to Spelga Mews and Abbeyfield schemes and 116k to new Kilkeel build).	
Western HSC Trust* Sevenoaks	£15,509	Cost per case	Cost per case	Cost per case	
Gnangara	£174,653	Cost per case	Cost per case	Cost per case	
Daleview	£8,812	£8,812	2014/15 rates have yet to be agreed	2015/16 rates have yet to be agreed	
Various Apex Housing Association Facilities	£7,128	£7,128	2014/15 rates have yet to be agreed	2015/16 rates have yet to be agreed	

St. Julian's House	£18,838	£24,929	2014/15 rates have yet to be agreed	2015/16 rates have yet to be agreed	
Total	£224,940	£40,869			

*WHSCT had used a 'block purchase' model 2012-13. This has changed to 'spot purchase', with services now purchased on an individual 'cost per case' basis.

The Finance department within the Northern Trust intends to respond to the Committee separately following the Committee's correspondence with Trusts.

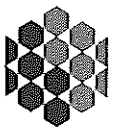
Q.9 Details of the new indicator of performance to measure the number of older people in supported living facilities –the wording of the indicator, the monitoring arrangements, and the date when the first set of data will be available;

A.9 This is one of the new 'HSC (Indicators of Performance) Direction (NI) 2014' indicators, developed by DHSSPS for use by HSC. DHSSPS has not yet associated a target with this indicator.

Full reporting using this indicator will be required by the end of March 2015. Interim reporting has commenced via Trust 'Delegated Statutory Functions' (DSF) data returns (annually in March) and ongoing HSC/ NIHE occupancy monitoring at local level. This system will be reviewed to inform the final reporting model for use 2014-15 onwards.

The working definition for 'Supported Living Facilities' being used by HSC is the NIHE definition; *'Supporting People funds a range of housing related support services for vulnerable older people to improve their quality of life and attain independence. These services can be provided in their own homes or in hostels, sheltered housing or other specialised housing support'.*

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA



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Our Ref: AGY/198/2014

Date: 3 April 2014

Dear Ms McLaughlin

Thank you for your letter dated 13 March requesting clarification on figures provided by the Department and the five H&SC Trusts following the Supported Living evidence sessions, which took place on 26 February 2014, and 12 March 2014, respectively.

The 20 facilities referred to by Trusts refers to those supported living facilities now jointly commissioned under the Supporting People programme for those who require relatively high levels of support. Examples include Barn Halt in Carrickfergus and Cuan Court in Ards. All tenants in these facilities will be receiving personal care support from the HSC.

The 414 facilities referred to in the briefing paper provided by DHSPSS includes these 20 facilities as well as the broader range of supported living accommodation including sheltered and FOLD accommodation, developed primarily as social housing, where tenants require a lower level of support and may not require any support from the HSC.

All Trusts are working to further develop their Supported Living options, a number of intended developments are being considered across Northern Ireland. While these developments are currently at different stages in the planning process it is clear that supported living has an important role in supporting people to remain as independent as possible.

I hope this information is helpful.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

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Our Ref: AGY/273/2014

Date: 28 April 2014

Dear Ms McLaughlin

Thank for your letter of April 10th asking for the Departments definition of supported living in the context of implementing Transforming Your Care.

The Health and Social Care Board have advised that the current definition of supported living, which was furnished in response to your letter of March 6th, will be reviewed in an effort to better reflect supported living within the context of Transforming Your Care going forward. I will share this definition with the committee when it has been finalised.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

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13 May 2014

Dr Kathryn Aiken
Committee Clerk
Committee for Health, Social Services & Public Safety
Room 144
Parliament Buildings
Ballymiscaw
Belfast
BT4 3XX

Dear Dr Aiken,

Re: Supported Living – Older People

Thank you for your letter dated 24 April 2014 seeking clarification regarding the DSD definition of Supported Living.

The term supported living is not defined in housing related legislation.

The Department for Social Development uses the term *Supported Housing* to describe the type of accommodation that is available through the Social Housing Development Programme for vulnerable people who require housing support services and/or an element of care and is intended to help individuals lead as independent a life as possible.

Supported housing accommodation provision includes:

- Self-contained units;
- Self-contained units with common room and/or associated communal facilities
- Shared housing units; or
- Shared housing units with common room and/or associated communal facilities.

The Health Committee has invited DSD to brief them on this issue under the wider auspices of their review of “Transforming Your Care” on the 11th June 2014 and full briefing will be provided at that time.

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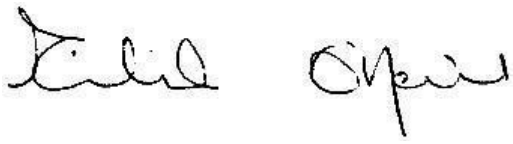

Social Inclusion & Support for People

Ext 38317

Cc Dr Kevin Pelan

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
Edwin Poots MLA

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Ms Maeve McLaughlin MLA
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Our Ref: AGY/321/2014

Date: 6 June 2014

Dear Ms McLaughlin

You have requested an evidence session from Departmental officials on supported living within the context of the Committee's review of Transforming Your Care and its impact on older people.

The meeting is scheduled to take place on 11 June 2014 and I would confirm that the witnesses attending on behalf of the Department and Health and Social Care Board will be:

- Sean Holland Deputy Secretary DHSSPSNI and Michael Sweeney Acting Director Mental Health, Disability and Older People;
- Fionnuala McAndrew Acting Chief Executive Health and Social Care Board.

A briefing paper is attached for your information.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

Tab B

Issues highlighted by the Committee

1. The definition of supported living

Supported living is the term given by Government to encompass a range of health care provision, health related adaptations, housing accommodation and housing support services designed to help vulnerable people retain their independence in their local community.

Supported Housing Accommodation

Supported Housing is one key supported living option. Supported housing relates to any accommodation provided for vulnerable people who require housing support and/or an element of care and is intended to help individuals lead as independent a life as possible in their own home.

Supported housing accommodation provision includes;

- Self-contained units;
- Self-contained units with common room and/or associated communal facilities
- Shared housing units; or
- Shared housing units with common room and/or associated communal facilities.

This type of housing accommodation will typically have housing related support services and where appropriate care packages in place with the focus being on assisting the individual to maintain a tenancy.

There are 414 such schemes for older people across NI.

Examples of supported housing schemes for older people include the following:

- Sheltered housing schemes (often called Folds) make up the vast majority of supported housing accommodation for older people. They provide

individual/and or shared housing units within one building with low level housing support services on site such as a warden or security system. These schemes are typically populated by older people who can achieve a high level of independence with little or no care intervention.

- Frail elderly schemes designed to meet the needs of people who have greater needs than can be accommodated in sheltered housing. These schemes are similar to sheltered schemes (Folds) with independent housing units on site however the scheme will be enhanced with additional facilities such as assisted technology, housing adaptations (wheelchair accessibility, ramps etc) and will have domiciliary care provided through one of the registered domiciliary care agencies.

2. The roles and responsibilities of various bodies involved in supported living for older people

The Housing Executive chairs a Supporting People Commissioning Body that includes representation from the HSC Board, RQIA, and Probation Board alongside officials from DHSSPS. The Commissioning Body approves business cases for proposed local schemes put forward by Area Supporting People Partnerships on which each Trust is represented.

The roles of those involved in the Supporting People scheme are as follows:

- Health and Social Care Trusts identify the need for new supported (social) housing and develop business cases which are then considered through the Supporting People commissioning arrangements. Health and Social Care Trusts provide funding for any social care required for tenants of supported housing schemes.
- DSD, through the Housing Executive, provides grant funding to housing associations to build supported housing for social rent. This grant covers around 70% of the build cost. Housing Associations borrow the remainder from banks or via bonds and repay this over a thirty year period.

- Housing Associations project manage the construction of supported housing schemes for social rent and become the landlord for the scheme once built. Housing associations then either manage directly the housing support services to tenants or contract these out to a specialist support provider (usually in the voluntary and community sector).
- The Housing Executive, through the Supporting People programme, provides funding for housing support services, including for those in supported housing. These services are designed to help people to develop the skills and confidence necessary to live independently without support or to maintain independent living with ongoing support.

3. The future projections for supported living places for older people

Within the current three year Supporting People programme (ending March 2016) the following facilities are planned:

TRUST	DEVELOPMENT	NO. OF TENANCIES	BUSINESS CASE APPROVED & COST	PROGRESS/ISSUES	ESTIMATED COMPLETION DATE
BELFAST	Grovetree	31	Outline Business Case	Site transfer (former care home). Programmed 14/15	unknown
NORTHERN	Greenisland	36	In development	Business Case at advanced stage. Environmental issues around timing of demolition. Should go on site 14/15	Anticipated 15/16
	Rathmoyle Ballycastle	28	In development	Issue with day care facility on site. Future of this to be determined. programmed 14/15	unknown
	Moylinney, Newtownabbey	24	Outline business case	Housing Association appointed	unknown

			submitted.		
SOUTH EASTERN	Cuan Court N'Ards	24	Yes	Approved.	Complete June 2014
	Ravarra Bangor	24	In development	Costings to be provided by Trust. Land Transfer process initiated.	Anticipated 15/16
SOUTHERN	Kilkeel	12	Yes	Mourne Hospital site planning was refused, planning appeal underway	unknown

4. The challenges and obstacles associated with the provision of supported living places for older people

At a meeting on 13th January, the Ministers for Health and Social Development tasked officials with working with stakeholders to identify difficulties and challenging in the delivery of supported living.

Subsequent to this, Officials held a workshop on 19th February with a range of stakeholders including the HSC Board, Trusts, NI Federation of Housing Associations and the Housing Executive at which a number of challenges were identified. These include:

- Length of time taken to fill new supported living facilities;
- Difficulties securing planning permission for some new developments;
- Greater clarity required on scheme design and funding early in the process;
- Promotion and awareness of supported living facilities.

Officials are currently in the process of identifying actions to address the range of concerns identified.

5. Resource/budgetary issues

As outlined in response to question two, funding for supported housing comes from a number of sources: HSC Trusts fund domiciliary care to meet personal care needs; DSD, through the Housing Executive provides grant funding to housing associations to build supported housing; the Housing Executive, through the Supporting People programme provides funding for housing support services.

To work effectively, budgets across government have to be as aligned as possible. During the current CSR period this has proved challenging as the DSD bid for funding was largely successful whilst the DHSSPS bid did not secure the level of funding required. Both Departments have worked closely during this CSR period, resulting in the transfer of some £6m to date from DSD to DHSSPS to provide sufficient revenue funding for new supported housing facilities to be developed.

DHSSPS and DSD Officials have commenced early discussions regarding future CSR bids.

6. The role of supported living for older people in the context of TYC

Supported Living provides an environment that is designed to help vulnerable people retain their independence in their local community. In this regard supported living is an important service that enables a range of people, including older people, to maintain tenancies in a range of accommodation. Supported living should, however, be set in the context of wider care provision: there are currently 18 frail elderly supported living schemes for those with high levels of need while 197 residential homes and 263 nursing homes are registered with RQIA to provide care to older people.

7. The relationship between the need for supported living places and the need for statutory residential home places

It is recognised that supported living accommodation and housing support services are important services targeted at a group of individuals at a certain point in the care continuum, i.e. where the person requires more assistance than can be provided in their previous home but not quite the ongoing 24 hour care available in a residential home.

Supported living accommodation is therefore unlikely to be suitable for many individuals currently living in statutory and independent sector residential care.

The vast majority of residential care in NI is provided by the independent sector. Should there be any change to statutory sector supported living, sufficient residential care will continue to be available for those whose needs can best be met in that environment.

8. Departmental engagement/knowledge of supported living for older people in other countries/regions

Supported Housing schemes for older people in Northern Ireland are designed in light of experiences and good practice nationally and internationally informed by experts such as the University of Stirling, an internationally recognised centre for research on housing and dementia. A number of supported housing schemes for older people in Northern Ireland are recognised as examples of innovation and best practice. These include Barn Halt in Carrickergus and Hemsworth Court in Belfast.

FROM THE MINISTER FOR HEALTH,
SOCIAL SERVICES AND PUBLIC SAFETY
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Ms Maeve McLaughlin
Chair
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Our Ref: AGY/430/2014

Date: 25 June 2014

Dear Ms McLaughlin

Thank you for your letter of 13 June 2014 as part of the Committee's ongoing review of Supported Living for Older People in the context of Transforming Your Care. You have asked if information is available on the number of individuals supported in their own home who could be supported in a supported living facility.

The Department collects information on domiciliary care through an annual weekly survey. This survey provides key indicators including the number of hours provided, the number of people being supported by domiciliary care and the balance of provision between the statutory and independent sectors.

However, the information collected by the survey does not enable the identification of specific individuals receiving domiciliary care in their own homes who could also be supported in supported living accommodation. The HSC Board has also confirmed that it does not hold this information.

As you will be aware, each individual's assessment of need will inform decisions about where best those needs can best be met. As outlined in the evidence session with Officials on 11 June 2014, it is the Department's view that there is sufficient capacity in terms of the existing 18 supported living facilities and the planned 7 new facilities, to meet the needs of older people in Northern Ireland.

I hope this is helpful.

Edwin Poots MLA
Minister for Health Social Services and Public Safety

Appendix 4

Research papers

Northern Ireland Assembly

Research and Information Service
Briefing Paper

Paper 29/14 14th February 2014 NIAR 108-14

Dr Janice Thompson

Specialised Grouped Housing for Older People - Introductory Briefing

1 Introduction - Meeting Older People's Specialist Housing Needs

In connection with the ongoing work of the Committee for Health, Social Services and Public Safety regarding the implementation of *Transforming Your Care* under the theme of Older People, the aim of this briefing paper is to provide an introduction to the subject of specialist grouped housing for older people, often referred to as sheltered housing.

The focus of this briefing is the policy around, and examples of, this type of housing in Northern Ireland and also the outworkings of the *Housing our Ageing Population: Panel for Innovation* (HAPPI).

HAPPI was established in June 2009[1] to investigate what reform was needed in the UK to ensure that new build specialised housing meets the needs and aspirations of older people.[2]

This paper also includes some good practice examples of sheltered housing for older people in England, including some highlighted in the HAPPI Report and also in the HAPPI 2 Report produced by the Westminster All Party Parliamentary Group (APPG) on Housing and Care for Older People.

Further briefings may be produced if required as the Committee's review in this area proceeds, including policy and good practice in other neighbouring jurisdictions and beyond if required.

HAPPI acknowledged that inadequate housing exacerbates health problems and creates others. As things currently stand in the UK, without better housing in the community to which an older person belongs,

> *the choice often lies between 'getting by' in unsuitable accommodation or up-rooting to some form of institutional home…Without a vision of an alternative, more positive, future, 'selling up' tends to be a last resort – realising a valuable asset as well as losing a much-loved home*[3]

It outlined a spectrum of housing options that are available to older people[4]:

1. Mainstream housing (perhaps adapted to meet the needs of the individual);
2. Specialised Housing (with access to support and care and usually designated for the over 55's); and
3. Residential Care (including residential homes, nursing homes and specialised care homes).

This briefing is focused on the second category, namely specialised housing.

The Westminster All Party Parliamentary Group (APPG) on Housing and Care for Older People (HAPPI 2), have highlighted that solutions to health and social care problems for older people so often lie in the provision of specially designed and high quality homes leading to[5]:

- Reduced risks of falls;
- Providing safety and security;

[1] HAPPI were commissioned by Communities and Local Government (CLG) in partnership with Department of Health to set up the innovation panel, as part of CLG's commitment outlined in 'Lifetime Homes1, Lifetime Neighbourhoods: A National Strategy for Housing in an Ageing Society', published by CLG in 2008.
[2] HAPPI (2009), Homes and Communities Agency, www.homesandcommunities.co.uk/ourwork/happi
[3] Why is meeting older people's housing needs a national priority? HAPPI, Housing our Aging Population: Panel for Innovation, 2009, page 11, http://www.homesandcommunities.co.uk/ourwork/happi
[4] HAPPI, Homes and Communities Agency, page 16, www.homesandcommunities.co.uk/ourwork/happi
[5] Best, R. and Porteus, J., Housing our Ageing Population: Plan for Implementation, (November 2012) , All Party Group on Housing and Care for Older People, page 15, http://www.housinglin.org.uk/Topics/browse/Design_building/HAPPI2/?parent=8649&child=8650

- Protecting against the effects of cold homes and fuel poverty;
- Enabling earlier discharge from and fewer re-admissions to, hospital;
- Preventing or delaying the need for institutional residential care; and
- Providing companionship that comes with retirement housing to combat the depression and poor health that can result from isolation and loneliness.

Alongside the requirement for suitable housing is the need to provide for 'Assisted Living' if necessary – this encompasses the use in the person's home of ICT based products, goods and services to support the "*physiological, psychological, psychosocial and socio-cultural components of daily living*" and enables the individual and any carer to enhance their ability to maintain independence and a quality of life.[6]

The research of Tinker et al (2013) highlighted that, across the UK, specialist grouped housing for older people originated as a form of 'sheltered housing', often a group of flats or bungalows, each with an alarm system linked to a warden (often living on site), and some communal facilities. However, the research noted that it is difficult to maintain the very frail elderly in such accommodation so, in addition, 'Extra Care' (or very sheltered) housing has developed with 24 hour care on hand, enhanced communal facilities and at the provision of one or more meals per day.[7]

The policy aim in NI for some time has been to shift care from institutional settings such as nursing and residential homes to provide greater provision of services for older people living in their own home or in supported accommodation. This is discussed in Section 2 in further detail.

A similar policy is in place in the Republic of Ireland as outlined in *Towards 2016, Ten Year Framework Social Partnership Agreement 2006-2015*[8]. Section 32.2 of that document highlights the priority actions for older people, including Priority 2, 'the provision of long-term care services for older people', which highlights that "*the continued development of sheltered housing options, with varying degrees of care support will be encouraged*".[9] Priority 3 in *Towards 2016*, covers 'Housing and Accommodation' and highlights that

> *good quality housing is important to supporting the independence of older people. In some instances, housing and care services delivered in an integrated manner are essential to allowing older people to live at home for as long as possible. In other cases, older people may need to move to alternative accommodation, including sheltered housing with varying levels*

[6] DALLAS – Delivering Assisted Living Lifestyles at Scale, SBRI Competition for development contracts, Technology Strategy Board, June 2011, https://www.innovateuk.org/documents/1524978/2274828/DALLAS+-+Delivering+Assisted+Living+Lifestyles+at+Scale+-+Competition+brief/29e8d709-453b-4e91-ab04-dfba03d0362b

[7] Tinker, A, Kellaher, L., Ginn, J. and Ribe, E. (2013) Assisted Living Platform – The Long Term Care Revolution, Housing Learning and Improvement Network, King's College London, September 2013

[8] Towards 2016, Ten Year Framework Social Partnership Agreement 2006-2015, Department of the Taoiseach, Dublin, Government of Ireland 2006,

[9] As above, page 62.

of support. Therefore, the range of responses include...the availability of a mix of dwelling types of good design across all tenures.[10]

This is to include the provision of social housing via downsizing schemes and specific sheltered housing options and to ensure that future Housing Action Plans address special needs in a more strategic manner and specify, in particular, the role of the voluntary and co-operative housing sector in meeting the associated accommodation requirements.[11]

2 Northern Ireland Policies – TYC and The 'Supporting People Programme'

In Northern Ireland (NI), the focus of *Transforming your Care*[12] (TYC), in this regard, is that everyone is entitled to continue living in their own home and remain independent, albeit with support, and that an individual's home should be the hub of care for older people. TYC confirmed that the policy aim for some time has been to shift care from institutional settings such as nursing and residential homes. Steps, therefore, should be taken to support greater provision of services for older people living in their own home or in supported accommodation.

Section 4.3.2 of the TYC Implementation Plan describes the key commitments for older people. One of the key commitments is "*Support Older People and those with Long Term Conditions to maintain their own independence and manage the functions of daily living in their own home or assisted housing, as opposed to an acute setting or long term care*".[13]

In addition the Plan states that "*community-based alternatives to residential care are increasing all the time, and there is a need to ensure that the availability and functioning of these is more widely known so that people can see the different styles of independent living that it is now possible to offer to older people, where the traditional response would have been to offer a residential placement. Due to improved availability of these types of community-based alternatives, it is expected that demand for statutory residential homes will further decline*".[14]

TYC did not go into detail on specific housing tenures or types of provision, however, research published by the NI Housing Executive highlighted that, for the purposes of TYC, sheltered housing should be seen as an older person's home. Older people may move into sheltered housing, even if capable of remaining in their original home, for reasons such as company, social inclusion, provision of communal facilities, proximity

[10] Towards 2016, Ten Year Framework Social Partnership Agreement 2006-2015, Department of the Taoiseach, Dublin, Government of Ireland 2006, pages 63-64,
[11] As above, pages 63-64
[12] Transforming your care, A Review of Health and Social Care in Northern Ireland, December 2011
[13] Transforming Your Care Strategic Implementation Plan, Section 4.3.2, http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Transforming-Your-Care-Strategic-Implementation-Plan.pdf
[14] As above

to services, support from the scheme co-ordinator and issues relating to cost and maintenance of housing.[15]

In NI, the Supporting People Programme was introduced in 2003 with the aim of commissioning housing support services aimed at improving the quality of life and independence of vulnerable people. The new Supporting People strategy (2012-2015) aims to build on the successes of the original strategy ('*Supporting People, Changing Lives' 2005-2010*). The NI Housing Executive is the Administering Authority for the programme.[16]

The Department of Social Development bid for and approve funding for the programme and allocate it to the NI Housing Executive in the form of grant funding. This in turn is used to fund the provision of eligible housing support services via funding agreements with providers - the total 2012/13 'Supporting People' budget was £66.4 million.[17]

'Supporting People' (SP) is delivered via 106 organisations, the majority of whom are voluntary and community organisations, ranging from small providers of a single service to larger providers of up to 20 services. Other service providers include Housing Associations, Health and Social Care Trusts and the Northern Ireland Housing Executive (NIHE).[18]

Specific SP service provision for older people is as follows (at March 2012)[19]:

- Total SP budget spend for older people services in 2012/13 was £8.93m;
- 425 accommodation based services providing housing to over 10,300 people. Sheltered housing is the main form of provision for older people, but some more specialist supported living provision also exists for frail older people and older people with dementia;
- In addition 10 floating support services support 345 people at any one time at a cost of £604,800. These services cater for a range of clients from isolated and rural people, to people with mental health/dementia needs;
- Funding of two Home Improvement Agencies' whose role is to advise and assist applicants who have a disability through the home improvement grants' application process, in particular the Disabled Facilities Grant. Older people with a disability are the main recipients of the service; and
- The majority of services for older people are provided by housing associations with a number of services provided by the voluntary and community sector and Health and Social Care Trusts.

[15] The role of sheltered housing in Northern Ireland and future issues, Final Report September 2012 prepared for the Northern Ireland Housing Executive by Fiona Boyle, page 21, http://www.nihe.gov.uk/the_role_of_sheltered_housing_in_northern_ireland_and_future_issues__published_september_2012_.pdf

[16] Housing Related Support Strategy 2012-2015, Northern Ireland Housing Executive, Supporting People, page 5, http://www.nihe.gov.uk

[17] As above, page 7

[18] As above, page 6

[19] As above, page 23

3 Specialised Group Housing

As stated above, the HAPPI Panel outlined a spectrum of housing options that are available to older people. The category of specialist housing is the focus of this paper and includes five sub-categories[20]:

1. Sheltered/retirement housing – independent living (own front door) and may include: 24 hour alarm system, warden, lounge, programme of activities;
2. Very sheltered/assisted living – independent living with managed care and support services. Features as above and may include: meals, domestic help, assisted bathing;
3. Extra care- independent living with managed on-site care and support services. Features as above and may include 24 hour staff, hairdressing;
4. Close care housing – independent living with on-site care and support, linked to a care home;
5. Retirement villages – large developments (often 100+ units) with a range of housing types and levels of care and support (sheltered, very sheltered/extra care, close care and nursing care) on one site.

In NI, the different categories of sheltered housing are defined in the Department for Social Development's guide for housing associations and are based on the person's level of support and care needs, combined with the type of accommodation and services provided. These categories are as follows[21]:

- Category 1– self-contained accommodation for the more active elderly, which may include an element of scheme supervisor support and/or additional communal facilities;
- Category 2– scheme supervisor supported self-contained accommodation for the less active elderly, which includes the full range of communal facilities;
- Category 3 – supported extra care accommodation for the frail elderly, which comprises the full range of communal facilities, plus additional special features, including wheelchair user environments and supportive management; and
- Category 4– scheme supervisor supported shared accommodation for the less active elderly with full range of communal facilities.

It is possible to rent or buy sheltered housing. Rented sheltered housing is usually provided by local councils/authorities or housing associations (for example, Clanmil[22] or Helm[23] in NI) that will each have their own allocation policy based on need. Some

[20] HAPPI, Homes and Communities Agency, page 16, www.homesandcommunities.co.uk/ourwork/happi
[21] The role of sheltered housing in Northern Ireland and future issues, Final Report September 2012 prepared for the Northern Ireland Housing Executive by Fiona Boyle, page 15
[22] Clanmil Housing, http://www.clanmil.org/
[23] Helm Housing, http://www.helmhousing.org/

sheltered housing is run by charitable trusts and each charity has a policy on who it will assist, for example residents who live in a particular geographical area, or workers who have retired from a particular trade. Local Abbeyfield[24] societies are voluntary organisations that run supported sheltered housing for 8–12 residents in a more family-style household. There are also some private providers of sheltered rented housing.[25]

In NI, registered Housing Associations are the main developers of new social housing for rent.[26]

Sheltered housing continues to be a popular housing option for many older people in NI as it enables residents to retain their independence with the assistance of a scheme manager (on or off site), telecare/assistive technology and the advantages of communal living. The NI Housing Executive (NIHE) highlighted that sheltered housing is however facing a number of challenging issues[27]:

- Younger people (50+) accessing services
- The wide age range of residents (aged 50 to 100+)
- The complexity of needs
- The varying levels of support required
- Questions over the desirability and suitability of physical design
- Providing services to older people in the local neighbourhood.

In responding to these issues, NIHE commissioned research around the current model and future role of sheltered housing. The research findings were published in September 2012 and some of the main conclusions at that time were[28]:

- The level of stock in 2011/12 was 289 sheltered housing schemes providing 7,926 units of accommodation;
- The majority of sheltered housing accommodation was viable and fit for purpose:
    - Housing associations rated the physical condition of their sheltered housing stock as very good/good (88%) and accessibility as very suitable/suitable (87%);
    - However, they indicated that one in five units (19%) were not very suitable in terms of space standards.
    - Five housing associations felt they had some non-viable sheltered housing stock, equating to around 120 units or 1.5% of the total Category 2 sheltered housing stock in NI.;

[24] Abbeyfield, http://www.abbeyfield.com/
[25] AgeUK, Sheltered Housing Information, http://www.ageuk.org.uk/home-and-care/housing-choices/sheltered-housing/
[26] The role of sheltered housing in Northern Ireland and future issues, Final Report September 2012 prepared for the Northern Ireland Housing Executive by Fiona Boyle, page 16
[27] Housing Related Support Strategy 2012-2015, Northern Ireland Housing Executive, Supporting People, page 27, http://www.nihe.gov.uk
[28] Conclusions extracted from The role of sheltered housing in Northern Ireland and future issues, Final Report September 2012 prepared for the Northern Ireland Housing Executive by Fiona Boyle, Executive Summary

- More than half (53%) of tenants were aged 75 and over and a further third (33%) were aged 65 to 74, 16% were under 65 (10% aged between 55 and 64 and 6% between 24 and 54) - increased numbers of people with mental health problems/ addictions/physical or other health problems are now living in sheltered housing;
- Occupancy - in 2010/11 around 3% of sheltered housing units were empty. Whilst occupancy was high at that time, it was concluded that the reason for this was related to the operation of the Common Selection Scheme[29] and the resultant increasing number of allocations of sheltered housing to individuals and groups who do not fit the definition of older, independent adults for whom sheltered housing was originally designed;
- The benefits of sheltered housing do not always appear to reach the target group of older people who might be interested in this form of accommodation;
- The qualitative elements of the research pointed to perceptions and attitudes as being key factors in putting people off applying for sheltered housing and/or accepting an offer of tenancy, mainly due to a perceived lack of both privacy and independence;
- Most tenants surveyed for the research had moved to a sheltered housing scheme close to their previous home (61% within two miles and a further 17% within five miles).

4 Good Practice Examples

4.1 Examples from the HAPPI Report

As part of their work, HAPPI made six study visits and reported on 24 case studies of specialist group housing from across the UK and Europe. This section highlights a selection of good practice case studies, from England, included in the HAPPI report that encompass the 10 components recommended by HAPPI for the design of retirement housing for older people summarised as follows[30]:

1. New retirement homes should have generous internal space standards, designed to accommodate flexible layouts;
2. Ensure design allows for plenty of natural light;
3. Building layouts to avoid internal corridors and single aspect flats to maximise light/ventilation and apartments should have balconies/patios/terraces with space for tables, chairs and plants;

[29] Category 2 sheltered housing is treated as 'General Needs' accommodation under the Common Selection Scheme - The Housing Selection Scheme is governed by a set of rules which are approved by the Department for Social Development, http://www.nihe.gov.uk/index/advice/apply_for_a_home/housing_selection_scheme.htm
[30] HAPPI, Homes and Communities Agency, page 38-39, www.homesandcommunities.co.uk/ourwork/happi

4. Homes to be 'care ready' to allow for new technology to be easily installed;
5. Building layout to promote circulation areas as shared spaces to encourage interaction and avoid any 'institutional' feel;
6. In all but the smallest developments, multi-purpose space should be available for residents to meet and take part in a range of activities. Such space could also serve the wider community. Guest rooms for visiting family and friends are also important;
7. Homes should engage positively with their environment, including the preservations of mature planting and new trees and hedges;
8. Homes should be energy efficient, well insulated, well ventilated and able to avoid over-heating by the use of passive solar design, use of deciduous planting and external blinds/shutters/awnings over patios etc.;
9. Adequate storage should be available inside and outside the home for mobility aids etc.; and
10. Shared external surfaces, such as pedestrian areas have proved successful and should have due regard to navigation difficulties that visually impaired people may have.

Darwin Court – Southwark (London)[31]

Darwin Court is a six-storey mixed-use building built in 2003. Access for residents is well organised as they can choose to enter their flats privately by two lift and stair cores from a quiet street on the park side of the building or through the more social main entrance.

There are 76 rented apartments (1-2 bedrooms, 8 wheelchair adapted) including 16 flats for frail older people. It was developed by the Peabody Trust, a major London charitable housing trust and a registered housing association.[32]

Residents are all over 50 years of age and there is a resource centre (free to residents but open to the local community) with pool, café, IT suite, fitness and activity rooms. The care needs of the residents range from none to 24-hour care and the balance of the resident-profile is well-managed in ages, care needs and backgrounds. Everyone is encouraged to live as independently as possible but with no stigma associated with needing additional care.

[31] HAPPI, Homes and Communities Agency, page 14, Case Study 3, Darwin Court www.homesandcommunities.co.uk/ourwork/happi
[32] The Peabody Trust, http://www.peabody.org.uk/home

Hartrigg Oaks – York[33]

This is a continuing care retirement 'village' developed by the Joseph Rowntree Housing Trust for those aged over 60 built in 1998[34] There are 152 bungalows in four variations arranged around the community building. The residents have access to a pool, gym, restaurant and other facilities. In addition, there is a 42-bed nursing home wing attached to the community building making care and catering viable.

The continuing care model provides residents with reassurance about future care should they need it and it is combined with an model of payment that acts like an insurance scheme – residents pay a fixed annual charge which covers a maximum of three hours/day home care and all care costs for those who move into full-time care in the nursing home wing. In practice, fewer residents than expected have made that move so the care facilities have been able to provide respite care for the wider community.

4.2 Examples from the APPG Implementation Report (HAPPI 2)

Prospect Place, Victory Pier, Gillingham (Kent)

Built in 2012, Prospect Place contains 60 one and two bedroom social rented apartments on one site for people aged 55 and over, with a range of communal facilities including a commercial kitchen, café, day room, hairdresser and a laundry. Social activities are arranged by and for residents. The sheltered accommodation for older people is part of a 775 home development which also includes a 100 bed hotel and 1,000 student homes and commercial floor space. There is a central green and a riverside walk as part of the development. [35]

It is classed as extra care housing as it has an extra care scheme with on-site care staff (24 hours / 7 days), non-resident management staff, community alarm service and some meals available. It is managed by Housing 21 – a social enterprise for older people.[36]

Broad Meadow, Dudley (West Midlands)

Broad Meadow is an extra care scheme in the Dudley Borough for people aged 55 and over and an award winning development built in 2011[37]. The scheme has 132 apartments comprising 90 two bedroom and 42 one bedroom apartments. There is a mix of rented, shared ownership and outright owned accommodation. The scheme is

[33] HAPPI, Homes and Communities Agency, page 41, Case Study 11, Hartrigg Oaks , www.homesandcommunities.co.uk/ourwork/happi
[34] Joseph Rowntree Housing Trust, http://www.jrht.org.uk/
[35] Best, R. and Porteus, J., Housing our Ageing Population: Plan for Implementation, (November 2012) , All Party Group on Housing and Care for Older People, page 7 http://www.housinglin.org.uk/Topics/browse/Design_building/HAPPI2/?parent=8649&child=8650
[36] Prospect Place, http://www.housingcare.org/housing-care/facility-info-159515-prospect-place-gillingham-england.aspx
[37] Winner of the Elderly Accommodation Counsel's 2012 Housing for Older People Gold Award

staffed 24 hours a day 7 days a week, by Midland Heart Limited[38], offering person centred care and support.[39]

Specific amenities include a gym, general store, activities hall, hair and beauty salon, games room, restaurant, bar and social lounge, launderette, green house and lifestyle centre. [40]

Marina Court, Tewkesbury, Gloucs[41]

Marina Court is a retirement development providing enhanced sheltered housing on a new estate for the over 55's. There are 75 self-contained one and two bedroom apartments and bungalows built in 2007. Each property has a lounge, kitchen and level access shower. Regular activities include coffee mornings, visiting speakers, exercise classes, a library, and visits from a therapy and wellbeing co-ordinator. The latter are delivered in partnership with local health services.

There is an Easy Living scheme with on-site care staff (24 hours / 7 days), non-resident management staff and community alarm service. The scheme is a mix of social rented housing and Shared Ownership.[42]

4.3 Examples from Northern Ireland

A selection of Housing Associations were contacted in order to provide examples that they considered to be good practice. The following responses were received:

Clanmil Housing Association Ltd – Savoy, Bangor

Clanmil Housing highlighted[43] the Savoy in Bangor, Co. Down (built in 1990) as a good practice development in social rented housing. It provides retirement/sheltered housing with 56 flats in a range of one to three bedrooms. It has non-resident management staff and community alarm service. There is a communal lounge, computer suite, laundry, guest facilities, a garden and hobby room. Some meals are available.[44]

Fold Housing Association Ltd

Fold Housing Association highlighted that it offers a range of housing options for older people including the following good practice examples[45]:

[38] https://www.midlandheart.org.uk/
[39] Broad Meadow, http://www.housingcare.org/housing-care/facility-info-158085-broad-meadow-russells-hall-england.aspx
[40] Best, R. and Porteus, J., Housing our Ageing Population: Plan for Implementation, (November 2012) , All Party Group on Housing and Care for Older People, page 21
[41] Best, R. and Porteus, J., Housing our Ageing Population: Plan for Implementation, (November 2012) , All Party Group on Housing and Care for Older People, page 20 http://www.housinglin.org.uk/Topics/browse/Design_building/HAPPI2/?parent=8649&child=8650
[42] Marina Court, http://www.housingcare.org/housing-care/facility-info-88056-marina-court-tewkesbury-england.aspx
[43] Personal Communication with Clanmil Housing, 6th February 2014
[44] The Savoy, Bangor, http://www.housingcare.org/housing-care/facility-info-87083-the-savoy-bangor-northern-ireland.aspx
[45] Personal Communication with Fold Housing Group Marketing Assistant, 13th February 2014

- *Sheltered housing* – (independent living for active older people). This provides safe and secure social rent accommodation with on-site staff delivering a low level housing support (but not personal care) and 24 hour telecare alarm system. Fold have sheltered housing schemes in most towns in NI, for example, Spafield Fold[46] in Holywood which was built in 1981 and has 41 flats in sizes 1 bedroom and 2 bedroom. It includes mobility and wheelchair standard properties and has resident management staff and community alarm service. There is a lift, lounge, dining room, laundry, guest facilities, a garden and hobby room.

- *Supported Housing* - such as Fold's flagship scheme at Barn Halt Cottages in Carrickfergus offers a unique model of housing and support services and incorporates the latest in assistive technology. This development was built in 2007 and has 26 one and two bedroom bungalows for those aged 60 and over, visiting management staff (staff on duty 7.30 to 10pm), community alarm service, lounge, laundry, guest facilities, a garden, activities room and hairdressing salon. It has a good social activity programme and outings organised by support staff.[47]

- *Housing with Care* – such as the Fold Loughview Scheme in Holywood offers social rent housing and 24 hour residential care and support to frail elderly and dementia clients. It was built in 1992 and has 49 one and two bedroom flats. It oicludes wheelchair standard properties. It is a Housing With Care scheme (24 hours / 7 days), non-resident management staff and community alarm service. It also has a lift, lounge, dining room, laundry, guest facilities and a garden. It has regular social activities and new residents are accepted from 55 years of age

Oaklee Housing

Oaklee Housing highlighted Castlerocklands in Carrickfergus as a good example. It was opened in 2002 and is comprised of 12 two-bedroom self-contained apartments (lift access) and 14 two-bedroom bungalows. There are also communal facilities including a lounge and a communal kitchen to cater for social events. There are numerous activities at the scheme, including bingo, coffee mornings, inter-scheme visits, exercise classes and communal meals on special occasions. Just across from the scheme are shops, a gym, and restaurants.

Trinity Housing

Trinity Housing highlighted Elmgrove Manor in East Belfast (built in 2000) as an award winning good example of sheltered housing scheme that is well integrated into the local community. It is situated on the Beersbridge Road, Belfast opposite Elmgrove Primary School. Trinity Housing described Elmgrove Manor as "*a real hub of the community in*

[46] Spafield Fold, http://www.housingcare.org/housing-care/facility-info-6842-spafield-fold-holywood-northern-ireland.aspx

[47] Barn Halt Cottages, http://www.housingcare.org/housing-care/facility-info-158063-barn-halt-cottages-carrick-northern-ireland.aspx

East Belfast and the tenants are supported to be active in the community through various initiatives including intergenerational projects"[48].

The accommodation comprises of 27 one-bedroom one-person flats, 8 one-bedroom two-person flats and 2 two-bedroom two-person flats. The scheme has a resident Scheme Co-ordinator managing Old Manor House.[49]

4.4 Use of Technology for Assisted Living

In NI, the TF3 consortium is the current provider of a Remote Telemonitoring Service ('TelemonitoringNI') to NI. The consortium, comprises Tunstall Healthcare, Fold Housing Association and S3 Group and is the largest provider of remote telemonitoring solutions in NI.

The contract was awarded by the European Centre for Connected Health (ECCH) in the Public Health Agency of Northern Ireland and TF3 began implementation of remote telemonitoring services for people with heart and respiratory conditions, diabetes and those who have suffered a stroke, from March 2011.[50]

The contract provides remote telehealth monitoring services to patients suffering from chronic conditions and by January 2013, the service had benefited over 1400 patients with long-term conditions in NI, helping them to better manage their health. The service enables nurses to remotely monitor patients' vital signs such as blood pressure and weight on a daily basis in their own home, where previously they would have had to travel to their GP or hospital.[51]

The contract also provides for additional services such as Telecare to be implemented. More than 1700 users have benefitted from Telecare. This has been done within each Health and Social Care Trust area with different access pathways and delivery models ranging from users with long-term-conditions, dementia and learning and physical disability to supporting reablement.[52]

In another example of use of technology, Delivering Assisted Lifestyles Living at Scale (DALLAS)[53] is a UK programme aimed at transforming the lives of people through the use of innovative technology to improve well-being and increase independence. The programme is jointly funded by the Technology Strategy Board (TSB), the National Institute for Health Research and the Scottish Government. Through an open

[48] Personal Communication with Trinity Housing, Corporate Services Officer, 13th February 2014
[49] Elmgrove Manor, http://www.trinityha.org/housing-info/2009/10/20/elmgrove-manor/
[50] Northern Ireland Choses TF3 Consortium, http://www.tf3consortium.com/news/northern-ireland-chooses-tf3/
[51] TF3 supports Northern Ireland Connected Health and Prosperity Event at European Parliament, http://www.tunstall.co.uk/news/333/tf3-supports-northern-ireland-connected-health-and-prosperity-event-at-european-parliament
[52] Telecare NI Telecare and use of assistive technology / Department of Health, Social Services and Public Safety, https://webgate.ec.europa.eu/eipaha/initiative/index/show/id/216
[53] DALLAS Programme, Service in partnership, http://www.imerseyside.nhs.uk/Innovations/delivering_assisted_lifestyles_living_at_scale.aspx

competition, four partnerships (consortia) secured a contract with the TSB and have been tasked with running this large scale innovation programme and testing it with communities throughout the UK.

Liverpool's 'Feelgood Factory' was one of the successful partnerships that encourages people living in Liverpool to plan for their future in order to better manage their health and social care needs, supported by Life Enhancing Technologies (LETs.) The consortia partners include Liverpool Primary Care Trust, Liverpool Community Health, Liverpool City Council, Riverside Housing and on the technology side - Philips,Tunstall and Informatics Merseyside.

The Feelgood Factory aims to make better use of existing, and deploying further, telehealth equipment and using technology to design lifestyles and home environments around individuals to support them to live at home for longer.

4.5 Use of Proactive Healthcare in Sheltered Housing

One case study from NHS England highlights the good practice of Solent NHS Trust which provides on-site health clubs for residents of supported housing run by local health and social care teams. Solent NHS and NHS Southampton city worked with nursing management, residents, wardens, carers and other accommodation staff to set up each health club. The clubs provide proactive rather than reactive healthcare, offering treatment and advice in a non-clinical, friendly environment. Patients are monitored and given advice about medication, lifestyle and prevention of falls.

In 2010, the first health club set up was “responsible for a 50% reduction in GP visits and an 8% reduction in hospital admissions compared with normal case management. Improvements were shown in conditions such as chronic leg ulcers and hypertension and on average 10 district nurse visits were saved per week across all health clubs.[54]

Solent NHS Trust have been contacted by RaISe for current information on the health clubs.

5 Some Issues for Consideration

The Westminster All Party Parliamentary Group (APPG) on Housing and Care for Older People (HAPPI 2, 2012), highlighted their concern that more had not been done since the 2009 HAPPI Report but noted a range of obstacles to progress in the further development of specialist housing for older people, including[55]:

[54] Solent NHS Trust, Case Studies, www.institute.nhs.uk/case_studies/nhs_live/establishing_health_clubs_in_supported_housing.html

[55] Best, R. and Porteus, J., Housing our Ageing Population: Plan for Implementation, (November 2012) , All Party Group on Housing and Care for Older People, page 14

- Capital finance is harder to secure with reductions in grants for housing associations and greater difficulties for all providers in borrowing from banks and other lenders;
- In providing homes for sale, there are uncertainties about the market – prices must reflect the higher space standards and cover the costs of shared communal areas and the expense of acquiring sites for building close to local amenities;
- For social housing – maintaining suitable rents can be difficult due to extra service charges for communal facilities while alternative revenue streams (such as Supporting People grants) are harder to come by; and
- Welfare reform has brought uncertainties.

Clanmil Housing Association Ltd highlighted to RaISe one of its perceived current problems in NI regarding sheltered accommodation. The assessment of requirement for sheltered/supported living is carried out by the NI Housing Executive. Once a client is assessed as having such a need a place is sought in a sheltered housing development. The Housing Associations have no control over the type of client that they are required to house and are seeing an increase in the number of clients with complex needs, including not just older people with anything up to 5 packages of care in place, but also younger clients with addiction and mental health problems.

This means that sheltered accommodation originally designed with the independent older person in mind is becoming a 'catch-all' used to house those with many needs and this impacts on other residents (for example, noise due to care workers coming in and out 24/7). In addition, employees of the Housing Associations may not be equipped to provide services for those with such needs.[56]

[56] Personal Communication with Clanmil Housing Association Limited, 6th February 2014

Northern Ireland Assembly

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Dr. Lesley-Ann Black

Caring for an aging population 'at home or in assisted housing': TYC proposals

The most radical DHSSPS proposals to change how the health and social care system currently operates is known as *Transforming Your Care* (TYC).[1] In the original TYC publication (2011), the theme of 'older people' was listed as one of ten major areas of care requiring transformation. Key to the proposals is to ensure that older people remain at home for as long as possible. As housing and health outcomes are inextricably linked, this has implications for those on the edge of formal care in terms of adequately meeting their needs. Whilst a large proportion of older people will have no particular need for specialist housing or care services, and remain happily in their own homes, an increasing number with long term conditions, disabilities, and the growing number of frail elderly will require additional support services and specialised housing if they are to remain outside more formal types of care.

This paper explores these issues in more detail.

[1] See: DHSSPS website. Transforming Your Care (2011).

Contents

Key points

- Caring for the aging population is a complex, cross cutting issue. Historically, there has been a tendency to react to crisis events rather than preventative support. There remains heavy reliance on formal (residential and nursing home) care, and informal care in terms of the role of unpaid carers – such as family members.

- In Northern Ireland, between 2010 and 2025, the number of people over 65 is expected to increase by 40%, and the very elderly (people over 85) is expected to almost double. This means that more people will have long term illnesses and disabilities. This has implications for how, and where, people will be cared for.

- The majority of older people want to remain living in their own homes, and policies such as *Transforming Your Care* have attempted to reflect this vision. However, the concept of care at home and in the local community is not new; Policies like *People First* (DHSSPS, 1990) and the *Bamford Review* (DHSSPS, 2007) also reflected this vision.

- Older people are the largest group of users of community health and social care services in Northern Ireland. They account for one fifth of the DHSSPS budget - currently £700 million. But the issue of keeping people at home or in less formal types of care is further complicated because responsibility for many aspects of "housing" rests separately within the Department for Social Development (DSD) - which has its own budget.

- Furthermore, housing and health outcomes are inextricably linked. Good housing has a preventive role in terms of health. Yet research shows that older people are more likely to live in unfit housing. This can lead to physical and mental health problems, resulting in unnecessary hospital admissions, demands on A&E, and longer hospital stays.

- TYC's lists 'older people', as one of its key commitments. TYC seeks to reduce the number of older people in formal care. In the initial publication (2011), TYC stated that it wanted to help older people to live independently "**at home or in supported accommodation**." However, in TYC's follow up Strategic Implementation Plan the wording has evolved somewhat, to older living independently "**at home or in assisted housing**". These are two different concepts, and clarification is needed on the terminology. In addition, such a transformation will require significant investment. Yet there is little detail as to how this specific aspect of transformation will be achieved within the implementation plan.

- A range of other issues have also been raised in the paper. Whilst DSD and DHSSPS have given assurance that they are working closely together, a more strategic, joined-up approach between departments and a wide variety of other stakeholders is required if the transformation is to be realised; taking account of demand, projected demographics - now and the longer term, the location of older people, cost estimations, investment required, and of course, people's preferences in terms of care and support.

- Indeed, whilst a range of options are available to help people live independently, it also appears that better information is needed to raise awareness in the older population about what assistance and alternatives are (and will) be available.

1. Our aging population: implications on health

Northern Ireland has the fastest-growing population in the UK. At the same time, life expectancy is also increasing. Currently 15% (around 290,000) of the population is over 65.[2] Estimates suggest that between 2010 and 2025, the number of people aged over 65 is expected to increase by around 40%, and the number of very elderly (people aged over 85) is expected to almost double.[3] This unprecedented demographic shift, and rising levels of patient expectations, has huge implications on healthcare and how people will be cared for.

Whilst older people contribute significantly to our society and longevity is to be welcomed, the rate of ill-health and disability is likely to increase, and more people are likely to require support. Older people are not a homogenous group and their needs are diverse. Whilst many do not require support, it is true that the older population are more susceptible to a range of medical conditions such as dementia, osteoporosis, malnutrition, sensory disabilities such as reduced sight or hearing, risk of falls, and multiple long term conditions, such as coronary heart disease and Type 2 diabetes. Some will struggle with everyday tasks at home and, coupled with poor health, this can result in a decreased quality of life. For others, their health may deteriorate very quickly and can mean that suddenly, they are no longer able to remain at home.

2. Housing and health

Most older people in Northern Ireland live at home. In terms of tenure, nearly two thirds of pensioners in Northern Ireland own their own homes (owner occupiers), with over one fifth living in Housing Executive or Housing Association accommodation (social housing).[4] A key issue for many older people is that they may be asset rich and income poor, thus sustaining their home can become costly and can inadvertently lead to health problems.

Indeed, housing is a social determinant of health. Inadequate housing contributes to many preventable diseases and injuries[5] and leads to health inequalities. Poor quality housing can cause numerous physical and mental health problems which can result in unnecessary hospital admissions, demands on A&E, longer hospital stays and even death.[6] The housing-health link becomes even more important for older people who may be more prone to falls and susceptible to cold or damp. Moreover, appropriate housing is known to have a preventative role and is linked to better health outcomes.[7]

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[2] Public Health Agency Website older people in Northern Ireland - living longer and healthier. http://www.publichealth.hscni.net/news/older-people-northern-ireland-%E2%80%93-living-longer-and-healthier Website accessed 13.12.13.
[3] NISRA (2010) National Population Projection.
[4] NI Housing Executive: Older people housing policy. Review Action plan 2008-2010, p 7.
[5] World Health Organisation Regional Office for Europe (2012). Environmental Health Inequalities in Europe
[6] Royal College of Nursing (2012). Health inequalities and the social determinants of health, p6.
[7] Tinker, A et al (2013) Assisted living platform – the long term care revolution, pii. Available online at: http://telecareaware.com/wp-content/uploads/2013/10/HLIN_Report_LTC_Revolution.pdf Accessed 28.01.14.

The NI housing Executive has conducted a number of research studies on the issue of housing and older people.[8] For example, the research indicates that older householders in Northern Ireland are more likely to live in unfit accommodation and to experience fuel poverty.[9] However, there has been little research conducted recently on a local level in light of TYC - in terms of housing, health and the needs of older people.

3. Caring for the older population in Northern Ireland

In terms of caring for older people, historically there has been a pattern of reacting to acute events and crises, rather than proactive and preventative support.[10] Unsurprisingly, older people are the largest group of users of community health and social care services in Northern Ireland.[11] One fifth of the health and social care budget, currently 19% (£700 million), is allocated to meeting their needs.[12] In terms of assessing future needs, the Belfast Local Commissioning Group identified that an ageing population will lead to:

- Increased nursing home and elderly mentally ill (e.g. dementia) placements;
- Increased continuing care packages; and
- Increased emergency department attendances and admissions.[13]

3.1 Departmental responsibilities

Caring for our aging population is a complex and cross cutting issue which includes a mix of assessments and eligibility criteria, coupled with provision of services from a range of organisations such as the DHSSPS, DSD, the NI Housing Executive, housing associations and other private and voluntary sector organisations.

Figure 1 shows how, for example, the Department of Health Social Services and Public Safety (DHSSPS) and the Department for Social Development (DSD) are involved in directly supporting older people both in terms of care and accommodation.[14]

[8] NI Housing Executive: Research on housing and older people http://www.nihe.gov.uk/research_older_people
[9] Dr M Keenan for the Housing Executive (NI) 2011 Meeting the needs of older people: the provision of home improvement (care and repair) services in Northern Ireland, p2.
[10] Department of Health (2008) Making a strategic shift towards prevention and early intervention.
[11] Northern Ireland Executive Website (Oct 2012) : Framework aims to improve older people's services – Poots http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-october-2012/news-dhssps-041012-framework-aims-to.htm Accessed 30.01.14.
[12] HSCB Social Care Directorate Submission to the Review (October 2011) as cited in DHSSPS Transforming Your Care (2011), p 22.
[13] Belfast LCG population plan, p51.
[14] Diagram taken from 'Adult Care and Support' leaflet, DHSSPS website.

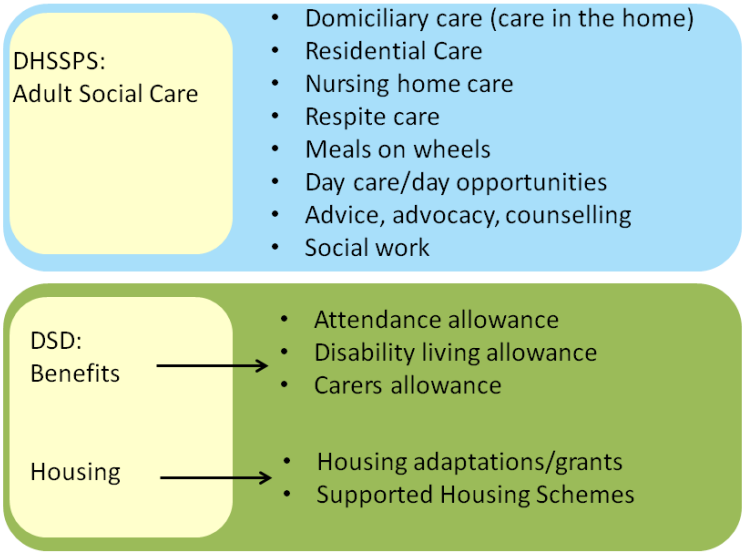

Figure 1. Roles of DHSSPS and DSD in the provision of older people's care

In order to understand the vision of TYC to help older people live independently at home for as long as possible rather than in more formal types of care, it is useful to briefly consider some of the main forms of care currently available (as shown in Figure 2 overleaf). These range from care at home through to more formal types of care.

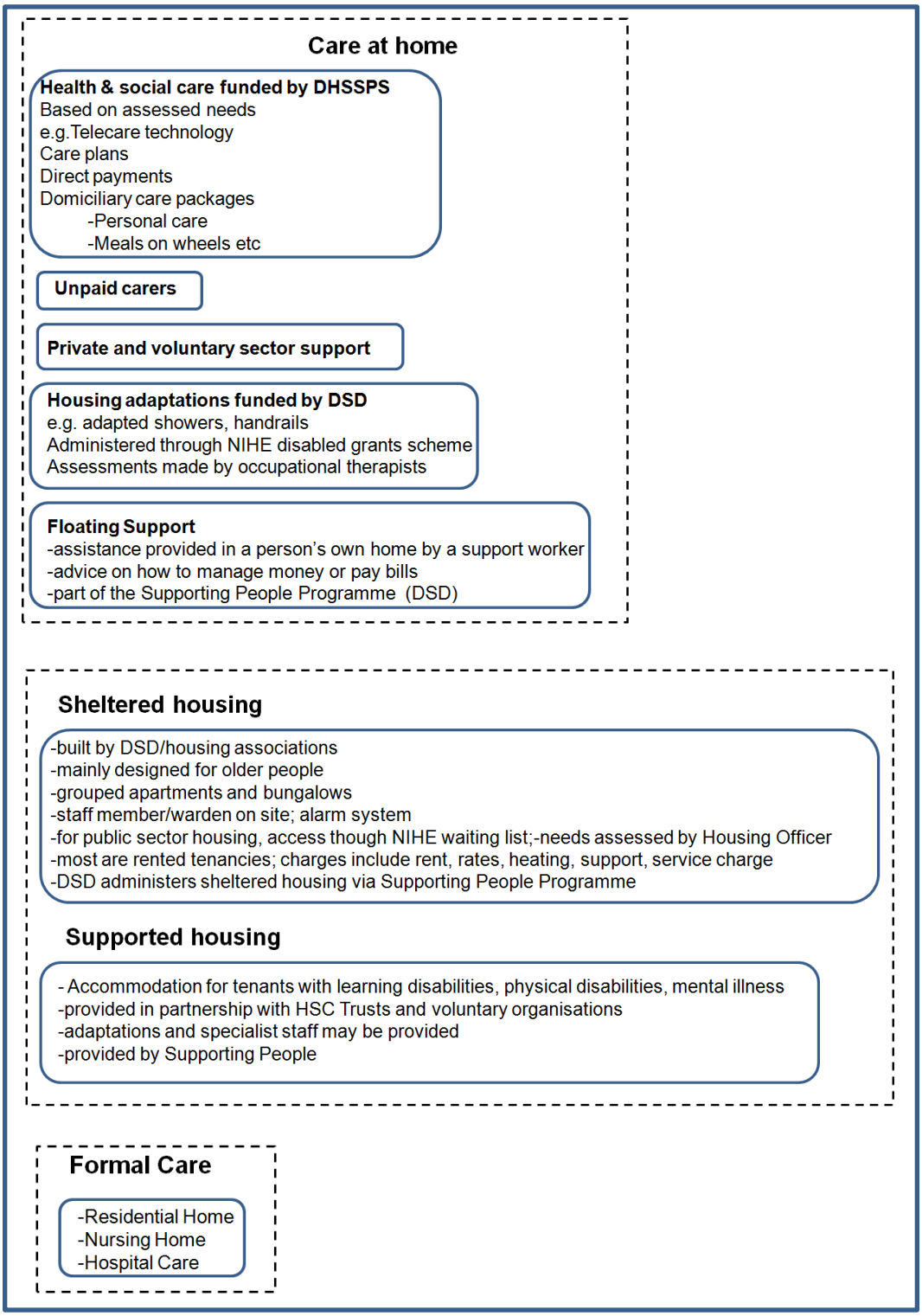

Figure 2. Some of the mains forms of care and support for the older population

4. Formal care

Currently, there continues to be high dependency on institutional (residential and nursing home) care for older people in Northern Ireland. According to TYC, almost

10,000 people aged over 65 live in nursing or residential care.[15] Likewise, hundreds of residential and nursing care homes for older people exist. The majority are run by private or voluntary organisations, with far fewer being run by statutory providers.

4.1 Nursing homes

Nursing homes provide 24-hour nursing care, mainly for residents with complex care needs. Figures show that *nursing* home packages have increased by 50% between 1999 and 2009.[16] Moreover, the proportion of older people living in nursing homes is currently 3.5 times higher than in England and Wales.[17] Yet Northern Ireland's *Patient and Client Council* (2013) states that "*there continues to be people within institutional care settings in Northern Ireland who could be receiving care in the home".*[18] The cost of nursing care (not including staying in the home itself) is funded by the Trusts at a rate of £100 per week. In addition, individuals are assessed as to whether they will need to contribute to the cost of their care.

4.2 Residential homes

Initial plans under TYC were to reduce the number of residential care homes.[19] Official figures suggest that since 2010/11, there has been a 15% decrease in the number of *frail elderly* in both statutory and independent residential homes.[20] According to the DHSSPS, this reflects a similar pattern across the UK. Reasons cited include greater availability of alternative forms of care - such as those provided by housing associations.[21]

In 2013, there was much controversy surrounding the possible closure of a number of *statutory* residential homes under TYC proposals. These plans have since been abandoned and, in November 2013, a new public consultation process was launched by the Health and Social Care Board entitled "*Making Choices: meeting the current and future accommodation needs of older people*."[22] However, the consultation does not include all statutory residential homes; instead 20 statutory homes run by the Trusts for the frail elderly (affecting around 284 residents) will be subject to the consultation, and may or may not be subject to closure. The consultation, which ends in March 2014, does not affect private or voluntary homes.[23]

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[15] DHSSPS (2011) Transforming Your Care, p59.
[16] DHSSPS Adult Community Statistics, 1998/99 at Table 3.2 and DHSSPS Adult Community Statistics, 2008/09 at Table 2.2
[17] Health and Social Care Board presentation. Available online at http://www.bgs.org.uk/powerpoint/spr13/orr_residential.pdf Website accessed 17.12.13.
[18] Patient and Client Council (2012) Care at home: older people's experiences of domiciliary care, p12.
[19] DHSSPS (2011) Transforming Your Care, p60.
[20] Health and Social Care Board (2013) Making Choices: meeting the current and future accommodation needs of older people, p 15.
[21] DHSSPS Transforming Your Care (2011), p 57. http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf Website accessed 12.12.13, p60.
[22] Health and Social Care Board (29 November 2013) http://www.hscboard.hscni.net/consult/Consultation-Care_Homes/Easy%20Access%20Document%20for%20Making%20Choices.pdf Website accessed 13.12.13.
[23] Health and Social Care Board (2013) *Making Choices: meeting the current and future accommodation needs of older people*, p 20.

4.3 Hospital Care

According to TYC, around 60% of acute hospital beds are occupied by people over 65, some of whom will be at the end stages of their life.[24] Many arrive on an unplanned basis, and, because there is no viable alternative in the community (or no domiciliary care package is available, or the proper adaptations have not been made) if deemed fit to return home, they can often face delayed discharge from hospital. Thus, older people tend to have longer hospital stays. Hospital care is also costly; in 2009/10, hospital care for older people accounted for around £115 million. Indeed, demand is also rising, and is likely to increase. Between 2006 and 2011, hospital admissions for older people increased by 18%.[25] In tackling these issues, TYC has endorsed a plan to introduce a re-ablement model across the province alongside better integration between hospital and community services.[26] Nevertheless, their efficacy to date is largely unknown and the re-ablement model has not been rolled out in all Trusts. In 2012 Age NI also criticised the DHSSPS for implementing different re-ablement models across Trusts, making it difficult to assess and compare approaches.[27]

5. Care at home

5.1 Role of unpaid carers

Many older people who require some form of care depend on the invaluable role of informal (unpaid) carers at home, through family members or friends. It is estimated that unpaid carers save the health service in Northern Ireland around £4.4 billion every year.[28] Yet research suggests that many of these carers are older people themselves, who find it increasingly difficult to cope physically, mentally and financially with caring responsibilities,[29] which often goes unrecognised. TYC acknowledges that more support is required for these carers.[30]

5.2 Role of domiciliary care

Those living at home or in a supported living environment that require additional support may be eligible for a domiciliary care package, if they satisfy certain criteria set by Trusts.[31] Domiciliary care varies from help with basic tasks like dressing or preparing meals, to intensive care, on a short or long-term basis.[32] Trusts must also decide whether or not to charge for the required service; however, the 'personal care' aspect of domiciliary care is currently free.[33]

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[24] DHSSPS (2011) Transforming Your Care, p59.
[25] DHSSPS (2011) Transforming Your Care, p61.
[26] DHSSPS (2011) Transforming Your Care, p62.
[27] Age NI (December 2012) Age NI's Response to the Service Framework for Older People, p6.
[28] Valuing Carers – Calculating the Value of Unpaid Care, Carers UK 2007 as cited in TYC (2011), p68.
[29] Alzheimer's Society: Carer Support
http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=546
[30] See TYC Vision to Action Post consultation Document, p40.
[31] DHSSPS (2010), Domiciliary Care Services for Adults in Northern Ireland 2010, p8.
[32] Patient and Client Council (2012) Care at Home Older people's experiences of domiciliary care, p10
[33] Response from DHSSPS to author. Response dated 20.12.13.

Domiciliary care can be delivered in the following ways via: statutory providers (operated by HSC Trusts), via independent providers (where Trusts have contracts with voluntary or private sector agencies), or via direct payments.[34] In 2012, 24,150 people were in receipt of Trust funded domiciliary care services in Northern Ireland[35] and around 6,000 clients over 65 were receiving "intensive" domiciliary care services (in other words, care for those with high level support needs). These figures do not take account of the number of families who purchase private domiciliary care.

In April 2011, the Health and Social Care Board set a target that at least 48% of care assessments recommend a 'domiciliary care package' rather than nursing or residential care to try to reduce admissions to formal care.[36] However, recent correspondence from the DHSSPS states that this target "*has been discontinued as it proved too intricate to measure due to the various different data collection systems in the Trusts*".[37]

Given recent financial cuts, a number of reports suggest that Trusts are now faced with restricting the amount of domiciliary care they can buy, and the price they will pay for it.[38] This has resulted in a shift away from the more general domiciliary services, such as 'housework' and 'meals on wheels' to a focus on priority duties like 'personal care'.[39] According to Age NI, the withdrawal of less complex domiciliary type services will result in significant health problems for those at the lower end of the care needs spectrum and will inevitably result in higher costs in the future.[40]

5.3 Sheltered and supported accommodation

RaISe paper NIAR 108-14[41] has provided a range of good practice examples of specialised grouped housing (from sheltered housing to retirement villages) and an overview of DSD's *Supporting People Programme* (which is administered by the NI Housing Executive). Supporting People helps vulnerable groups (including older people) to live independently in their own homes, sheltered housing or other specialised supported housing. It does this by funding a range of housing related support services, such as assistance with maintaining tenancies, providing advice, wardens, and by working in partnership with health and social care Trusts and housing associations, amongst others.[42]

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[34] These are cash payments in lieu of social service provisions, designed to increase choice and independence. They let the person being cared for (or their carer) decide how/by whom the service will be delivered.
[35] United Kingdom Home Care Association (Feb 2013) An overview of the UK domiciliary care sector, p3. http://www.ukhca.co.uk/pdfs/domiciliarycaresectoroverview.pdf p23. Website accessed 13.12.13.
[36] DHSSPS Transforming Your Care (2011), p 60. http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf Website accessed 12.12.13
[37] Response from DHSSPS to author. Response dated 9.01.14.
[38] United Kingdom Home Care Association (Feb 2013) An overview of the UK domiciliary care sector, p3. http://www.ukhca.co.uk/pdfs/domiciliarycaresectoroverview.pdf p26. Website accessed 12.12.13.
[39] Patient and Client Council (2012) Care at Home Older people's experiences of domiciliary care, p6.
[40] Age Concern Help the Aged NI (2009), One Voice: shaping our ageing society in Northern Ireland, Belfast: Age Concern Help the Aged NI, p46.
[41] Thompson, J. Specialised grouped housing for older people. NI Assembly RAISE briefing, 14 February 2014.
[42] NI housing Executive. The supporting people programme. Available online at: http://www.nihe.gov.uk/print/supporting_people_programme Website accessed 12.12.13

6. Policies and strategies concerning the care of older people

6.1 DHSSPS policies

Several policies have been developed in relation to older people's care. One of the first was the DHSSPS's '*People First: Community Care in Northern Ireland in the 1990's'*. Although it was developed over twenty years ago, it remains the main policy framework regarding community care. *People First* advocated that people should remain in their own homes for as long as possible instead of more formal types of care. A number of other strategies have been developed since *People First*, such as the *Caring for carers strategy* (2006),[43] *Living matters: Dying matters - A palliative and end of life care strategy for adults in NI* (2010)[44], the regional strategy for *Improving dementia services in NI (2011)*,[45] a *Living with long term conditions framework (2012)* [46] and a *Physical and Sensory Disability Strategy and Action Plan (2012-2015).*[47] In 2011, an *Older Peoples Service Framework*[48] which sets out a range of standards older people should expect was also developed. Whilst baseline indicators were outlined in the Framework, no comparisons about its effectiveness can been drawn to date.[49]

6.2 DHSSPS and DSD: Who cares? (2012)

In 2012 the DHSSPS and DSD jointly published a discussion document entitled "*Who Cares? The future of adult care and support in Northern Ireland*".[50] This document is intended to raise awareness about the growing pressures on the healthcare system, indicating that the way care and support is funded is likely to change and that people will have to make preparation for their future and contribute towards the cost of their care. In terms of accommodation provision, *Who Cares?* seems to acknowledge the role that residential and nursing home care will play in the future:

> *We also believe that we need a range of **alternative options** for people who can no longer be supported in their own homes, such as **supported housing**, which provides people with that little bit extra help and security, while at the same time enabling people to remain in as **domestic an environment as possible**. Residential care and nursing homes will continue to play an important role in supporting the most vulnerable in our communities.*

[43] DHSSPS (2006) see http://www.dhsspsni.gov.uk/ec-carers
[44] DHSSPS (2010) Living matters, Dying matters http://www.dhsspsni.gov.uk/8555_palliative_final.pdf
[45] DHSSPS (2011) Improving Dementia Services in Northern Ireland. Available online at http://www.dhsspsni.gov.uk/improving-dementia-services-in-northern-ireland-a-regional-strategy-november-2011.pdf Website accessed 15.1.14.
[46] DHSSSP (2012) Living with long terms conditions framework http://www.dhsspsni.gov.uk/living-longterm-conditions.pdf
[47] DHSSPS (2012) *Physical and Sensory Disability Strategy and Action Plan* http://www.dhsspsni.gov.uk/disability_strategy_and_action_plan_-_2012-2015.pdf
[48] DHSSPS (2011) Service Framework for Older People. Available online at http://www.dhsspsni.gov.uk/service_framework_for_older_people-2.pdf Website accessed 15.1.14.
[49] DHSSPS (2011) Older People's Service Framework http://www.dhsspsni.gov.uk/showconsultations?txtid=59058
[50] DHSSPS website. Who cares? (2012) http://www.dhsspsni.gov.uk/who-cares-future-adult-care-support-ni-discussion.pdf Website accessed 12.12.13.

The second stage of the consultation process entitled the *Reform of Care*[51] will include proposals for reform and how care and support is funded.[52] Following this, a *Final Strategic Document* - setting out the agreed future direction of care reform for Northern Ireland is due to be implemented.

6.3 OFMDFM – Older People's Strategy (currently in draft form)

The Office for the First Minister and deputy First Minister (OFMDFM) has overall responsibility for developing a cross-cutting older people's strategy. However, their previous strategy, entitled *'Ageing in an Inclusive Society'* (2005), was criticised by the age sector who felt that "*there needed to be a clearer connection between older people's priorities and delivery programmes in a range of policy areas such as health, housing and transport*."[53] In 2009, Age NI reviewed the strategy and criticised it for lacking in targets and not meeting its objectives.[54]

Given the gaps in the previous OFMDFM strategy, a revised strategy '*An active aging strategy for older people'* is in development in association with the Age Advisory Panel (comprising of a large number of older citizens and chaired by the Commissioner for Older People in Northern Ireland).[55] The strategy includes seven key topics, one of which specifically relates to the 'Health and Social Care' of older people. Yet concerns have been raised by the NI 'Pensioners Parliament'[56] namely that proposals are vague, there exists a lack of clarity how changes can be implemented, and whether sufficient funding will be available for the elderly to support the anticipated levels of community care required. A consultation on the draft strategy is intended to lead to final proposals being published later in 2014. Yet to date, Northern Ireland remains without an older people's strategy in place.

7. TYC –'home' as the hub of care and support

Central to this paper is TYC, the review of health and social care published in 2011.[57] A key element of TYC is a "shift left" from acute hospital-based care towards a model of care that is delivered closer to people's homes whereby healthcare services are accessible through primary settings and in local communities.[58] TYC states:

> *Ultimately, older people want to **stay at home**, living independently for as long as possible, and the current model of care does not always provide the support needed to do so. Too often, this results in **reliance on institutional care** with*

[51] Response from author to DHSSPS. Response dated 20.12.13.
[52] Response from author to DHSSPS. Response dated 20.12.13.
[53] OFMDFM (2005) Ageing in an Inclusive Society http://www.ofmdfmni.gov.uk/ageing-strategy.pdf Website accessed 15.1.14.
[54] Age NI (2011) Briefing Paper for OFMdFM Committee: Older People's Strategy, p 2.
[55] Currently Claire Keatinge. See OFMDFM website http://www.ofmdfmni.gov.uk/index/equality/age.htm Website accessed 15.1.14.
[56] Summary report (2013) Response of the NI Pensioners Parliament to the OFMdFM Presentation on the Draft Active Ageing Strategy http://www.ofmdfmni.gov.uk/pensioner-parliament-response-draft-active-ageing-strategy.pdf
[57] DHSSPS (2011) Transforming Your Care. Available online at http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf Website accessed 31.1.14
[58] Ibid p22.

> ***crisis intervention*** *as the order of the day. This is not consistent with a shift to the wellbeing model the public expects.*

It then goes on to say:

> *The Review supports the trend towards* ***independent living – at home or in supported accommodation*** *– and expects to see a very significant reduction in provision of long-term residential places in the next five years.*

Following the publication of TYC, a public consultation entitled *TYC - Vision to Action* followed.[59] Views of respondents were set out in a *Post Consultation Report*. Regarding older people's care, the following themes emerged from respondents[60]:

> *"There must be choice in the models of care available because people's needs are different. For some older people, care closer to home may not be suitable to meet their needs, considering their health and social circumstances."*
>
> *"It will be essential to invest in services such as flexible respite (for carers), rapid access to health and social care support and domiciliary packages if we are to help more older people to live independently."*
>
> *"Many older people cannot manage at home but do not require intensive nursing support therefore there is a need for residential care until Trusts or housing associations can provide supported living alternatives."*

From the post consultation, it was agreed that a draft Strategic Implementation Plan would be updated and to reflect the responses. In turn a final *Strategic Implementation Plan* was produced in October 2013 which sets out the transformation process over the next 3-5 years.[61]

According to the Plan, the transformation of services will result in funding being moved from the current 'hospital services budget' and reinvested into primary, community and social care services. TYC identifies a 5% reduction in the hospital services budget by 2014/15 – which will equate to a recurrent shift of resources of around £83 million per annum.[62] The Plan cautions that operational planning and consultation may impact on the timing of the anticipated outcomes, which will continue to be reviewed, which could speed up, or slow down implementation.

[59] TYC Vision to Action Consultation document: Available online at http://www.tycconsultation.hscni.net/wp-content/uploads/2012/10/TYC-Vision-to-Action-Consultation-Document.pdf Website accessed 31.1.14
[60] TYC Vision to Action - Post Consultation report, pp59-63.
[61] Health and Social Care Board (2013) TYC Strategic Implementation Plan final version. http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Transforming-Your-Care-Strategic-Implementation-Plan.pdf
[62] Health and Social Care Board (2013) TYC Strategic Implementation Plan final version, 27.

The Plan describes a model of delivery for local services - both at home and in the community via 17 Integrated Care Partnerships (ICPs).[63] ICPs have chosen to focus initially on pathways for 'frail elderly' and long term conditions for all ages,[64] as shown in Figure 3.

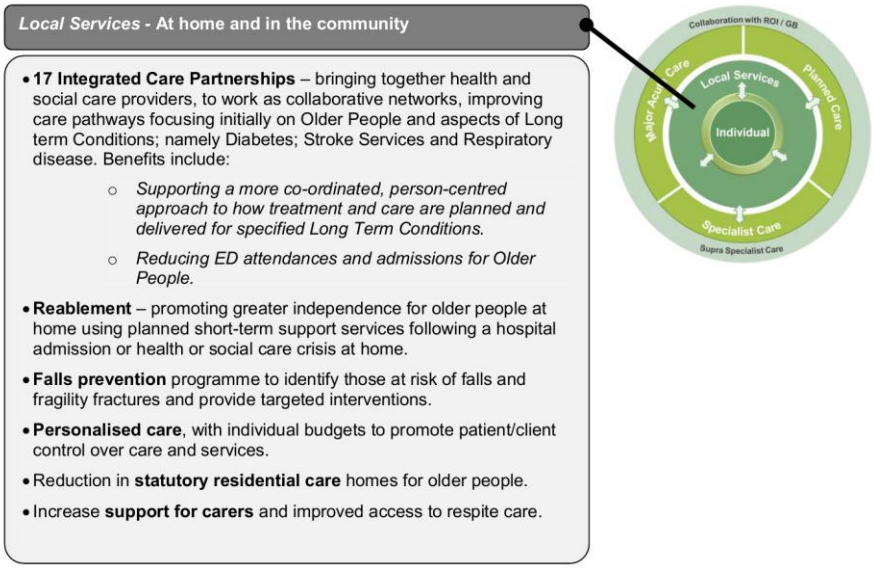

Figure 3. TYC proposals for local services- at home and in the community[65]

The Plan also lists 17 'key commitments' in terms of deliverables, the second of which concerns 'older people'. The section on older people contains a number of goals:

- To maintain people in their own home or assisted housing
- A significant change and benefits such as a reduction in admission from falls.
- Introduction of re-ablement, and, as a result, for example, a reduction in new referrals for domiciliary care (please note, however re-ablement is only a short period of intense help, whereas domiciliary care can be much longer term).
- Improved support and respite for carers
- Improvements in access times for cataract and audiology services
- Implementation of a dementia strategy
- Services will develop safeguarding in line with policies and procedures.[66]

The first goal of the older people section is of interest to this paper. The wording states it will:

> *"Support older people and those with long term conditions to maintain their own independence and manage the functions of daily living in their* ***own home or assisted housing****, as* ***opposed to in an acute setting or long term care****."*[67]

[63] ICPs are collaborative networks of care providers; doctors, nurses, pharmacists, social workers, hospital specialists, other healthcare professionals and the voluntary and community sectors, and service users. Each ICP is based around natural geographies of approximately 100,000 people.
[64] Health and Social Care Board (2013) TYC Strategic Implementation Plan final version, 35.
[65] Health and Social Care Board (2013) TYC Strategic Implementation Plan final version, p6.
[66] Health and Social Care Board (2013) TYC Strategic Implementation Plan final version, pp37,38.

However, there is no further detailed information attached to this goal as to how this will be achieved, but one would assume it will involve elements of those listed above and partnership working with a range of organisations. It is also important to highlight that the wording of the original TYC review (2011) advocated that it *"supports the trend towards independent living – at home or in* ***supported accommodation.****"* This wording has evolved somewhat in the strategic implementation plan goal to "*in their own home or* ***assisted housing.****"* No definition of assisted housing is provided, and these are different concepts. It is unclear if "assisted housing" is taken to incorporate supported accommodation (which typically represents a group of housing accommodation for people with more intensive needs) whereas, "assisted housing" is more likely to refer to services in the home like housing adaptations or telemedicine technology. Further clarity on this is needed.

The Plan goes on to talk about the need to raise awareness of alternatives to residential care:

> ***Community-based alternatives to residential care*** *are increasing all the time, and there is a need to ensure that the* ***availability and functioning of these is more widely known*** *so that people can see the different styles of independent living that it is now possible to offer to older people, where the traditional response would have been to offer a residential placement. Due to improved availability of these types of community-based alternatives, it is expected that demand for statutory residential homes will further decline.*

7.1 TYC Local Commissioning Group (LCG) population plans

As part of TYC, local commissioning groups (LCGs) in each of the five HSC Trust areas also produced population plans for their region to highlight current and projected needs, outcomes, deliverables and the overall finances required for transformational change between 2012-2015.[68] These plans include details on housing for the older population (and other groups, such as those with disabilities), however the terminology in the plans ranges from 'supported housing', 'supported living', 'sheltered housing', and 'assisted housing' in the context of older people.

For example, the Belfast LCG plan lists one of its 'prioritised initiatives' is to "*extend supported housing and assistive technology for more dependent clients*". [69] It also talks of "*a substantial reduction in residential care and long stay care in hospital, offering supported housing as an alternative to institutional care*".[70]

The Northern LCG population plan describes further partnership with the NI Housing Executive, and an "*increased focus on the use of technology in delivering home based*

[67] Health and Social Care Board (2013) TYC Strategic Implementation Plan final version, p36.
[68] All five plans are available on the HSC Board website http://www.transformingyourcare.hscni.net/consultation/
[69] Belfast LCG Population plan. http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Belfast-LCG-Locality-Pop-Plan-September-2013.pdf, p51.
[70] Ibid, p31.

services (such as telehealth and telecare solutions)"[71] *and supported living accommodation available to older people*" and "*better use of sheltered housing and alternative services"* with *"continued need for nursing home provision*".[72]

The South Eastern LCG links older people to its re-ablement service, established in 2012 stating, "*This service aims to support older people to maintain their own independence and manage the functions of daily living in their own home or assisted housing, as opposed to in an acute setting or long term domiciliary care*."[73]

The Southern LCG states in its plan: "*The preferred future model for those people who require residential support will be through a range of provision methods, and as part of this, we will work with Supporting People Partnership / NIHE to develop business cases for supported housing for older people. It is expected that in future there may be no statutory residential homes in the area*."[74] It goes on to say that one of the enablers will be the availability "*of 'Supporting People' funding through NIHE and efficient processing of business cases via DHSSPS to achieve full implementation of the resettlement programme and alternative options for statutory residential care*."[75]

Likewise, the Western LCG states that it will develop "*Housing with care options for older people*" focusing on dementia options. Under its prioritised initiatives, it states that it will "*reduce residential care placements with a view to cease residential care provision*".[76] It also states that in partnership with the NI Housing Executive and independent sector, it will *"maximise adapted housing models, further develop floating support and peripatetic services to maintain people in the community*."

The population plans provide general costing information, but more detailed costing estimates are missing in terms of projections for keeping older people at home. Only one Trust (South Eastern HSC Trust) mentions "assisted housing", referred to in the Strategic Implementation Plan in the context of older people.

It would also be important that a holistic approach is adopted in terms of planning services and facilities to avoid the gaps that may lead to some services being available in certain Trust areas but not others.

7.2 Population projections

Another important aspect of housing and the older population is to look more widely at where the greatest rate of growth will be (see Figure 4). In addition to NISRA

[71] Northern LCG population plan, section 3.4 http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Northern-LCG-Locality-Pop-Plan-September-2013.pdf, p11.
[72] Northern LCG population plan, section 3.4 http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Northern-LCG-Locality-Pop-Plan-September-2013.pdf, p49.
[73] South Eastern LCG population plan, http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/South-Eastern-LCG-Locality-Pop-Plan-September-2013.pdf, p31.
[74] Southern LCG population plan, p31. http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Southern-LCG-Locality-Pop-Plan-September-2013.pdf
[75] Ibid, p72.
[76] Western LCG population plan http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Western-LCG-Locality-Pop-Plan-September-2013.pdf, p44

projections for the older population, research from the NI Housing Executive suggests that between 2006-2016, there will be higher rates of growth in the over 55 population in the south and west of Northern Ireland (much of which is rural) which is projected to increase by over 25%, whereas growth in this age group is only projected to increase by 3% in Belfast.[77] This also has implications in terms of *where* facilities and services are built or located. Further research is needed in terms of the projections on a longer timescale, and particularly projections in the over 85 age group, in order to adequately plan where the greatest need is likely to be in the future.

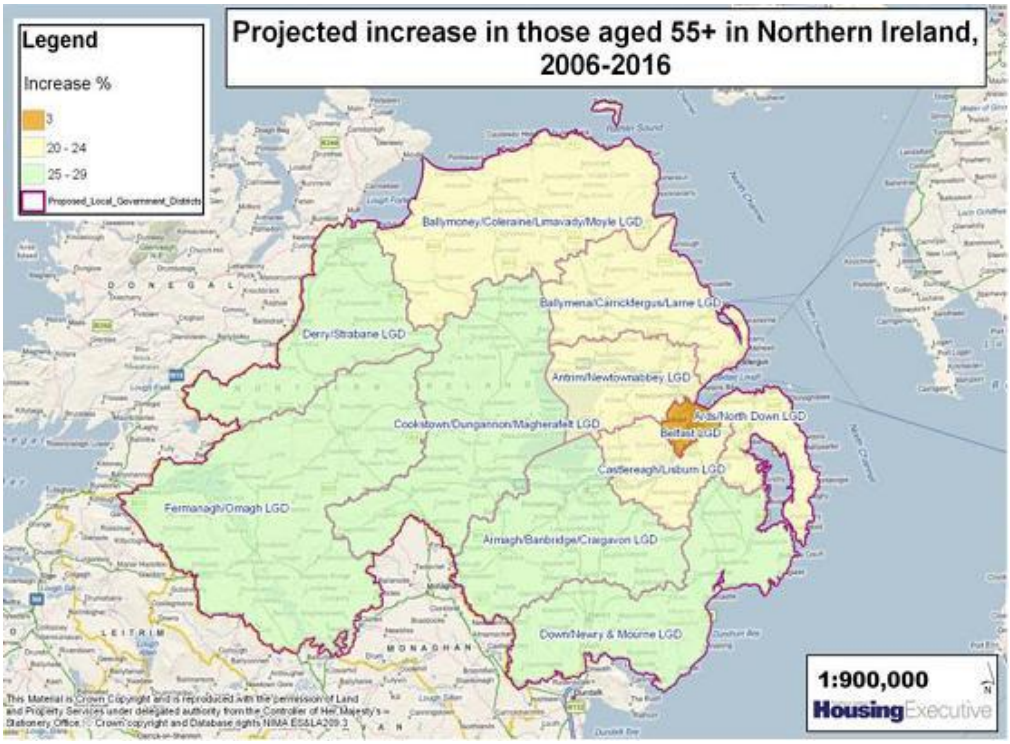

Figure 4. Projected increase in over 55s (2006-2016) (NI Housing Executive)

8. Committee evidence

The HSSPS Committee heard evidence from DHSSPS and Health and Social Care Board officials on assisted living options for older people in the context of TYC. Officials briefed members on a range of initiatives for older people. However, the evidence session also identified a number of gaps in terms of information. For example, officials were not able to provide information on the number of supported living units to be built for older people, as this was incorporated in data for other clients, such as those with learning disabilities. Information on the Supporting People budget in the next few years was also not available, as this information falls under the remit of DSD.

Officials did report that the DHSSPS had spent £3.7 million on supported accommodation for older people in the previous year. Yet there was no indication of future spending levels, and it was explained that some Trusts do not report this data in

[77] Joe Frey, Head of Research NIHE presentation at CARDI Housing and aging event, February 2014

a uniform way (for example, some Trusts report this within their domiciliary care budgets).[78] Members voiced concerns over many of the gaps, but were informed by officials that Ministers in DSD and DHSSPS have recently asked their officials to work better together on this issue - including the sharing of information.

9. Written responses by DHSSPS

The author recently contacted the DHSSPS about their views on the older population in relation to the TYC proposals. Firstly, the DHSSPS was asked to explain the definition of assisted/supported accommodation, and what this encompasses:

> *Assisted living or supported accommodation, within the Government's Supporting People Programme, aims to help vulnerable people to live as independently as possible in the community. The programme established the means to manage accommodation on a partnership basis and to strategically commission housing related support services that aim to tackle social exclusion by preventing crisis and more costly service interventions. It plays an important role in the continuum of care by providing an environment for people who cannot live independently in their own home but who may not yet require the additional personal or clinical inputs required in residential and nursing care.*

The DHSSPS was asked if this support ranges from community bungalows to alarm systems, and if different models of supported/assisted living exist:

> *There is a continuum of housing related support for older people. This provides a range of options and choices for older people relevant to their need. For example, an older person who has low to moderate support needs may be able to live in their own home with support from family, friends, befriending services, and electronic assistive technology. Floating support services, funded by Supporting People, provide information, advice and help, for example, someone to support people to manage their money and pay their bills and this can be provided in a person's own home and in supported living accommodation. These do not provide personal care. Trusts can provide a range of services including personal care to those who have been assessed as having more complex needs.*[79]

The DHSSPS was also asked how people would be supported "to live independently in their own home or in **assisted housing**".

> *Following assessment, a range of health and social care services appropriate to need are available, such as re-ablement, intermediate care, respite, day care, direct payments, specialised nursing services, allied health professionals, telecare, care assessments and care pathways, community development initiatives (befriending schemes) and Supporting People initiatives.*

[78] HSSPS Committee evidence session with DHSSPS and HSC Board Officials 26.2.14.
[79] Personal correspondence between DALO DHSSPS and author. Response dated 17.2.14

A profile of the number of supported accommodation/assisted living providers in Northern Ireland was also sought:

> *Across Northern Ireland there are 28 different service providers (5 statutory, 14 Housing Associations and 9 voluntary) providing housing support services to older people in over 400 services.[80] The total capacity of all the accommodation based services is approximately 10,000 clients, with the vast majority of the services nearly or fully occupied. There may be waiting lists for individual services.[81]*

The DHSSPS was also asked what grants are available to older people to help them remain in the own homes/supported living accommodation?

> *There is a range of floating support services available to older people in their own homes. Floating support providers can also signpost older people to other services and grants available to them.*

In terms of contracting out work to providers (e.g. alarms, handrails), the DHSSPS was also asked if they have a role in this. They replied:

> *The Social Housing Development Programme is administered by DSD NIHE and delivered by Housing Associations.*

The DHSSPS was also asked what finances/resources have or will be put in place if the level of supported living increases, especially for older people. However the DHSSPS response to this appears rather vague as the ring fenced monies is likely to have been as a result of the resettlement agenda stemming from for example ringfenced monies linked to the Bamford review:

> *To date, specific ring fenced finance has been made available by DHSSPS to advance projects for people with a learning disability or mental illness in order to resettle them from specialist hospitals. This funding complements the capital and support money provide by Supporting People to develop projects on a collaborative basis. Projects for older people and people with disabilities have been funded by reprovision of existing resources within these programmes.*

The DHSSPS was also asked how older people become aware of the option of assisted/supported accommodation and what is being done to raise awareness of this as an option?

> *NIHE district offices can refer to sheltered/supported accommodation. Regional complex needs officers can identify needs of housing applicant in partnership with Social Services. Information is also available on the Supporting People website, the HSC Trusts' Intranet (e.g. Barn Halt Cottages) and information*

[80] These figures represent the combined total of sheltered housing, frail elderly and dementia schemes
[81] Personal correspondence between DALO DHSSPS and author. Response dated 17.2.14

leaflets and also contact with relevant HSC professionals/practitioners. Health and Social Care professionals may also identify the need for a supported living option on the basis of their assessment of a person's need for support.

Finally, the DHSSPS was asked what role the Supporting People initiative has in TYC – has DSD/NIHE been in contact about the TYC strategic implementation plan proposals and what joint progress has been made to date?

Staff from the Health and Social Care Board and Trust are in regular contact with Supporting People/NIHE/DSD colleagues on a wide range of issues. The Supporting People Commissioning Body is the primary vehicle for progressing supported living developments across Northern Ireland and has well established joint planning arrangements. Regular meetings also take place with DSD which have focussed on a range of issues including the proposed reduction/withdrawal of Special Needs Management Allowance and its potential impact on services. Communication between the relevant parties has been both open and productive.

For illustrative purposes, the DHSSPS also provided an example of how someone is assessed for a particular tenancy. The example given was for Barn Halt Cottages in Carrickfergus, and this is provided in Appendix 1.

10. Discussion

As the policy intention is to keep older people at home (including those who are frail) for as long as possible with a reduction in formal care, there is a need to ensure community care and support services are adequate, strategic, and joined-up. As housing and health are administered by different departments, this adds to the complexity. In addition, DSD's *Supporting People Programme, which is one aspect of* helping people live independently, is currently under review. Furthermore, as over 70% of older people in NI are currently owner occupiers, it may be more difficult for this group to access grants, and social housing schemes, such as those administered by the Housing Executive, may not be their preferred choice of accommodation.[82]

The outworking's of TYC could also mean that there are more elderly people, possibly with poor health, living alone due to personal circumstances. This also presents new challenges in terms of reducing risk of injury, vulnerability, pressures on services and budgets for example, domiciliary services and the quality of care, and public health issues like loneliness and isolation.

Advocates suggest that any future model must promote independence and place the older person centrally as their own designer of care - with suitable options available

[82] Personal correspondence between author and Age NI on 4.3.14.

and people made aware of the choices available.[83] In addition, prevention of crises will be a key component to the success of any new model.

11. Some potential issues for consideration

- Population projections and the location of older people are vital to TYC, especially in the longer term.
- Future needs and demands for different housing options is difficult to predict and quantify, however we do not know whether provision is currently sufficient, nor the extent of unmet need. It is difficult for Health Trusts to accurately predict targets for older people in relation to their future housing needs.
- There is limited information and research on older people's housing preferences and their health outcomes in Northern Ireland. Likewise, there may be, for example, rural communities in Northern Ireland where choice in terms of supported accommodation is inadequate.
- There is some confusion regarding the TYC terminology “supported accommodation” and “assisted living”. Clarity is needed on these distinct terms.
- There is little detail in the TYC Strategic Implementation Plan in terms of “how” older people will be assisted to "remain at home or **in assisted housing**". The vision of TYC could appear somewhat aspirational, with no longer term plan beyond 3-5 years.
- DSD and NIHE were not involved in the development of TYC.
- There are implications regarding constraints within the health and social care budget, as keeping older people at home will require much more investment. There are no detailed or estimated costings for this available.
- It is difficult to ascertain if the risk of crises will be averted under the model proposed in TYC. For example, it may be insufficient to support someone who is particularly frail and living alone in their own home with a series of daily domiciliary care visits.
- A concern highlighted by DSD and DHSSPS is the impact misalignment of funding streams may have on the joint commissioning process. Trust funding is allocated on a yearly basis, whereas DSD budgets are aligned with Comprehensive Spending Reviews (every 3 years). This can create challenges in terms of future planning and further work is required to realign funding for jointly commissioned schemes. The misalignment of funding was one of the factors leading to a case that attracted much media attention – ‘Gnangara’ in Enniskillen – a state of the art dementia scheme commissioned jointly by DHSSPS and DSD and brought forward through DSD.[84] However the original needs assessment carried out by the Western Trust was no longer applicable when the scheme was complete. This led to underutilisation (places not filled). These types of issues have made housing associations more tentative to commit to future housing projects that are jointly commissioned.

[83] Tinker, A et al (2013) Assisted living platform – the long term care revolution, pi. Available online at: http://telecareaware.com/wp-content/uploads/2013/10/HLIN_Report_LTC_Revolution.pdf Website accessed 28.01.14.
[84] Via DSDs Social Housing Development Programme

- If care is delivered in a supported housing environment, it could mean that the current model of residential care in institutions is being moved to smaller supported housing schemes instead, where the intention for older people to live independently in a place that is considered their own home is not being achieved.
- There also appears to be mixed emphasis in terms of policy direction - for example, there is an indication that there will be a "reduction in residential care" (as cited in TYC), whereas in others, it is indicated that "residential care will continue to play an important role in supporting vulnerable people." (*Who Cares?* DHSSPS).
- Questions remain over how care "at home" will be regulated and governed in the future, and the quality of this care. There are also implications in terms of Welfare Reform which need to be further explored.

12. Conclusion

TYC has identified older people as a key area requiring transformation. Housing is a crucial ingredient in enabling older people to live comfortably and independently at home or in community based alternatives. Whilst TYC advocates the home as the hub of care and support, there is little evidence of what the costs for this will be, if crises can be averted, or if there will be better health outcomes by keeping people at home or in supported living with various types of support.

Currently a range of stakeholders are involved in the complex mesh of care and accommodation for older people, however, more joined up, strategic planning between government departments, the Housing Executive and other private, voluntary and community organisations is warranted, if this key aspect of TYC is to be realized. Whilst demand may be difficult to predict, given population projections, we know that a growing number of older people will need support in the future and that the current budget will not be sustainable. Sufficient investment in health (and the promotion of health aging) and housing is key to success, as is a range of choices for older people, and age appropriate ways to raise awareness about the choices available.

Appendix 1. Barn Halt Cottages[85]

The DHSSPS was asked to provide an example of the assessment process for a tenancy for frail elderly people. The example they have provided relates to Barn Halt Cottages, Carrickfergus which was built specifically for this group. This scheme is provided by Fold Housing Association.

Assessment Process:

- The person applies by completing a Housing or Transfer Form as appropriate.
- NIHE Complex Needs Officer links with the NHSCT's Senior Practitioner who asks the appropriate social worker/named worker to carry out the assessment with the applicant.
- The completed assessment is returned to the NIHE Complex Needs Officer.
- The Allocation Panel in Barn Halt consists of NHSCT, NIHE and Housing Association representatives, who meet to discuss the applications.
- Applicants need to have at least 10 hours of care and support needs.
- The Allocation Panel meets monthly and prioritises any waiting list.

The assessment includes the applicant's background, events leading to the application, physical and sensory impairments, mental health needs (memory, cognition, and dementia), mobility (including the receipt of DLA/Attendance Allowance), and current care/support arrangements.

The typical costs associated with Barn Halt Cottages are as follows:

1 person (1 bedroom)	2 person (2 bedrooms)	3 persons (2 bedrooms)
Basic rent £53.63 Service charge £29.97 Rates £ 7.59 Support charge £175.24	Basic rent £60.55 Service charge £34.47 Rates £ 8.57 Support charge £175.24	Basic rent £62.28 Service charge £34.47 Rates £ 8.81 Support charge £175.24
Total £266.43 per week	Total £278.83 per week	Total £280.80 per week

The DHSSPS has also advised that if a person is assessed as being entitled to Housing Benefit, then they may have their rent paid for them fully or partially depending on their financial situation. The vast majority of people who reside in supported living accommodation receive Housing Benefit which also means that their Housing Support costs are covered, so they do not pay this charge.[86]

[85] Personal correspondence with DHSSPS and author. Response dated 17.2.14
[86] Personal correspondence with DHSSPS and author. Response dated 17.2.14

Appendix 5

Letters to HSC Trusts and responses regarding promotion on websites

Committee for Health, Social Services and Public Safety

Mr Martin Dillon
Interim Chief Executive
Belfast Health & Social Care Trust

3 July 2014

Dear Mr Dillon

Review of Transforming Your Care and Older People – role of supported living

On 12 March 2014, the Belfast Trust gave evidence to the Committee on its review of supported living in the context of TYC.

One of the themes explored with the Trust was the promotion of supported living.

At its meeting on 2 July, the Committee considered the information on the Belfast Trust's website (on 30 June 2014). The Committee noted that the section entitled "Supported Housing for Older People" refers to Fairholme, Sydenham Court and Mullan Mews. However, no reference is made to Hemsworth Court which the Trust advised the Committee was also a supported living facility. The Committee notes that Hemsworth Court is listed in a separate section of the website under "Residential homes for the elderly".

The Committee requests an explanation as to why Hemsworth Court was not included within the section of the website entitled "Supported Housing for Older People". It also requests the Trust's view on whether it believes that the current listing of Hemsworth Court under "Residential homes for the elderly" is consistent with good promotion of Hemsworth Court as a supported living facility, particularly given the difficulties in securing occupancy for that facility.

I would be grateful for a response within 10 working days of receipt of this letter.

Yours sincerely

Kathryn Aiken

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Kathryn Aiken
Clerk, Committee for Health, Social Service and Public Safety

cc. Jonathan Bill, DHSSPS

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Belfast Health and Social Care Trust

Trust Headquarters
A Floor, Towerblock
Belfast City Hospital
Lisburn Road
BELFAST
BT9 7AB

15 July 2014

Ms Kathryn Aiken
Committee for Health, Social Services nad
Public Safety
Room 410, Parliament Buildings
Ballymiscaw
Stormont
BELFAST
BT4 3XX

Dear Ms Aiken,

Review of Transforming Your Care and Older People – Role of Supported Living

Thank you for your correspondence dated 3 July 2014 and thank you for drawing to our attention the error on our website in respect of Hemsworth Court, this now been corrected.

I can advise the Committee that soon after Hemsworth Court became available for occupancy in July 2013 the Trust initiated and established a service optimisation group to fully promote and secure the integration of Hemsworth Court into the wider Shankill Community. The Trust Co-chairs this with Helm Housing.

Membership of the group includes:

- Tenant and Carer Representation
- Local Churches
- Community groups
- Local Schools / Colleges
- Alzheimer's Society
- Community policing
- Local library and leisure centre

The purpose of the group is to optimise the scheme as a community resource through a range of activities to encourage the local community to access the scheme thereby facilitating community development and enhancing the quality of life of tenants (*see example of this in attachments*). This also serves to promote interest from local people to explore this option for themselves or family members.

The Trust is also working in partnership with the Alzheimer's Society in developing a dementia friendly community initiative in the Shankill Road area, raising awareness and understanding of the condition and the services available to support people.

Furthermore the Trust's management team for Hemsworth Court is working continuously to promote the scheme both within health and social care teams and with the wider community.

At this point in time Hemsworth Court, which has 35 flats in total, has occupancy of 25 tenants with plans in place for full occupancy by September 2014.

It is important to highlight that the process of securing tenants for dementia schemes requires a lead-in period of time as each prospective tenant needs considerable time for the life-changing assessment and decision making process involved including:

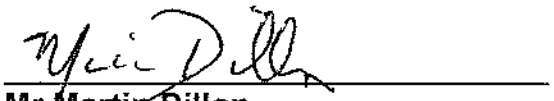
- Ensuring people are at the appropriate point of the condition to ensure they can fully benefit from the model of support
- Considering all aspects of the financial implications for each tenant, including benefit checks
- Selling or moving on from current property
- Family consultations

I would like to emphasise that Belfast HSC Trust does not view Hemsworth Court as a facility we have difficulties securing occupancy for.

I trust this information provides the Committee with the reassurances it seeks.

I would also like to take this opportunity to extend an invitation to the Committee to visit Hemsworth Court at any time.

Yours sincerely



Mr Martin Dillon
Interim Chief Executive

Att.

community arts partnership

connecting creativity and community

3-5 Commercial Court | Belfast | Northern Ireland | BT1 2NB
tel: +44 (0)28 9092 3493
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Press Release

Community Arts Partnership* launches, "Community Arts and Dementia"

The Community Arts Partnership, the organisation at the forefront of the promotion, development and delivery of community arts practice in Northern Ireland, launched a new report today, "Community Arts and Dementia" at the Belfast Trust's supported housing facility, Hemsworth Court .**

The report, funded by CAP's principal funder the Arts Council of Northern Ireland***, emerged from evaluative processes applied to community arts projects, facilitated by the Community Arts Partnership, working with older people experiencing Dementia between 2010 and 2013.

The report incorporated information from professionals working in both community arts and the health profession to add a wider context for the work.

Primarily the report suggests that a consistent community arts approach, offering opportunities for participants experiencing dementia to make decisions about their creative lives as autonomously as possible, provides a pathway for those with dementia to maintain connectivity to the world around them as well as stimulating "cognitive, physical, psychosocial and spiritual well-being."

Given the increase in the number of people experiencing dementia, government reports suggest upwards of 60,000 people will be diagnosed with dementia by 2051, this report will be of benefit to organisations and individuals, community and community arts organisations, arts professionals, healthcare providers and anyone seeking to support their work with qualitative as well as quantitative evidence taken from work in the field.

Conor Shields, Community Arts Partnership's Chief Executive said,

"As community arts practitioners we know that the practice of community arts can help our society creatively, culturally, socially and economically. Our research shows that any community arts practice, properly applied, enables older people to reconnect with the intrinsic artistic abilities which we all share. This in turn can help mitigate some of the isolating aspects of life with dementia and improve health and well-being generally. Seeing smiles of delight and witnessing the joy of real creative achievement brings rewards for a wider community as well.

We know that the number of people being diagnosed as experiencing dementia is increasing and we also know that the arts can play a role in alleviating at least some of the difficulties associated with the disease."

principal funder

arts council of Northern Ireland | LOTTERY FUNDED | arts council of Northern Ireland | Belfast City Council | LOTTERY FUNDED | Big Lottery Fund | Building Change Trust | EUROPEAN UNION Investing in Your Future | European Regional Development Fund 2007-13

To see the emergence of a just, inclusive, peaceful and creative society, where difference is welcomed and participation is valued.

We have a two-fold approach to arts development:

- firstly supporting access and participation by seeking to affect policy through advocacy and leadership and
- secondly, promoting authorship and ownership through the active engagement in projects and programmes.

We offer a platform for policy consultation and development, whilst at the same time, develop new creative opportunities for artists, communities and individuals through:

- **Arts workshop programme**
- **Arts workshop services**
- Advocacy
- Information
- Research
- Platforms for networking and sharing experiences
- Professional training
- Other initiatives to promote engagement.

CAP is supported by its principal funder, the Arts Council of Northern Ireland.

For more information please feel free to contact Gordon Hewitt - Information and Policy Manager - Community Arts Partnership - Subscribe to our growing arts news network. www.comartspartner.org

3-5 Commercial Court | Belfast | BT1 2NB Northern Ireland

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****Hemsworth Court**

Hemsworth Court provides modern, high quality homes for people living with dementia in a homely and secure environment. Developed in a partnership between Helm Housing and the Belfast Health and Social Care Trust, Hemsworth Court provides support to the tenant within their own home over a 24 hour period, supporting them to remain as active and independent as possible.

*****The Arts Council of Northern Ireland**

The Arts Council of Northern Ireland is a non-departmental public body (NDPB) of the Department of Culture Art and Leisure (DCAL).

The Council was established as a statutory body by the Arts Council (Northern Ireland) Order 1995 on 1 September 1995. It is funded via grant-in-aid by the Department of Culture, Arts and Leisure (DCAL) and is managed by a Board. Members are appointed by the Minister for Culture, Arts and Leisure.

Bob Collins, Bob Collins CBE, Chairman of the Arts Council, said:

"It was important to the Arts Council to support this key research through our Arts & Older People's programme, because we recognise that we live in an ageing society in which dementia increasingly affects so many of our lives, directly and indirectly. The evidence indicates that the arts offer tangible health benefits to people suffering with dementia, including unlocking memory and alleviating depression and anxiety. This research by the Community Arts Partnership now shows us how active engagement in participatory arts can also address related issues such as isolation and provide a sympathetic, stimulating and inclusive environment that can make a meaningful contribution to improving quality of life, socially and creatively, as well as medically."

Katie Campbell, Service Manager, Older People's Services, ****Belfast Health and Social Care Trust said,

"For people living with dementia, involvement in community art at any level provides vital opportunities to give expression to forgotten abilities and to tap into new discovered skills and creativity.

Participation in the arts can be a liberating experience for people with dementia. It facilitates self-expression, promotes individual abilities, builds self-esteem, restores confidence and creates natural opportunities for people with dementia to integrate with their community, benefitting not only them as individuals, but the community and the arts organisations they are working with.

Tenants at Hemsworth Court, through their active engagement in numerous community arts activities, have enjoyed major benefits and genuine social inclusion. Their participation and experiences clearly demonstrate the active role they are playing in their own community as valued citizens."

.....

Notes to Editors

***Community Arts Partnership**

Community Arts Partnership takes the lead in the **promotion, development and delivery of community arts practice**, in the belief that the arts can transform our society at a cultural, social and economic level. We support and collaborate with community groups, centres of learning, artists, arts centres and other organisations in Northern Ireland and beyond.

Our mission is

To take the lead in the promotion, development and delivery of community arts practice, to affect positive change.

Our vision is

****Belfast Health and Social Care Trust

Belfast Health and Social Care Trust delivers integrated health and social care to 340,000 people in Belfast and part of the Borough of Castlereagh. It also provides specialist services to all of Northern Ireland.

With an annual budget of approximately £1bn (spending about £3m each day) and a staff of 20,000, it is one of the largest Trusts in the United Kingdom.

In Belfast Trust **hospitals**, there are approximately 210,000 inpatient and day patients a year, 680,000 outpatients and more than 200,000 people come to the A&E departments.

In the **community** Belfast Trust is corporate parent to 600 children in care – the majority in foster care. The Trust is also responsible for between 500 and 550 children on the child protection register – and every year receives 800 referrals for children in need of support – mostly in their own home.

The Trust provides services for **older people** through nine residential homes and also commissions services from the independent and voluntary sector to support older people who wish to remain in their own homes.

Improving health and wellbeing

Alongside the Trust's commitment to delivering safe, timely, high quality and cost-effective care, the Trust has a higher purpose – to improve health and wellbeing and reduce inequalities by using the size of the Trust as a force for good, working in partnerships with other organisations such as those responsible for housing and education.

History

The Trust came into existence on 1 April 2007. It was formed under the Belfast Health and Social Services Trust Establishment Order Northern Ireland 2006 – and is responsible for the services formerly delivered by six Trusts which were merged on 31 March 2007.

These Trusts were

- the Royal Group of Hospitals and Dental Hospital Health and Social Services Trust
- the Mater Hospital Health and Social Services Trust
- North and West Belfast Health and Social Services Trust
- South and East Belfast Health and Social Services Trust
- Green Park Health and Social Services Trust
- Belfast City Hospital Health and Social Services Trust.

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Committee for Health, Social Services and Public Safety

Ms Mairead McAlinden
Chief Executive
Southern Health & Social Care Trust

3 July 2014

Dear Ms McAlinden

Review of Transforming Your Care and Older People – role of supported living

On 12 March 2014, the Southern Trust gave evidence to the Committee on its review of supported living in the context of TYC.

One of the themes explored with the Trust was the promotion of supported living.

At its meeting on 2 July, the Committee considered the information on the Southern Trust's website (on 30 June 2014). The Committee noted that there was no information on supported living facilities for older people, despite the Trust having three schemes (Spelga Mews, Scarva Street, Sloan Street).

The Committee requests an explanation for this omission, and the Trust's view on whether this is consistent with good promotion of supported living as an option for older people.

I would be grateful for a response within 10 working days of receipt of this letter.

Yours sincerely

Kathryn Aiken

Kathryn Aiken
Clerk, Committee for Health, Social Service and Public Safety

cc. Jonathan Bill, DHSSPS

Committee for Health, Social Services and Public Safety
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Southern Health
and Social Care Trust

Quality Care - for you, with you

Chair
Roberta Brownlee

Chief Executive
Mairead McAlinden

Our ref: MMcA/amcv/ew

10 July 2014

Ms Kathryn Aiken
Clerk, Committee for Health, Social Services
& Public Safety
Room 410, Parliament Buildings
Ballymiscaw
Stormont
BELFAST
BT4 3XX

Dear Ms Aiken

REVIEW OF TRANSFORMING YOUR CARE AND OLDER PEOPLE – ROLE OF SUPPORTED LIVING

The Trust presented to the Health Committee in March 2014 on the range of Sheltered and Supported living options available to older people in the Southern Trust area.

With specific regard to the older people's schemes you mention, none are under the management of the Southern Health and Social Care Trust (SHSCT). Two are run by Abbeyfield UK (NI) and the third is run by Fold Housing Association.

SHSCT has a partnership with Fold as highlighted in the committee submission to fund the care costs for clients with dementia in Spelga Mews. This service is actively promoted by Memory Service staff, following professional assessment and application of eligibility criteria, as it is a very limited resource and needs to be actively targeted.

Currently the Trust funds the care costs for 12 clients (11 from Older People and 1 from Mental Health) at a cost of £265 per week each.

Abbeyfield UK (NI) schemes whilst under the supported living umbrella were developed several years ago, before the current "Supporting People" strategy and as such are more akin to sheltered schemes.

The Trust does not have access to up to date information on vacancies within sheltered and supported schemes due to NIHE website restrictions. We have therefore chosen the route of signposting to the range of scheme providers in the area to enable interested individuals to fully explore this option with the organisation who offer this service.

As a result of bringing this to our attention, we will explore the feasibility of including this information on our website to ensure another mechanism is available to signpost to schemes provided by Housing Associations in our area.

Yours sincerely

Mairead McG

MAIREAD MCALINDEN
CHIEF EXECUTIVE

Committee for Health, Social Services and Public Safety

Mr Hugh McCaughey
Chief Executive
South Eastern Health & Social Care Trust

3 July 2014

Dear Mr McCaughey

Review of Transforming Your Care and Older People – role of supported living

On 12 March 2014, the South Eastern Trust gave evidence to the Committee on its review of supported living in the context of TYC.

One of the themes explored with the Trust was the promotion of supported living.

At its meeting on 2 July, the Committee considered the information on the South Eastern Trust's website (on 30 June 2014). The Committee noted that the section entitled "Supported Living" provides information on Cedar Court and Cuan Court. However, no reference is made to St Paul's in Lisburn.

The Committee requests an explanation as to why no information is provided on St Paul's in Lisburn, and whether the Trust believes that this omission is consistent with the promotion of supported living as an option for older people.

I would be grateful for a response within 10 working days of receipt of this letter.

Yours sincerely

Kathryn Aiken

Kathryn Aiken
Clerk, Committee for Health, Social Service and Public Safety

cc. Jonathan Bill, DHSSPS

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South Eastern Health and Social Care Trust

Ms Kathryn Aiken
Clerk
Committee for Health & Social Services and
Public Safety
Room 410
Parliament Buildings
Ballymiscaw
Stormont
Belfast
BT4 3XX

17th July 2014

Dear Ms Aiken

Thank you for your letter dated 3rd July 2014.

The Trust is currently developing its new website which will provide information on all Trust delivered services. The new website has not been officially launched as there is still further information to be populated.

Although St Paul's Court Supported Housing Scheme is not directly managed by the Trust but by Praxis Care, I agree that it would be a good opportunity to reference the Scheme on our website.

I would like to thank you for bringing this oversight to our attention and I can assure you that the information on Supported Housing will be updated.

Yours sincerely

Nicki Patterson
Director of Primary Care, Older People &
Executive Director of Nursing
on behalf of Hugh McCaughey
Chief Executive

cc Jonathan Bill, DHSSPS

Committee for Health, Social Services and Public Safety

Ms Elaine Way
Chief Executive
Western Health & Social Care Trust

3 July 2014

Dear Ms Way

Review of Transforming Your Care and Older People – role of supported living

On 12 March 2014, the Western Trust gave evidence to the Committee on its review of supported living in the context of TYC.

One of the themes explored with the Trust was the promotion of supported living.

At its meeting on 2 July, the Committee considered the information on the Western Trust's website (on 30 June 2014). The Committee noted that the section entitled "Supported Living" only provided details of facilities for mental health and learning disability. There was no reference to supported living facilities for older people.

The Committee requests an explanation for this omission, and the Trust's view on whether this is consistent with good promotion of supported living as an option for older people. The Committee also noted that it could see no reference to the Gnangara facility on the Trust's website. Given the serious problems in relation to securing occupancy for that facility, the Committee requests an explanation as to why it is not being promoted on the Trust's website.

I would be grateful for a response within 10 working days of receipt of this letter.

Yours sincerely

Kathryn Aiken

Kathryn Aiken
Clerk, Committee for Health, Social Service and Public Safety

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Western Health
and Social Care Trust

Chairman
Gerard Guckian

Chief Executive
Elaine Way

4 September 2014

Ms Kathryn Aiken
Clerk
Committee for Health, Social Service & Public Safety
Room 410
Parliament Buildings
Ballymiscaw
Stormont
Belfast
BT4 3XX

Dear Ms Aiken

Re: Review of Transforming Your Care and Older People
- Role of Supported Living

Thank you for your letter of 3 July 2014 with regard to the above matter and I apologise for the delay in responding.

The Trust acknowledges an oversight on its behalf in not including details of supported living facilities for Older People on the Trust's website as you have pointed out. This will be rectified immediately.

In relation to the Gnangara facility specifically, while it is also not referenced on the Trust's website, please be assured that the facility is promoted locally by Trust staff and this oversight will also be rectified immediately. Where a need for accommodation is identified through the assessment process, consideration is given to suitable facilities and options presented to clients and families. Gnangara is included in this process where it is deemed that it can meet the Health and Social Care needs of the individual concerned. Ultimately, however, the decision to avail of a place in any facility is one for the individual and their family to make and the Trust will continue to present all options to potential residents.

You should also be aware that the Trust is developing an Older People's Portal, which is an on-line resource accessible to the public. It details all of the services that are available to Older People in the Trust area and has been developed in conjunction with our Community and Voluntary Sector partners. It is anticipated

that this will assist in making information on available services accessible to even more older people in the Western Trust area when it is formally launched. It can be accessed on www.olderpeopleconnected.hscni.net

I hope this response addresses the issues you have raised, however, should you have any further queries please feel free to contact Mr Alan Corry Finn, Director of Primary Care & Older People's Services, at the address below or (028) 7161 1247.

Yours sincerely

ELAINE WAY, CBE
CHIEF EXECUTIVE

Appendix 6

Information on the Pavilions development in Lisburn and Cedar Court in Downpatrick

Housing in an Ageing society

This brief outlines issues relating to Housing in an Ageing Society, drawing on published research from the Joseph Rowntree Foundation (JRF) and case studies from WJ Law and Clanmil Housing. This brief also draws on roundtable discussions from an event facilitated by Stratagem NI at Clifton House Belfast in June 2013.

About the roundtable

The event at Clifton House is the first in a series of roundtables which seek to stimulate debate through promoting an informed dialogue between policy analysts, practitioners and decision makers. These roundtables provide an interactive forum for senior policy personnel from different sectors to meet and discuss key challenges associated with an ageing society in Northern Ireland.

As the debate on the long term funding of housing, care and support continues to mature, this event brought together housing, health and age sector professionals to discuss what wider social and environmental issues should be addressed when considering housing and care needs for older people. Research from the JRF Better Life programme was presented followed by contributions from Age NI, WJ Law, Clanmil Housing and the Belfast HSC Trust. Participants also took part in a roundtable discussion to discuss the barriers and solutions in addressing housing needs in an ageing society.

A Better Life for Older People – Policy and practice implications from current JRF research

Housing with care has been an important area of research for JRF. A programme of work on housing with care was completed at the end of 2012, under the overall framework of *'A Better Life*', with a particular focus on older people who have, or are developing, high support needs. As part of this, JRF commissioned research on the affordability of retirement housing in the UK alongside major projects examining key aspects of living in housing with care schemes. Grounded in the perspectives of older people, this research examined issues such as affordability, choice, quality of life and the roles and responsibilities in Housing with Care

A summary brings key findings and practical ideas together from the three studies. This round-up covers key messages and practice examples from JRF studies, concluding that:

- Housing with Care (HWC) is valued by residents. It can enhance quality of life for those with high and increasing needs, supporting independence, privacy and control, as well as many rights;
- Everyone involved has an on-going part to play in creating conditions where tolerance, privacy and inclusion can thrive;
- Raising understanding of the lived experience of particular groups, and communicating positive messages about diversity, are key to creating a welcoming ethos;

- Providers can facilitate mutual support and resident-led initiatives through background support;
- Some residents benefit from a 'navigator' – a staff member or family carer to help co-ordinate various aspects of their lives;
- Role confusion can adversely affect residents and can be found across organisational models. A clear shared vision and understanding amongst commissioners, providers and residents of what a particular HWC scheme does, and for whom, is essential. Clarity of roles and responsibilities should be balanced by some flexibility;
- Affordability is specific to individual circumstances and partly subjective. In the context of HWC, there are uncertainties, inconsistencies and complexity. Some housing, care and support costs are ineligible for state subsidy, so reducing residents' incomes below the notional income floor.
- Residents need individualised information about costs, subsidies and state benefits applicable to them, with support and advocacy to navigate the system.

WJ Law – How the private sector is responding to an ageing society

A family-owned business with over 100 years' experience of designing homes and building communities, WJ Law has developed a new model for elderly care at Ballantine Garden Village, Lisburn. Developed from best practice from its experience of retirement villages worldwide, WJ Law has worked closely with healthcare organisations, FOLD, Balmoral Healthcare and Age NI to ensure that the needs of older people are at the heart of the design.

The retirement village at Ballantine showcases how older buyers can buy a home which is designed to be visually attractive with all the features to be readily adapted as care needs increase over time.

70% of pensioners are homeowners. The case for equity release allowing owners to look after themselves is strong. Older people wish to remain in their own home, plus the costs of a care home are prohibitive. The WJ Law collaboration provides a welcome solution to the existing dismal choice of "being a burden to your family", or institutionalisation.

The Mullan Mews Model

Mullan Mews is a supported housing scheme providing specialised accommodation and support for 30 older people with dementia enabling them to maintain a high level of independence and social inclusion. The physical design of the scheme and the support provided compensates for the disability caused by dementia and promotes an active and rewarding lifestyle for the tenants. It consists of five terraced houses with each house containing six en-suite single bedrooms. Each house also has two living rooms, kitchen/dining room, utility room, downstairs toilet and landscaped garden.

Supported living in the community offers an alternative to residential care for people with dementia that focuses on maintaining quality of life. Mullan Mews is an excellent example of partnership working between Clanmil, Belfast Trust and the Northern Ireland Housing Executive's 'Supporting People Programme'.

The roundtable discussion

Participants in the roundtable discussion were given the opportunity to discuss the policy and political context focusing on the key challenges and opportunities associated with housing and care in an ageing society.

Three questions, which were drafted in conjunction with Age NI, were posed to participants on the day. A summary of the feedback from these discussions is as follows:

Question 1 – Improvement

What are the main barriers and the potential solutions in addressing housing needs in an ageing society?

Key challenges:

- The various housing models available to older people is a complex system and is difficult to understand;
- More clarity on different models could be achieved if there was closer collaboration between sectors and government departments;
- There needs to be a greater number of options including a mix of statutory and individual contributions to cost;
- There is a lack of co-ordinated approach between agencies and government departments;
- There is a lack of a central government strategy on housing in later life;
- The Commissioner for Older People could play a key role in facilitating the cross-sectoral dialogue and to strengthen the link from person to policy-maker;
- There must be a strategy for mixed tenure and an intergenerational focus with health and education;
- Cost and affordability is a significant barrier, people must be encouraged to plan for their future: perhaps using the NEST 'Living Wage' pension campaign to get people 'scenario planning';
- Ageist attitudes can lower the needs of older people as a priority;
- The lack of a suitable housing supply and funding, particularly where money is used for new schemes rather than for improving existing schemes;
- Access to finance needs to be improved so that people are able to make the move;
- There is a high level of rural dwellers and this must be addressed.

Suggested Solutions:

- We need to future-proof our lives through early planning. We therefore need to prepare for and inform the next generation of older people to plan for their future housing needs;

- We need to educate politicians about the value of supported housing rather than traditional residential care;
- Closer work between DSD and DHSSPS is required;
- Letters could be sent to people to encourage them to develop their own care plans;
- One table suggested the establishment of a one-stop-shop for information so that advice can be used as a preventative measure;
- A community based approach is needed. Loneliness and isolation must be a key consideration, not just the physical needs. Often things such as kinship and community ties are more important;
- On the political improvements, there must be a higher level of engagement and the issue must gain higher priority with the Executive.

Question 2 - Information and signposting

What can be done to improve information available to older people and their families when planning for housing needs in later life? How can we best achieve clarity on the type of housing options available to older people?

- Information needs to be available both on paper and electronically and available in churches, credit unions, leisure centres and doctors' surgeries.
- We could use pension campaigns as a means to piggy-back messages about having scenario-planning;
- Rehabilitate the term "Equity Release" and consider a government backed scheme. Highlight co-ownership and the range of providers;
- Create a one-stop-shop for information, perhaps through the Housing Executive or the Housing Rights Service;
- Ensure information is available at key points in life, for example during a person's forties or early fifties;
- Review regulation and provision of financial advice, and put it on par with debt advice as a priority for local incomes, for example an "Age NI" approved status;
- Consider a brokerage service, independent from other services to simplify access to information;
- Education is needed on the issue, especially on the choices that are open to people. Education must happen early in the life cycle so that people plan now for the future;
- Local services must be extended, such as the 'Handy Van service'. Schemes for people who need partial support, such as having small repairs and gardening jobs done;
- A local community hub is important to tackle isolation and loneliness;
- It is a very complicated and bureaucratic system. Perhaps at age fifty a care plan letter should be sent to each individual. More should be done at a younger age.

Question 3 – Collaboration

What practical steps can be taken to foster greater collaboration and communication between the health, housing and age sectors in addressing housing in an ageing society?

- Greater integration of the views of Age Sector groups into policy. There should be no repeats of the debacle around the care home closures;

- Revisit the housing strategy. Consider setting up a task force with independent governance;
- A regional government approach is needed that integrates housing, planning, education and health. That would support strategic thinking;
- Get data on what needs to be done and where housing needs to be built;
- Funding for projects has always supported capital projects not revenue; that has always had the potential to be a white elephant;
- In terms of revenue, long-term sustainable support across government departments is badly needed;
- Highlight the Programme for Government and its role in prioritising strategic collaboration;
- The Commissioner for Older People must be supported as the lead agent in bringing together the sectors around housing in an ageing society. Get the Commissioner for Older People to challenge officials directly;
- Collaboration is needed to change the image of supported living and care;
- It is important to support people and any partnership needs to actively include older people and their views;
- Perhaps a central government strategy or taskforce should be developed to support collaboration on housing in an ageing society;
- Communication options and provision of advice about the changes people can make to remain in their own home;
- There should be strategies in place to support people through the 'Transforming your Care' (TYC) and housing strategy;
- There should be more discussions with the private sector;
- A 'bottom-up approach' should be utilised in the design of future homes;
- There needs to be more people willing to pay for and into housing schemes. Perhaps the Commissioner for Older People should have a role in pulling all of this together.

Supported Living

Supported living is a new kind of accommodation for frail older people and older people with mild to moderate dementia. It provides the care and support needed to allow tenants to live independently in their own apartments, surrounded by their own furniture and belongings. Older people have told us they value having a choice and control over how they live their lives. Supported living promotes independence and enables older people to lead healthier and more active lines within their own community.

Cedar Court, Downpatrick which opened in 2012, is a purpose built supported living facility for older people, developed in partnership with Trinity Housing Association. It has 12 apartments for frail, elderly people and 12 for those with mild to moderate dementia. Each apartment has a living room, kitchen, one or two bedrooms and bathroom and is equipped with assistive technology to enable people to live independently. For example, staff will be alerted if a tenant gets out of bed in the night and doesn't get back in, and a discreet check will be made. Highly trained Trust staff are on duty at all times, and the level of support is tailored to the needs of the tenant. Some tenants like to do their own shopping and cooking and go out to community events, while others spend more time at home and require more help with domestic and personal care. Visitors are always welcome and families often stay over.

This person centred, flexible care offers safety and security while promoting independence. It allows tenants to "age in place with the type and level of support adjusted as people's needs change.

The apartments for those people with dementia are arranged around secure courtyard gardens and there are internal communal spaces to cater for organised leisure and recreational activities. The building has been designed with wide corridors and low level glazing to maximise sky visibility and daylight. Subtle signage and assistive technology to maintain residents' safety will enhance a sense of wellbeing and create maximum choice for those living in the scheme.

Supported Living can change lives. Tenants at Cedar Court have told us:

"I used to be in a residential home but this is much better. I manage my own medicines and I can eat what I like, when I like. My health has improved since moving here."

"I like to go into town every day to do my shopping. It makes me feel part of the community, and I go bowling as well."

"You can shut your own front door and have privacy, or you can enjoy the company of the other residents."

A second scheme, Cuan Court, in Newtownards, is being built in partnership with Apex Housing Association, and will open in Spring 2014.

Information about the referral process to either facility can be obtained from your key worker.

To hear what tenants and staff have to say about Cedar Court, please watch our video below.

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