Northern Ireland Assembly

# Committee for Health, Social Services and Public Safety

# OFFICIAL REPORT (Hansard)

## Community Meals: Health and Social Care Trusts

**7 March 2012**

NORTHERN IRELAND ASSEMBLY

# Committee for Health, Social Services and Public Safety

## Community Meals: Health and Social Care Trusts

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**Members present for all or part of the proceedings:**
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Mark H Durkan
Mr Samuel Gardiner
Ms Pam Lewis
Mr John McCallister
Mr Kieran McCarthy

**Witnesses:**

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|---|---|
| Ms Marie Heaney | Belfast Health and Social Care Trust |
| Mr Patrick Graham | Northern Health and Social Care Trust |
| Ms Charlotte McArdle | South Eastern Health and Social Care Trust |
| Mrs Angela McVeigh | Southern Health and Social Care Trust |
| Mr Alan Corry Finn | Western Health and Social Care Trust |

**The Chairperson:** I invite representatives of the five trusts to come to the table. I will hand straight over to you to make your presentation. I will then go back over issues that I raised with members. Thank you for your papers, including the updated versions of some of them.

**Ms Charlotte McArdle (South Eastern Health and Social Care Trust):** Madam Chair, I am the chair of the five trusts' collaborative. With your permission, we have a proposal to put to you. Obviously, it is your meeting, and we will be guided by you. However, I propose to give a short context overview of the region, and then each of the five representatives will talk about what is specific to their trust. Otherwise, there will be duplication of information.

I will start with the overview and then go straight into the South Eastern Trust's specific presentation. As a starting point, we searched back to find the original guidance that was developed in 1978 for the provision of what was the meals-on-wheels service at that time. I have a direct quote from the guidance, which I found in the Northern Board's paperwork:

*"The meals on wheels service should only be provided to elderly and handicapped persons in need who cannot cook a meal or obtain a cooked meal from another source or who without the service would be nutritiously at risk."*

That was the original guidance set out in 1978. As a result of that guidance, different services have grown up over the past couple of decades.

The overall needs assessment is carried out in each of the five trusts. It is a very individual assessment and covers many areas, of which nutrition and the provision of meals is one. It also considers things like social networks, the ability to get out of the house, clubs, luncheon clubs, church groups and the social events that the person might attend. It also includes family support and what the family contribute to the package of care, neighbourhood support, the individual choice of the older person, which is a very important decision, and the availability of local services. Those local services are different across the five trusts and also vary depending on whether they are in an urban or rural area. That is all taken into account and the assessment is overseen by qualified social workers. It is quite a complex assessment, and each assessment is verified by the social worker.

Turning to service provision, I and my colleagues accept that the service has evolved in a disjointed way. If we were starting from scratch, that would certainly not be the way in which we would plan to develop a service. However, given that the service is of a significant age and was developed at a time to meet a particular definition, it has evolved. That is why we have different models and different pricing structures, very much meeting the local demands of our older people. That varies across the organisations. For those reasons, therefore, it is inequitable in that there are different services and different pricing structures. My personal view is that it is also inequitable because people who receive the meals-on-wheels service also receive care from the health and social care trust. Many older people are living on their own in the community on their old-age pension, with no access to a meals service. They are fully funding their own meals, and we need to address that issue of the inequity of the service.

I know from reading the Hansard reports and other information that you have some concerns. We are seeking to improve that position, and that is why the collaborative, which I chair, was established. It started only last year, and we have met on a number of occasions. We agreed what things needed to be worked on, and one was around the inequity of the service. We also looked at what we could standardise. You will remember that, post RPA, many of our trusts merged and there were different protocols, principles and service provision. Each trust went through a process to try to standardise some of that. On a regional level, there were five different sets of criteria that we tried to standardise into one so that it would be easier to manage, it would be the same for every client across Northern Ireland, and easy for the staff to work through a model that would get them a result. That is what we have done.

We also need to look at the model of the service. I think that the service needs to modernise to fit with modern living and the many options that are available for meals that were not there in the 1970s.

We have Transforming Your Care (TYC), which is the vehicle for us to make a lot of those changes and to focus our services on individual needs assessments, by working with the client, taking their wishes into consideration and providing local services in local areas and, where possible, with the client. I think that that is encouraging us to rethink how we will deliver, modernise and future-proof our service, because what it is providing today certainly will not be fit for the next generation of older people. Given the demographic pressures on the system and the fact that the rate of dementia will double between now and 2017, we particularly need to think about demographics, the growing number of older people and how we will maintain the service. So all that needs to be factored into a new service model.

We are also working to the nutrition strategy launched last year, which, again, sets out guiding principles. It is very much focused on nutrition, preventing malnutrition and supporting good nutritional assessment. That is being implemented across the five trusts. There is also the requirement for regional reform and modernisation as well as the "quicker" programme from the board, whereby each trust has to be more efficient with its resources, live within a set budget, and release money back into the system in order to enable us to take forward Transforming Your Care. There is no question that

there are constraints on how we deliver the service, so we need to make it as efficient as we can. The collaborative was set up based on those principles and is now taking them forward.

As I said, I know that you have some concerns about nutrition, and I would say that all the trusts have health and well-being plans in place. Good nutrition is a fundamental requirement of living and a basic need. It is very much the focus of the work being done by the health and well-being teams in the trust. The nutritional strategy is being implemented, and each of the trusts is required to have a lead director for that. I am "it" for the South Eastern Trust. We have set up a programme board, and there are work streams across hospitals and the community to take that strategy forward.

I know that you have been given some of this information already. There is a very strong focus on re-ablement, the purpose of which is to try to assist older people to live safely in their own environments for as long as possible. It is about, for example, supporting them through a period of acute illness; getting them back to their maximum potential; supporting them in that time to see what their long-term care needs are; and supporting them through meal provision and a good nutritional assessment. Each of the trusts has implemented an assessment tool to do that.

As regards your concerns, I want to reassure you that nutrition is very much part of our assessment. When an assessment is completed, it is referred either to a GP, a community nurse or another professional, if required. If there is any suggestion or concern that a client is undernourished or needs nutritional support, that will be done as a matter of course. Where nutritional concerns are raised, the trust will ensure that the client has access to a meal and will put that service in place by whatever means necessary with the agreement of the client.

Some people, including many of our dementia clients, are not able to eat their meals, so our domiciliary care workers support and assist those patients and clients at meal times. That will continue.

The reduction in community meals is not really an indicator of the overall reduced meal provision. I do not have the figures for you today. However, a huge amount of resource is going into our domiciliary care service. Domiciliary care workers and home helps assist people to prepare, heat, plate, and, if need be, eat their meals. That is where a large part of the trusts' resource is going. In the longer term, it is a more sustainable model than the current meals-on-wheels service.

If I may, I would like to spend a couple of minutes going through the evidence from the South Eastern Trust. As I said, we are looking at the demographic issues, the need and the deprivation across the trust. In 2009, we had 45,885 people aged between 65 and 84, and roughly another 6,500 aged over 85. That will grow again by 2014, as you will see from the figures in front of you. However, it will grow significantly by 2019, with a 32% increase in those aged between 65 and 84 and a 45% increase in the over-85s. In addition, there are six wards in the South Eastern Trust that are in the top 10% of the most deprived areas, so we know that that is a significant issue. That is why we are keen to try to look at changing the service model to meet that demand, moving forward.

Since 1993, our local arrangement in the South Eastern Trust is that we have had a cook-from-chilled meal service. Our domiciliary care service is delivered to 4,489 older people in the trust, many of whom, as I said, receive help in preparing or eating their meals. We charge £4·97 for the chilled meal service, to which the client contributes £2. Therefore, the trust's contribution is £2·97. As well as that, 900 meals are provided for older people each week in statutory or voluntary day care settings.

I do not propose to go through all of it, but the next part of our submission provides you with a profile of clients who receive meals, including age group and the number of meals. You will see that our meal service has reduced from 878 in 2007 to this year, where it sits at 561. However, again, I hope that it is clear that other measures are in place. It is not purely a reduction in the provision of a meals service; there are other ways of assisting people to receive nutritional support.

To finish, I would like to mention our needs assessment and future plans. We currently use the Northern Ireland single assessment tool, which is a very detailed assessment that takes several hours to complete across a range of professionals, mainly in social work and nursing. Part of that assessment focuses very much on nutrition. Any professional can refer a client whom they think is at

risk of malnutrition to a GP, dietician or community nurse. All referrals for domiciliary care are prioritised by using the regional access criteria for domiciliary care, which sets out where we should focus our resources and staff, and what groups we should target most. As I said, our health development staff deliver a range of programmes, many in conjunction with the community and voluntary sectors, to promote good nutrition.

Moving forward, we plan to fully roll out the re-ablement service, and you will hear that from other trusts. Each of us is at different stages with re-ablement, so it will take a little time to roll it out. The screening tool for malnutrition is being implemented in the South Eastern Trust and the other trusts, where extensive day care services are available, many of which provide meals. We are due to re-tender this year, so there will be scope for us to think a little differently about how we will provide that service, moving forward. We signpost clients: those who may not require a higher level of care-package intervention are signposted to other service providers or to where they can access support with their meals, if we are not providing a service. There is a small-grants scheme that delivers a range of healthy eating programmes, such as the Cook It programme, with which some members may be familiar, assist people to re-learn how to cook.

That is the information from the South Eastern Trust. I am not sure whether you want to ask questions now or hear from the other four trusts first.

**The Chairperson:** Thank you for your overview and your presentation on behalf of your trust. I will allow the other trusts to give a short presentation. I cannot give you as long as Charlotte, who got that length of time because she was presenting the overview. However, I think that it is important to hear short presentations. Members are keen to ask questions, because we have been looking at this issue for some time. We will hear those presentations in whatever way you have agreed to do them and then get back to questions.

**Mrs Angela McVeigh (Southern Health and Social Care Trust):** I will present on behalf of the Southern Health and Social Care Trust. Similar to the outline that Charlotte provided, the context for change in the Southern Trust is very much focused on the development of the enablement ethos. The context for change in the Southern Trust, as Charlotte outlined, takes on board the recommendations in Transforming Your Care. The services that we provide are underpinned in that ethos of re-ablement. Committee members will recall that, on 7 December, at Daisy Hill Hospital, I gave a short presentation on the Southern Trust's re-ablement service. Members had a chance to see one of our service users, Marie, in a short video clip. Marie represents the future for us in how we support older persons to gain and regain many activities of daily living. She was one of our clients who went through the re-ablement programme. Having had an injury in her home, Marie was afraid to go back into her kitchen and did not feel that she would be able to get back out to the shops again, but she has now gained her independence and is able to provide for her own nutritional needs.

As a trust, we are focused on working in partnership with the individual and their family. We are listening to what people want, and people are telling us that they want to be independent, to have increased choice and control, and to stay in their own homes and communities. As part of that, we are working in increased partnership with our voluntary and community and independent sector partners in helping to provide a full range of community care services that older people and others can link into.

We are under the same constraints as other trusts in respect of maintaining our budget and working within the resources that we have available. That means that we have to target our resources at those in greatest need and to provide an equitable service based on assessed need. The Southern Trust is similar to the South Eastern Trust in that, as Charlotte pointed out, our older population is increasing, so this is an increasing challenge for us.

Where do we start within the Southern Trust? As Charlotte said, we start around the fundamentals of an assessment of need, using the Northern Ireland single assessment tool. Each year, in the Southern Trust, we assess 1,800 new referrals. In addition, we review, on an annual basis, 5,000 people who are currently receiving a package of care. We work in partnership with individuals, families and communities to see whether that individual can manage on their own. Do they need to be signposted to other community services? Can we provide for their nutritional needs in some of our other funded services, such as day care, a luncheon club or a social centre? Can we help to support them to

access shopping through our community transport partners? As a trust, we support a significant number of people, through our domiciliary care services, to heat, plate or eat a meal, if that is required. As always, if our assessment finds that an individual has no other way of supporting their nutritional needs, the trust will provide a subsidised meals-on-wheels service.

Meals on wheels is only one very small part of a whole range of services provided in the trust to support people's nutritional needs. Just over 2,500 people are supported every day through their domiciliary care package. We provide 6,000 meals each week: 2,000 of those are trust-subsidised meals on wheels, and 4,000 of them are provided through our day centres, luncheon clubs or social centres. Each year, we provide approximately 300,000 meals to our population.

We have a health and well-being strategy in place. It helps to support the fundamentals of prevention around healthy eating and how to access good nutrition, as well as supporting people through our healthy cooking programmes. We fund a range of community transport options to support individuals in getting to the shops. We have been using that, through our re-ablement service, to go with the individual to get them back into the way of shopping again if they have lost that skill. Like the other trusts, we have access to a range of dietetic and other professional staff to provide advice and treatment if people are identified as being at risk of malnutrition.

I will finish by giving the outcomes. As a trust, we are using a re-ablement ethos to underpin the work that we are doing. We are supporting people to remain independent in their own homes. We are targeting our resources at those in greatest need. We are helping to integrate people into the community and to reduce isolation. We commit over £8 million a year to support our voluntary and community partners, much of which goes to support our meals service. We are providing increasing choice and control for people, and that is very much in keeping with the Transforming Your Care recommendations. As I said, we have a significant community and voluntary sector infrastructure. As a trust, we are committed to managing within our available resources as we are required to do.

**The Chairperson:** I do not want to put the rest of the team off speaking, because I am keen for you to have your opportunity, but members are keen to get into questions. So, I encourage you to be brief.

**Mr Patrick Graham (Northern Health and Social Care Trust):** Today's briefing paper has just been circulated. I appreciate that there will be questions on the earlier paper that was submitted last week, but, hopefully, I will be able to pre-empt some of those with what I am about to say.

I reiterate what Charlotte said about the original guidance from the Northern Health and Social Services Board going back to 1978. We have to put that at the focus of our attention. I know that there will be concerns about the reducing numbers of meals on wheels, but, between 1978 and 2003, the number of meals on wheels provided in the Northern Board area stayed relatively stable. The numbers increased in 2003 when we entered into a new way of providing assistance to people, with the provision of meals in their own homes through a contract with an independent provider. That was introduced at a time when there was great difficulty in recruiting and retaining home care workers, which might seem difficult to believe in the current climate. However, given that difficulty in 2003, we had to look at an alternative way of providing meals for people in their own homes. That explains the Northern Trust's significant increase in meals provision after 2003 and the subsequent reduction.

The range of options that have been open and available to people, which Charlotte and Angela referred to, has increased significantly in the past five to 10 years, never mind over the past 30 years. Things like microwave ovens would not have been in general use in 1978.

I will repeat some things, and I am sorry if it appears repetitive, but we need to focus on the point about needs assessment. The Northern Ireland single assessment tool, which Charlotte referred to, has particular domains in it regarding food and nutrition. There are significant resources in the community that people can be referred to. GPs are an immediate gatekeeper in respect of nutrition and identifying issues. There is a district nursing service and a home care service, which goes to people's homes. Therefore, there are significant triggers to identify issues.

With regard to the method of meals provision, colleagues have and will refer to the significant range of meals provision in their areas, from the voluntary and community sector to independent providers. Regional, independent providers of meals, which some trusts contract with, provide an excellent service. Meals also come from the education and library boards. We still provide assistance with meals to a significant number of clients in their own homes. The meals that we provide are not just for older people. We have significant numbers of people — over 2,000 — from our day centre and adult centre caseloads, who receive meals. Those people will not be attending day care five days a week, but a monitoring process can be undertaken with them.

The re-ablement service has also been referred to. I will give you a slightly different slant on that. We have introduced new programmes in our day centres that focus on why people are attending our day centres, with the emphasis on short-term programmes with a re-ablement and rehabilitative process. If an individual receives meals on wheels or a meal is delivered to their home, or if they cannot reheat a meal or carry out basic activities of daily living, we assist them to gain that independence in a day care setting.

The other issue is around social isolation. In the previous Hansard report, it is stated that issues that people have concerns about include social isolation. We have good examples in that area. They may not be as widespread as they need to be, and I think that one of the learnings from this exercise is that there is a lot that we can learn from each other as trusts. However, there are good examples of local meals provision. Age Concern in Cookstown, which some members might be familiar with, offers an excellent service. We are developing befriending schemes throughout the Northern Trust area, starting with east Antrim. There are a range of good morning/good evening schemes, which can provide contact for an individual. We are also looking at building local economies and local communities. The provision of meals by people and outlets in their own localities is one way of encouraging the local economy and of building local support for people.

There is a role for all in the provision of meals, from the voluntary, statutory and independent sectors. I assure the Committee that if we identify somebody who has no other way of accessing a meal or somebody who can be provided with a meal but needs assistance to eat or to reheat it, the trust will provide assistance. The issue for us is whether the trust will be funding all of that.

**Ms Marie Heaney (Belfast Health and Social Care Trust):** I am presenting on behalf of the Belfast Health and Social Care Trust. In the interests of brevity, I will give only the key facts. Like the other trusts, Belfast has a very significant and growing older population, particularly in the over-85 age group. That is set to double over the next 10 years, and there is evidence that those individuals require three times the intensity of health and social care.

Belfast provides a very comprehensive meals service based on an individual assessment of need and targeted at those least able to provide a meal for themselves. That is where the subsidised meal is targeted. Our local arrangements are unique in one sense in that we have our own in-house food production unit known as Knockbracken Foods. It is the hub of all community meals delivery in Belfast. Knockbracken Foods provides 234,000 meals a week to all our day centres for all client groups. It also delivers to all our luncheon clubs, and it provides for much of the voluntary sector. It provides 50,000 meals per annum for that sector. We also run a number of 'Cook it!' programmes through that voluntary sector contract.

In our traditional meals on wheels, under a cook-chill model, we are still providing meals to 1,347 clients. Like other trusts, we are providing significant numbers of domiciliary care packages — almost 3,000 — whereby meals and nutritional support are part of the overall package.

Knockbracken Foods has been our focus because we provide a lot of employment through it. We are tied into that arrangement, so we have not taken forward any major change in the meals service. However, with Transforming Your Care and the introduction of re-ablement, we recognise that nutrition and community meals will require to be reviewed over the next year and will probably require some significant consultation with key players.

Our plans are to introduce re-ablement across all social care services this year. We are planning to develop a gateway re-ablement service for all new and review referrals for domiciliary care that includes meals. That means that, in future, older people will receive a short intensive period of assessment and re-ablement provided by occupational therapists and highly trained social care staff. That service will assess all the activities of daily living and seek to restore as many as possible. The gateway re-ablement model will not only consist of a statutory re-ablement team but will be integrated with and have access to housing, voluntary and community sector staff.

As the representatives from other trusts have said, there may be new and innovative ways of providing meals in the future that are more inclusive and provide opportunities for people to come together. Shopping and meals provision will be reviewed in partnership with others and will include the full implementation of the Department's nutritional strategy. Our cost to clients remains £1·50.

**Mr Alan Corry Finn (Western Health and Social Care Trust):** I am the director of primary care, older people's services and nursing in the Western Trust. The Western Trust serves a population of almost 300,000. Around 38,000 of those people are over 65, and around 16,000 are over 75. We serve a geographical area of 5,000 square kilometres, which is a real challenge. Some areas in the Western Trust have the highest deprivation in Northern Ireland. Many older people living in the Western Trust area are socially isolated in many ways, particularly those living in the very rural areas. Strabane is the second most deprived area in Northern Ireland. Derry is third, Limavady seventh, Omagh seventeenth and Fermanagh twenty-second in ranking. In some of the areas of lower ranking, there are issues in the local communities because younger people are emigrating these days, and, therefore, there is not the local support that you might expect.

We have 31 providers in the trust area, and that is a historical arrangement that we inherited from the previous legacy trusts. In keeping with the local community and the rurality of our trust, we have small local providers to make sure that the meals service is accessible for all. We supply around 149,000 meals a year. We served 1,026 clients in 2011, ranging from people receiving meals twice a week to those receiving them five times a week. In 2011, the total cost was £697,000. The unit cost is, on average, £4·68. The average client contribution is around £2·24, and I recognise that that is not in keeping with the departmental guidance. I will come to that later in the presentation. The average trust subsidy is £2·44. A meal provided by statutory sector providers, which is the education side, costs around £3·55. That does not include the transport costs.

We apply the current access criteria in the Western Trust to all community meals schemes throughout the trust. We consider whether a vulnerable person living alone in the community is unable to prepare or cook a meal; whether the person lives with someone who is unable to prepare or cook a meal; whether the person lives with someone who is unlikely to be motivated to cook a meal; whether the person does not have access to cooking facilities; or whether the person has specific nutritional needs due to illness or infirmity. Those individuals need to have the ability to understand instructions on food hygiene and safety, which we provide information on, or, if they are unable to understand instructions, to accept assistance from another designated person.

I will outline the five-year figures. In 2007, the total number of clients was 1,199, and, in 2011, it was 1,026, which is a reduction of 14%. In keeping with other trusts, we provide somewhere in the region of £20 million a year for domiciliary care, around £13 million of which is on older people's services. While a large proportion of those people are receiving personal care, such as being helped to the toilet and helped with eating, a lot of people are receiving help to support them in preparing a meal, and they are not counted in the meals-on-wheels service. In addition, local populations have access to luncheon clubs, and people go there more for social reasons than for the receipt of a meal. Again, they are not counted in the figures. People are in receipt of flexi-care, help with shopping, and so on. Client choice also comes into it.

Like other trusts, we use the Northern Ireland single assessment tool (NISAT) to assess need. We are organised into four geographical localities in the Western Trust where we have integrated service delivery teams, including nurses, social workers and allied health professionals working alongside general practitioners and local communities. They will be very quick to pick up if anyone has nutritional needs.

We carried out a review of our meals in 2011, and we recognise some of the things that have already been mentioned by other trusts, including the departmental circular. As I said, some of that was historical, and our plan is to bring an alignment of client charges in 2012.

As regards the tender process, we have historical contracts that we review on an annual basis based on costs and quality, and we have to review that again following this piece of work. We have to make sure that we have local accessibility, which is really important.

We have worked on the regional collaborative, as Charlotte has mentioned, and our corporate management team considered the regional access criteria in September 2011. We have undertaken an EQIA initial screening. As a result of that, we will carry out some stakeholder events during March to hear what local people want and need. Furthermore, in keeping with other trusts, we are at the early stages of re-ablement, and we anticipate that that may reduce the need for some community meals. However, in relation to demographics, the Western Trust has the largest proportion of predicted over-65s in Northern Ireland. The Northern Ireland average is around 24% — that is the mid-census prediction. In some of our areas, certainly in the Waterside area of Derry and in Limavady, there will be a 39% increase in over-65s. So, while we may see a reduction in need because of the application of re-ablement, we will have a huge increasing number of older people. The other issue is about empowerment and encouraging people to tell us exactly what it is they need and want.

**The Chairperson:** Thank you very much for a substantial presentation. I thought that it was important that the trusts be given an opportunity to speak to their paper. The problem is that when you have five witnesses giving five presentations to five papers, you get a lot of questions. As the Chair, I get a wee bit of leeway to ask more questions. I am saying that to members because we have departmental officials in after this session.

On a positive note, I want to congratulate you, Alan, because you are the only person whom I heard mention the Department's circular. I will come back to that.

On Charlotte's point, how often do you meet? Patrick said that you can learn lessons from each other, which I think is useful. How often does the collaborative meet on specific or general issues relating to this?

**Ms McArdle:** The collaborative was established last year. We met every two months until the point where we got the criteria agreed by the five executive management teams in the trusts and started the implementation process in October. We have met twice since then. There will be a plan of work in respect of tendering arrangements, costs and roll-out. So, we plan to meet every two months.

**The Chairperson:** OK. Before I ask the trusts specific questions, I have another general question. If somebody is concerned about a client's nutrition, the client is sent to a GP, who in turn gives them supplements. The issue is that there is no joined-up approach. If there were, whoever makes the referral to the GP would think, "If we can get the client involved in the community meals system, they do not necessarily need to go down the route of getting supplements from the GP". There does not seem to be a link-up between the community end of it and the GP end of it.

**Ms McArdle:** In practice, what happens is that the district nursing sister will probably be the one who undertakes the assessment. As a result of that assessment, she will point the person concerned in whichever direction is most appropriate. It will often be a GP, because the GP is responsible for that person in the community. However, as Alan mentioned, she will more than likely work with integrated teams. The district nursing team and the integrated social team are, in most cases, in the same building and in the same office. They will talk to each other, and that will often instigate the need for a domiciliary care assessment. I do not think that the nutritional assessment and the provision of sip feeds or supplements is the first option.

**The Chairperson:** Are you not concerned that we are spending a substantial amount of money on supplements?

**Ms McArdle:** We are spending quite a bit of money on supplements. It is my understanding that a piece of work has been done in the Ards area between the primary care partnership (PCP) and community pharmacists with dietetic support. Supplement use mainly happens in nursing homes rather than in people's own homes or in domiciliary care. It is particular to nursing homes. That is my understanding from that work. To be honest, it is a concern and needs to be tackled. However, I caution against a general assumption that the use of supplements happens in community care.

**The Chairperson:** So are you saying that the majority of people suffering from malnutrition are from a nursing home background rather than a community background?

**Ms McArdle:** No, not at all. And I am not saying that such people are malnourished. There may be some reason why they cannot eat and need a temporary measure.

**The Chairperson:** OK. I just wanted that to be clarified.

This question is specifically to your trust. We talked about the Department's guidelines. We are told that the price is set at £1·50. The Southern Trust and the Belfast Trust are the only two trusts sticking to that rule. Congratulations to them on that. The Northern Trust is charging £4·76. Everybody is aware of the circular, so why are three trusts ignoring it?

Let me explain it as if to a two-year-old. If a circular comes from the Minister, you would assume that the trusts implement it. Two of the trusts are doing that. Again, congratulations to those two trusts. Three trusts are not. Where is the link-up between the Minister and the Department and the trusts? Why are trusts ignoring a directive that comes from the Minister?

**Mr Corry Finn:** I do not think that we are ignoring it. As I explained, in our trust, a lot of it came about from a historical perspective. It was about local provision and what the costs were etc. As soon as we became aware of the departmental circular, and through the trusts' collaborative, which was clearly a piece of work that needed to be done, we recognised the need to come in line with the departmental circular. It is a matter of getting there, and our plan is to do that this year.

**The Chairperson:** I know that Patrick wants to come in on this, but the point that you are making is that it is not being ignored; you are working towards it. You talk about the trusts meeting collectively and coming up with collective decisions, so why is the Western Trust carrying out an EQIA on criteria that were agreed by all the trusts?

**Ms McArdle:** The criteria have got nothing to do with the circular; the circular is purely about —

**The Chairperson:** I know that it is nothing to do with it. I am just concerned that you are saying —

**Ms McArdle:** We have already done an EQIA in the South Eastern Trust in relation to the eligibility criteria.

**The Chairperson:** Did all trusts do that?

**Mr Graham:** Not specifically.

**Mrs McVeigh:** I will speak for the Southern Trust. The sub-eligibility criteria, which are what I think you are referring to, were provided at a time following the issuing of the 2008 circular. Three community trusts came together with an acute trust to form the Southern Health and Social Care Trust in 2007. We came with different legacy arrangements and different approaches. We were very concerned that two things were happening: we had the three-band criteria from the previous health and social care board in the southern area that we were working to as our commissioners, and we then had the departmental circular that came out in 2008. We had legacy arrangements and teams from the previous trusts working in different ways. We were very anxious that we provided guidance for our staff in the application of the eligibility criteria. That is what it is — it is guidance to help to support them. I know that you have a copy of it, and, if you look at it, you will see the algorithms that help to take our staff through. In that way, we can ensure that when you have an assessment, no matter where you are

in the trust, that assessment will be conducted equitably across our different areas and teams. It is purely guidance to help to support the teams.

**The Chairperson:** Why did you not do an EQIA on the criteria when the other two trusts did?

**Mrs McVeigh:** It was standardising practice and helping to support our staff in the application of the eligibility criteria.

**The Chairperson:** I am still concerned that a circular that came out from the Department in 2008 is still being ignored by three of the five trusts in early 2012.

**Ms McArdle:** The circular that came out in 2008 required some clarification, because the wording of the more recent one is very specific.

**The Chairperson:** Charlotte —

**Ms McArdle:** The one that we have received this year is very specific. Hitherto that, many of the trusts are providing different services and have different charging structures that do not necessarily fit with the guidance.

**The Chairperson:** Did you say that to the Department?

**Ms McArdle:** Yes.

**The Chairperson:** You raised that with the Department?

**Ms McArdle:** Yes.

**The Chairperson:** But it still sent out a circular that three of the five trusts are ignoring.

**Ms McArdle:** We have had discussions with the Department about that.

**The Chairperson:** But there is still a circular in place.

**Ms McArdle:** There is still a circular. That is why we need to try to standardise things across the five trusts, so that we are all doing and saying the same thing.

**The Chairperson:** I appreciate that, but you need to appreciate that a circular went out in 2008, and you are saying that another one was sent out on top of that, and there is still no change in three of the five trusts.

**Ms McArdle:** We are working towards that. It is not something that we can do overnight.

**The Chairperson:** I will bring in Peter before opening up to members, and then I will come back on stuff.

**Mr Graham:** You are causing me an identity problem here; it is Patrick.

**The Chairperson:** I am sorry, Patrick.

**Mr Graham:** We are talking about two different circulars. There was a 2008 circular on eligibility criteria for domiciliary care services. Every year, there is an update to a departmental circular about the amount of the charge that should be levied on meals. There are two different circulars. As for the charge —

**The Chairperson:** So when did the first circular come out about the price of a meal?

**Ms Heaney:** It comes out every year.

**The Chairperson:** When did it stick at £1·50? When was the first time that that came out?

**Ms Heaney:** £1·50 is for this year.

**Mr Graham:** It was November 2011.

**The Chairperson:** How much was it the previous year?

**Ms McArdle:** It was £1·35.

**The Chairperson:** How much was it the year before that?

**Ms McArdle:** We do not have that.

**The Chairperson:** That is OK; we will get that. When it was £1·35, did all the trusts agree to that?

**Ms McArdle:** No. The circular this year uses different wording. It has very specific and very clear guidance. Up to this point, many of the meal services that we are providing were not the same as what the circular was saying. Therefore, there were some clarification issues. The way in which the service was being provided was different from a meals-on-wheels service. This year, the guidance is extremely clear; there is no room for manoeuvre with that. We all understand that, but it will take time for us to get to the circular advice.

**Mr Corry Finn:** Clearly, we need to standardise the price in line with the circular, but we also need to standardise the service. In my locality, some people receive from statutory services, health service facilities or education, but some receive from a hotel; some get a two-course hotel meal. The money will go only so far, so we have to standardise it.

**The Chairperson:** When was the last time that you met the Department on this specific issue?

**Ms McArdle:** As a collaborative, we have not had a formal meeting. We have had communication with departmental officials. We have ongoing discussions with our departmental officials.

**The Chairperson:** Yes, as trusts, but not as a collaborative?

**Ms McArdle:** Through the collaborative, the departmental officials are in contact with me as chair, and keep up to speed with what we are at, where we are going and what our time scales are.

**The Chairperson:** What about the cost and the criteria?

**Ms McArdle:** We have had a number of discussions with them over recent months. I cannot really be more specific off the top of my head.

**Mr Brady:** Thanks very much for the presentations. I will start with Charlotte and then move on to Angela because, obviously, my constituency is in the Southern Trust area. It is the trust that I have the most experience of dealing with. In your regional overview, Charlotte, you said that, where there are concerns about a client's ability to eat meals because of dementia, stroke or mental ill health, the trust will allocate domiciliary care staff to assist the client to eat. Will the time that is allocated be appropriate to the client's needs? I am sure that you are probably fed up hearing about the magic figure of 15 minutes which, apparently, can stretch to hours. It is a big issue for people. I am too not sure what can be done in 15 minutes. From personal experience with my mother, what is allocated really does not work. Obviously, you will have someone who is difficult to feed because of their condition. Will the time that is allocated be appropriate?

**Ms McArdle:** The time that is allocated should be appropriate to the task that the domiciliary care person is undertaking. That is allocated by the social work team. The 15-minute call business, for want of a better word, is something that we need to bottom out because it is one or two individual experiences. It is not always the case. Very few 15-minute calls are put in to the system. The only reason for a 15-minute call would be if there is one task to be done. Often, that might be something

like heating a meal. It is often that the care worker goes to do that and something else comes up, which means that the length of time they are staying is longer.

**Mr Brady:** With respect, that may depend on which trust happens to be dealing with your case at that time. I am not being facetious, but, in my experience over many years, 15 minutes is allocated for whatever needs to be done.

When somebody qualifies for the subsidy, is it means-tested?

**Ms McArdle:** Yes.

**Mr Brady:** I wanted to check that. I am thinking about benefit checks being done. I am not sure that that is necessarily the role of a social worker or the person who does the assessment, but, with the under-uptake of the like of pension credit, which is something like £1·9 million a week, that seems like something that could be dealt with by people doing an assessment, not just of physical or mental needs, but of social needs in that sense.

I will move on to Angela. Like others on the Committee, I have gone out with Domestic Care when it delivers meals on wheels. I went out in the Armagh area, and all the people we visited were in their 80s. Earlier, Paula raised the holistic approach with regard to social isolation, etc. If you look at the figures, there is a cumulative reduction of 77·55% in the Southern Trust area between 2009 and 2012, and there have been no referrals in that period. Why is that? Are we luckier in the Southern Trust in that we have better health and the people live longer, live more healthily and, therefore, do not need it, or is there some other reason?

**Mrs McVeigh:** Thank you, Mr Brady. I will go back to some of the information that I provided you with previously and refer to some of the NISRA statistics that are available for 2010. In that period, the Southern Trust was the second-highest provider of domiciliary care services, providing an average of 11·3 hours a week, compared with the Northern Ireland average of 10 hours a week. We are also the second-highest provider of intensive domiciliary care, providing more than 10 hours per person per week. As a trust, we have a significant investment in community care services generally, and we also work significantly in partnership with the individual in looking at their own assessed needs. As well as that, we have a commitment and a responsibility to look at a range of other community services that can help support that individual, and we also look at what their family is able to provide.

We are there to help support people — not take away their individual choice and control. That is the essence of what we do. At the end of the day, we are there to support those who are in greatest need, and that is supported by the work that we are doing.

Yes, there has been a reduction, but that has been part of a whole planned process of review. As I said, in 2009 we introduced the sub-eligibility criteria to help guide and support our staff. Since then, they have been applying that to all of the reviews. We have a statutory requirement to do an annual review, or more frequently if needed. Therefore, within that, any individual who did not meet the eligibility criteria for a meal will have had it withdrawn. However, before that happened, we would have explored a whole range of options available for that person and we would have been giving them time for other arrangements. We clearly indicated to every individual how to get back in contact with their key worker if there was a change in their circumstances or if there was anything that happened that would have triggered a reassessment of their need.

Finally, as a trust, we provide 6,000 meals every week to our at-risk population, which equates to roughly 300,000 meals a year. Therefore, we do have a significant investment in meals. However, we are also very conscious that we have a responsibility to ensure that we use our resources well, that we stay within the budget available to us, and that we target those most in need.

**Mr Brady:** Thank you. Part of the problem for some individuals is actually accessing the services. Someone who is cynical, and, of course, I am not, would suggest that that kind of reduction might indicate that a cost-saving exercise was in place.

**Mrs McVeigh:** Picking up on what some of the other trusts were saying, when we formed as a new trust in 2007, we inherited three legacy community trusts and one acute trust. At that time, we were doing things very differently in each of the three legacy trusts. Therefore, we have spent quite a bit of time reforming and modernising our whole service. You are probably aware of the significant work that we have done in our domiciliary care workforce, and how we have increased the range of training and provision for them. However, as well as that, have looked at engaging much better with our community and voluntary sector partners, and we have done significant work in that way. As I said previously, we have committed over £8 million per year to support our partners in the community and voluntary sector. I make no apology for saying that as a trust we have to work within the budget that we have. However, we have a significant budget, and we are using that to target people who are most in need.

**Mr Brady:** I accept that you had the legacy of the three community trusts, but, from what I have heard today, there are five trusts, which, in many ways, are taking different approaches to the same problem. The fact that you now have a collaborative approach may lead to some uniformity, and that can only be a good thing.

**Mr McCarthy:** Thanks for your presentation. I have a general question and a question to the South Eastern Trust. My main concern is that, because of the resources that you are tied to, there will be an ever-increasing number of lonely, elderly, isolated constituents, who will go wanting. That is the main concern. I asked Dr Janice Thompson about this. The drop in Mickey's trust is 77%, and it is 42% in the South Eastern Trust. Therefore, I am concerned that some people are going to miss out. However, how does each trust explain the apparent drop in requirements for community meals, despite the fact that we are consistently told — and we know that it is true — that there is a growing elderly population. Some 38% of older people who are admitted to hospital are suffering from malnutrition. That simply does not add up. Is that acceptable to the trusts?

**Ms McArdle:** The reason for the reduction is not purely that we have taken meals off clients, because that simply is not true. There are several reasons for the reduction, but it is mainly because there is more choice and flexibility in respect of how people can access a meal. There are now ready meals and local stores. Families are now better equipped to support someone having a meal, because, as Patrick said earlier, technology has moved on in the past 30 years. Therefore, there is much more convenience in preparing a meal.

Many of our clients have moved on in their care provision. Therefore, a lot of them are now more dependent, and a meal is not the answer. Many of the clients are in residential or nursing care, and many of the clients have died. There is a whole range of issues for why the numbers have dropped, but it is mainly around choice and flexibility.

**Mr McCarthy:** What about the 38% that we have been told are admitted to hospital, and one of the reasons is malnutrition. That cannot be acceptable to you, me or anybody else.

**Ms McArdle:** That figure might be from some peer-reviewed literature that you have received.

**Mr McCarthy:** Yes, it was from Dr Thompson.

**Ms McArdle:** I do not have the evidence for that. There are very few people admitted to hospital with malnutrition as a cause for admission. In hospitals now, and maybe at a later date —

**The Chairperson:** In fairness, Dr Thompson said that malnutrition was a secondary condition. She has the evidence for that.

**Ms McArdle:** Understanding the primary condition is important, because many primary conditions may lead to malnutrition, or the person may not be physically able to or want to eat a meal in any shape or form. It is not that they are being, by implication, starved. It may be because their primary condition does not allow them to be nourished either because of the process of metabolism or because they have a had significant event after which they are not able to eat. Therefore, there are a whole range of issues that need to be unpicked.

**The Chairperson:** If it is not recorded, that is an issue.

**Mr McCarthy:** Absolutely. Charlotte, on pages 2 and 3 of your submission, the use of purchased ready meals is cited. Surely, it is not nutritious to eat ready meals every day. If a person can only prepare that type of meal, should they not be categorised as being at risk and given more help to eat well?

**Ms McArdle:** As part of our collaborative group, we have a dietician from the South Eastern Trust at the table, who reliably informs us that many of those ready meals are quite nutritious, and the nutritional information is available on the pack.

**Mr McCarthy:** But it might not be wise to accept that when purchasing one of those. It might be full of salt and God knows what else that may not be nutritious.

**Ms McArdle:** There are low-salt options, but that is not to say that if you cook a meal, it is any more nutritious. If you over-boil vegetables, for example, you have lost the nutrition. There are pros and cons for both. It is probably good to have a mix, as many families are reliant on. For those who do not have families, the trust, as many of us have said, will provide a meal. There is no issue with that.

**The Chairperson:** For some people, cooking a meal is a choice, but, for some people, having to get a meal provided is not a choice, and that is the case with salt and nutrition. We need to recognise that.

**Mr McCallister:** The late Jim Wells has arrived. Every time we discuss this issue in an evidence session, we seem to end up with more questions than answers. It has been sold that re-ablement has been at the core of some of the reductions. When did each trust actively start re-ablement?

**Mrs McVeigh:** I can speak for the Southern Trust. We commenced our re-ablement service in April last year. When we talk about re-ablement, we mean the specific service that is headed up by an occupational therapist, and the re-ablement element is provided through re-ablement support workers. We have that in place in two of our areas, and it is being rolled out across the rest of the area. To date, we have provided a re-ablement service to 264 individuals, 53% of whom have not needed any further domiciliary care support at that stage. That is not to say that, at some stage, they will not come back into the system, but that is where we are. From April last year, just over two of our teams have commenced that service. It is important to note that, while that is a specific re-ablement service, the ethos of re-ablement has been there before, and it is about maintaining independence, choice and control for people and supporting them to live independently in their own homes and own communities. So, while we have a specific re-ablement service, all of our teams, irrespective of where they are, are working to support that re-ablement ethos in the trust.

**Mr McCallister:** Particularly in the Southern Trust, Angela, you had a 77·5% drop, with re-ablement counted as one of the policies leading to that, yet it had not even been in place for a full year.

**Mrs McVeigh:** You are quite correct. It is listed as one of the reasons, and as we roll it out across the trust, we will increasingly find that, through re-ablement, more and more people will be supported to be as independent as possible. I said previously that, in 2009, when we introduced our sub-eligibility criteria as guidance for our staff, they started to use that when they were carrying out the reviews of people who had a domiciliary care package. We then evidenced a reduction in the number of people who had a meal through that process.

**Mr McCallister:** When, roughly, did everybody else start this? Was it in and around that time?

**Mr Corry Finn:** In the Western Trust, we are at an earlier stage of implementation. We have our group up and running and have done our homework, and we are at a very early stage of implementation.

**Mr McCallister:** You have not officially started?

**Mr Corry Finn:** We have begun, but it is too early to say what the difference will be in level of dependency. As Angela said, people may well re-enter the re-ablement service because it does not necessarily prevent a level of dependency for ever, but it might postpone it to a later stage of your illness or frailty.

**Mr McCallister:** I accept that. The problem that we as a Committee have is that, in the Southern Trust, Angela started almost a year ago and has a 77% reduction. Charlotte and the South Eastern —

**Ms McArdle:** We started about a year ago or thereabouts.

**Mr McCallister:** So you started a year ago and are on a 42% reduction from the 2009 figure. The Northern Trust is on a 45% reduction, yet the Belfast —

**Mr Graham:** I am sorry, John; we started in September 2010 and we have been running for about a year and a half.

**Mr McCallister:** Right, so you have had a 45% reduction, and Marie, who represents the Belfast trust, has had a 0·5% increase.

**Ms Heaney:** Belfast is still in the planning stages of re-ablement. We are taking a fairly broad view of it as a trust.

**Mr McCallister:** I want to get my head around this from the Committee's perspective. How is there such a disparity if you are using a single criterion? From the Department's evidence last time, it was not even clear that there was a single criterion. There were things that came up at that evidence session with the Department: the £1·50 charge seems to have been broadly ignored by the trusts, and in the question-and-answer session — in answer to a question from the Chairperson — it emerged that people over 75 and on pension credit got that free. I do not know whether that —

**The Chairperson:** That is not true, and it has been rectified; sorry.

**Mr McCallister:** Fair enough; at least that has been clarified.

The big query is about how you end up with so many things all over the board. There are figures for the start of each re-ablement, and there are figures that are going up and down, and the figures for Belfast are the same. Are your figures for day care rising or staying fairly level?

**Ms McArdle:** They are rising. Respite time is one of the things that carers ask us for so that they can carry on and do their normal daily business. Often, the only respite that they get is one or two days a week when their relative is in another facility, and in that period, they are free to do whatever they need to do. Often, that is what makes the difference between someone being able to live at home or having to go into long-term residential or nursing care. That will continue to rise.

**Mr McCallister:** If you added those figures in, would they dramatically change the likes of Angela's 77% reduction and your 42% reduction?

**Ms McArdle:** They will. However, it is clear that the three trusts that have implemented re-ablement and are fairly well down the line are those that are seeing the biggest reductions in the meals service. There is something happening, and we are suggesting that re-ablement is a key part of that. Re-ablement cannot happen unless there are workers going in to support the carer at home. Extra domiciliary time is going into assisting individuals to get back to their maximum independence. That is the aim. There is someone there during and after the re-ablement, supporting the individual to make, heat, plate or eat a meal. That is happening in a different context.

**The Chairperson:** Or it could be a reduction in services.

**Mr McCallister:** To follow on from Kieran's point —

**The Chairperson:** Just to clarify things, John, there is a letter from the Minister that outlines the mistake that we mentioned earlier.

**Mr McCallister:** I accept that; that is fine.

**The Chairperson:** Can I push you?

**Mr McCallister:** I will be very brief. I just wanted to highlight that the 38% figure was taken from a survey of hospitals in Northern Ireland. One of your hospitals has contributed to —

**Ms McArdle:** Was that in Northern Ireland or all of Ireland?

**Mr McCallister:** Northern Ireland. We do not know which one, but one of your hospitals has contributed to that situation.

**The Chairperson:** You nearly got into a political debate there with that last comment.

**Ms McArdle:** There is one in the Republic of Ireland. The figures are there. I raise that because one of the papers that I read referred to mixing Northern Ireland and Southern Ireland into the same paper. Therefore, the statistics would obviously be different.

**Mr McCallister:** It was a UK survey.

**Mr Gardiner:** I thank Ms McVeigh for her presentation, representing the Southern trust area, which is mainly my constituency. John has asked some of my questions already, so I will not overlap them. I want to ask you about the budget for senior citizens, and I want you to prepare yourselves. Do not call people old people; they are senior citizens. One day, you might be called an old person yourself, and your hackles would go up, and it is not fair. It does not give a person great encouragement or enthusiasm to live. Respect them, and refer to them as senior citizens.

Where are the meals provided from in the Southern trust area? How do you help people to meet their nutritional needs?

**Mrs McVeigh:** Thank you, Mr Gardiner. I think you have asked three questions there. The 2010-11 budget that we have for older persons — sorry, for senior citizens —

**Mr Gardiner:** Thank you.

**Mrs McVeigh:** — was £37·6 million. That was for all of our domiciliary care services. During that time we spent £41·3 million, so we have overspent slightly in that area and, obviously, that is one of the areas that we have to focus on to ensure that we stay within budget. You asked about the providers. We have contracts with five providers, four of which are independent sector providers — my paper on page 9 details that — and one of which is a social enterprise provider.

You also asked about re-ablement. Sorry, Mr Gardiner, was it about re-ablement or about how we provide nutritional support?

**Mr Gardiner:** Nutritional needs, yes.

**Mrs McVeigh:** As I said during my presentation, the essence of what we do is very much around the individual assessment, looking at the needs of the individual and the range of supports that person has available to them. We do provide for the individual in their own home. As I have already said, almost half of the people that we provide a domiciliary care service for actually have some element of that, which is there to support their nutritional needs. We provide 4,000 meals every week through our day care luncheon clubs and social centres. We also significantly support the voluntary and community sector. It is important that I mention one of the areas related to something that Mr McCarthy raised about social isolation. We fund the voluntary and community sector to work to support senior citizens. That might be through befriending or a good-morning call. It could be a whole range of community sector provision within that community. It is very important that we also use technology, such as Carecall. We have a whole range of ways of supporting those vulnerable and isolated individuals within the community.

**Mr Gardiner:** Do you have many complaints from senior citizens about carers going in and sometimes there are things missing from the house? I will make that a bit clearer. I have a relative who is a senior citizen and receives home care. Her pension was going down and down each week that she got

it. The police were called in and detected who was taking the money. It was the carer, unfortunately. Do you have many cases like that coming before you?

**The Chairperson:** We need to be very careful that we are not stepping into an issue of policing.

**Mrs McVeigh:** I would not be able to give you that information now, because I do not have it with me, but if you want to approach me outside of the meeting I will certainly discuss that with you.

**Mr Gardiner:** That is fine; I just want to highlight it.

**Ms P Bradley:** It has been very beneficial for all of us to get each trust in and find things out. John stole a little bit of what I wanted to know, because I worked for the Northern Trust when re-ablement was introduced, and I am a great believer in it. I believe it works. It does not work for everybody, but I do believe that it works. I just wanted to match the figures up. I understand that the Northern Trust no longer subsidises the meals for new clients but it still subsidises existing clients. Is that correct?

**Mr Graham:** I will clarify that, because there was one point that I wanted to come back on about the cost in the Northern Trust of £4·76. That was submitted in the earlier paper. There are a number of instances where we do charge £1·50, as per the departmental circular. For the meals that are delivered through the contract that we have with the independent provider, we have applied a higher client contribution to the lunch, and a lower client contribution to the tea, so we are charging more for the lunch than the circular outlines and charging less for the tea. There are reasons for that, and I could get into the massive detail on that. We acknowledge that we are charging more for lunch, but we are charging less for tea than the circular outlines.

**The Chairperson:** It still means that people in the Northern Trust are charged around £800+ a year extra than those in the Belfast Trust.

**Mr Graham:** Anybody who we have assessed as needing assistance with a meal — they have no other way of getting it, no relatives and no other option — can choose to use one provider or another.

**The Chairperson:** Having no other option does not really give you much of a choice. I would appreciate it if you would give us figures for how many you charged the full amount and how many you charged different amounts in the evening. Sorry, Paula, I just needed to make that point about the postcode lottery across trusts. Apologies.

**Ms P Bradley:** You have put me off my train of thought now, Chair. We are talking about standardising the whole thing across all the trusts. Heaven help us all in north Belfast. This will be standardised, and Belfast will fall into line with the rest of the trusts. We will have what looks like being a sizeable decrease in the number of people in Belfast who receive meals. I know that you said that the review will take place next year and then there will be the re-ablement scheme. Re-ablement is not the be-all and end-all, and I would not paint it as such. It does not work for a lot of people. For many people, re-ablement is not some miracle cure. I am concerned for Belfast.

**Ms Heaney:** It would be wrong to predict any decline in meals provision. We will carry out a full review of meals. A key thing for us is that we provide the meals. We are a major producer of meals. Knockbracken Foods belongs to Belfast Health and Social Care Trust. We need to be clear that any change will be a statutory requirement. We will be required to consult with trade unions if we are changing any service provided by staff, and we will need an EQIA of that issue alone. I would be very reluctant to predict a decline until we conduct a full review of services.

**Ms P Bradley:** We find that, with the postcode lottery, Belfast is still not too bad on that.

I believe in patient or client choice. I am 100% behind that. It should be up to the patient or client what meal they have. It is their decision and their choice. I might be speaking out of turn a little bit, but I know that, for a long time, they were not given as great a choice as the one they have now. I understand the reduction in figures due to choice.

I remember the single assessment tool well. I am so glad that I do not have to look at another one of those, because they were absolutely dreadful, long oul forms to fill in. I still find it really quite worrying that there is such a differential in the number of meals that are provided in each trust. Frankly, I do not care who provides the meal. That is not what we are here about or what we are interested in. All that we are interested in is the fact that there are people who need it. We know that there are people who need it. There are people out there who do not have family and who are unable.

The point was made that malnutrition may involve a raft of other issues. That is my exact point. We need to look at a holistic approach. It is not just about getting someone who is not eating to eat. There are people out there with medical conditions and mental-health conditions; I know all those things. The point that we are trying to make is that you, as healthcare workers or whatever, need to look at a holistic approach and see that there is not a one-size-fits-all solution.

We cannot put a line through it and say, "Those are the criteria. You have not met those criteria, so you are not getting it". There is so much more to it. The form that we were given two weeks ago was about, "Can you prepare a meal?" It did not really say, "Do you need a meal?" I know that the criteria forms that we saw two weeks ago were not part of the single assessment tool. However, I looked at those and thought that they do not tell me about that person's mental health or any conditions that they might have that would stop them from being able to prepare a meal or to have a meal delivered. They do not tell me that.

**Mrs McVeigh:** Ms Bradley, the guidance was put in place to help to support staff in the application of the eligibility criteria. The important thing is around the assessment. This is a guide. The essential thing, as you have identified, is to look at the whole range of issues that are important to that person. Our teams that do those assessments, which, primarily, are social work and district nursing teams, are trained to look at the broader picture to make sure that they are not looking at a single issue. It has to be individualised to that person and has to take on board what their family, if they have a family, are able to provide for them. It is a whole range of considerations, such as what their neighbourhood is like, what their community is like and what else there is. It also has to take on board things such as their mental health. Although we have put in guidance, it is very much guidance. At the end of the day, it is a professional assessment and working with the individual to identify how best to meet their nutritional needs.

**Ms P Bradley:** I agree with empowerment, choice and all those things. When I get to that age, I want to be empowered enough to make those choices. We all would. We will look at this very closely over the next three or four years of the mandate to see just what the levels of malnutrition and home care are. I am delighted to hear all trusts saying that they now have home helps who can go in and make meals. That is brilliant; that is great news. For so long, we were not able to do that because we did not have the staffing or the time. I am delighted to hear that all trusts are now able to do those things. We will monitor that. This will not go away; we will not leave it alone. It will have to be monitored over the coming years to see just what the levels of provision and home care are. As we all know, it is very much part of the health and social care review to keep people in their homes. I wholeheartedly agree with that as well. We have to continue to review this.

**Mr Durkan:** I welcome the panel. There is a distinct lack of uniformity in service delivery across the trusts and, therefore, a lack of uniformity in the style of presentation today. That makes comparison among the trusts and the statistics that we have been given more difficult.

I will be a wee bit parochial to begin with. You will be glad to hear that, Alan. The model of delivery in the west works very well. You spoke about the annual review of the contract. Bearing that in mind and giving cognisance to the pricing and costs that are stipulated in the circular, do you envisage much of a change to that model? That would obviously have implications for service users and providers.

**Mr Corry Finn:** As I said by way of introduction, some of the way in which we deliver the service has been historical. It has grown up that way because, as you will know, in parts of the west, it is quite difficult not only to get people to deliver meals but to get carers. Someone may live halfway up a mountain. We know how challenging that has been with ice and snow over the past couple of years. The staff at the trust have been able to respond to that in partnership with local communities, which is good. Our model is reflective of our geography and how things are done. We try to find local solutions

to local problems. When we review our contracts, we need to be careful to make sure that they are responsive to local needs. Clearly, the money situation will have to be sorted out by the trust. It will have to find the money to be in keeping with the departmental circular. We will have to do that; that is what we are required to do, but it will be a challenge. Nobody is coming to us with additional money, so that money will have to come from somewhere else in our budget. I cannot predict what it will look like in the future. I cannot predict, like Belfast, what it will mean in terms of re-ablement and how that will impact on the number of people who receive meals. It is all about local provision and being sensitive to local needs.

**Mr Durkan:** You said that no one was coming with additional money. I recognise that greatly. Mickey asked whether a lot of this was down to cutting costs. I got a sense of denial coming from the representatives of the trusts that that was the case. You should not come here feeling like you are on trial or whatever. Angela talked about having to do as much as possible with the budget that you have. You should be asking us as many questions as we ask you.

Charlotte, you spoke about signposting to other providers when you are unable to provide because someone does not meet the criteria. Can you expand on that? Anecdotally, we have heard that that might be as little as telling someone that there is a garage down the road with a hot food deli.

**Ms McArdle:** There are a range of options, and that is one that some people like. Some people are happy to look at it as an alternative, although not for every day of the week. In a menu of options, if you like, it would be one to be considered. If a family member is able to order online, Tesco will provide a home delivery service. Local voluntary and community groups are only too happy to be involved, and we contract with many of them anyway for the provision of meals or for taking people to a luncheon club. Bryson House or those kinds of providers are happy to be involved. Many church groups provide social events that include a hot meal, and we encourage people to look at all the options.

You asked the question about us asking the Committee as many questions, but I am not sure that the rest of the Committee would agree with that.

**Mr Durkan:** The Department then.

**Ms McArdle:** Sue mentioned the postcode lottery. It is a bit of a postcode lottery, and we know that. However, that is partly because the services have grown up in different shapes. It is difficult to say that you can get a two-course meal from a hotel at the same price as you can get a meals-on-wheels service from an independent provider. They are two different things and cannot possibly be the same. The question is: who bears the cost of that? We made the point at the start that there are many people in receipt of a pension who are not receiving services from us. They are living off a pension and finding it difficult to heat their house, but they have to provide their own food. Yet, there is an expectation that if you need a care package, you can have a subsidised meal along with a number of other benefits. I do not think that the question is about the provision of the meal; it is about the cost of the meal and who bears that cost.

**The Chairperson:** The good thing is that the Department is sitting listening to this presentation. We want a positive outcome on all this. Therefore, it is important that we have a joined-up approach. The reality is that people's needs do not change, and we need to ensure that we are not taking away services that are needed, which would put pressure on other services and go against the ethos of the Compton review.

**Ms Lewis:** I thank the panel members for their contributions. You will have to forgive me because, with the amount of information in front of us — especially this week — I find it very confusing, and, as Mark said, the different formats are not helpful for comparing.

Along with other members, I am concerned about the statistics that we have received on malnutrition. I hear what you are saying, and I hear about all the good work that is being done, and it is fantastic. There are social events, and people are being fed at those events. There is also re-ablement and all that. However, before today, I thought that that had been in place much longer than it has been, which confused me when I saw the drop in the figures for community meals. We have also been told that

£19·2 million is spent annually on oral nutritional supplements. You would expect that, with service provision going up, it should be better for older people and that they should be getting what they need. Hopefully, there will be a downturn in that amount in subsequent years.

I am still at a loss. I want to address my question to Patrick, as I am interested in the south-Antrim area. There have been no referrals in the past three years. Does that mean that the trust is simply not referring people for community meals? How is it possible that no new person required a community meal in the past few years?

**Mr Graham:** As was talked about earlier, we carry out assessments. We carry out the NISAT, the eligibility and the other matrix that Angela referred to. We signpost most of our people to alternatives, and there are people who choose their own alternative. Significant numbers of people still get meals while attending our day centres, and significant numbers get assistance in their homes. One of the points that we made at the outset was that a reduction in the meals-on-wheels figures is not necessarily evidence of a reduction in meals provision. It is one element of meals provision. There are voluntary organisations out there that provide meals. I referred to Age Concern in Cookstown, because I live in Cookstown. It is extremely keen to expand the service that it offers. One of the things that we want to get from today — Mark mentioned asking Assembly Members or Committee members — is consistency.

**Ms Lewis:** I agree totally. If someone's needs cannot be met by some of the alternatives, can they have a referral for a community meal?

**Mr Graham:** Absolutely.

**Ms Lewis:** So, it is simply the case that everybody has been satisfied in some other way and has not needed a referral.

**Mr Graham:** We have been able to find alternative ways of providing meals as opposed to the meals-on-wheels service or the community meals contract that we have with the independent sector.

**Ms Lewis:** That sounds like good news. I am still baffled by the rise in the malnutrition statistics. The numbers are very large.

**Mr Graham:** That is something that we all have to look at.

**Ms Lewis:** In the statistics that we have, Northern Ireland is the highest, at 38%, compared with England, Scotland, Wales and the Republic of Ireland.

**Mr Dunne:** I thank the panel very much for coming along. It has been very informative. I think that we all very much appreciate the work of the meals service. Some of us have been out and about with the people who provide the meals-on-wheels service. We were impressed with what they do. There is a social side of it as well. It is a social-type service, and we certainly saw that at first hand.

The point was made about consistency. We have obviously seen a lot of inconsistency today. You, Patrick, made the point earlier about the need for consistency across the trusts. Would it be fair to say that, at the end of the day, one size will not fit all and that there are different requirements in various areas? The west is different from city locations; it has totally different needs and requirements. Costing has been mentioned. It is important that the criteria are seen to be set and applied consistently.

**Mr Graham:** I do not think that we will get a consistent model of meals provision because things have developed in each locality for particular reasons. There will still be a fairly wide variety of methods of provision from the model that is in the Western Trust to the model that is in other trusts. It depends on geography as well. It depends on the capacity of local communities and the voluntary and community sector. When we talk about re-ablement, we need to re-able not only individual service users but communities to become more involved. In some ways, in the Northern Trust, the way in which we have provided meals in the past has perhaps disabled some voluntary and community organisations locally from getting involved.

**Mr Dunne:** It has disabled them?

**Mr Graham:** I think so, because we have gone for a particular mode of delivery. Earlier, I talked about learning from this experience. There are different methods and ways of providing meals. The collaborative that Charlotte referred to gives us an opportunity to explore how everybody is doing it. It is not the case that one shoe fits all, but the costing issue has to be standardised.

**Mr Dunne:** We all learned from the information about the Belfast Trust that we got a few weeks ago. I think that Knockbracken Foods was fairly new to a lot of us. We have some information today that the Minister provided to the Chair. The Belfast Trust unit costs are not clarified. Will you clarify roughly the unit costs of the Belfast provision?

**Ms Heaney:** For Belfast, the breakdown given in the briefing paper shows that Knockbracken Foods' meal preparation costs are £2·33, plus a further £1·90+ for distribution, administration and client monitoring, which is paid to Domestic Care, making the total cost of the meal £4·26.

**Mr Dunne:** OK.

**Ms Heaney:** The client contribution is £1·50, with a subsidy of £2·76, which is broadly similar —

**Mr Dunne:** The unit cost would be slightly less than most of them. Does that cover delivery?

**Ms Heaney:** The delivery cost is included in the £1·93. Those are figures provided by Knockbracken Foods, which is a business unit.

**Mr Dunne:** It is run by the trust.

**Ms Heaney:** Yes. It has a considerable number of trust employees.

**Mr Dunne:** You are providing for the contractors as well; is that correct?

**Ms Heaney:** We have one contractor, Domestic Care Services, which distributes food to many of our hospital wards, day centres and residential care homes and to individual community clients. It also provides meals, under contract, to other trusts.

**Mr Dunne:** Does Knockbracken Foods do that?

**Ms Heaney:** Knockbracken Foods is a major supplier as a production unit. As I mentioned earlier, any change to the model would cause us significant concern. We would have to do a significant amount of consultation with trade unions and others. The model works very well for us at the moment.

**The Chairperson:** OK. It has been a long presentation. To go back to Marie's last point: were any consultations done in other trusts on the issues raised around re-ablement, Knockbracken Foods and Domestic Care? Did the trusts carry out any consultations on any of the changes?

**Ms McArdle:** No. What we thought we did was to standardise practice where two or three trusts were coming together. We took bits of each of the three and put them together. So, we were not making a change but were trying to make sure that it was the same across the trust boundaries.

**Mr Graham:** I will offer a variation on that. When we looked at the introduction of the eligibility criteria, we immediately contacted our main provider, Domestic Care, to discuss the potential impact on the contract that we had with them. We contacted them at as early a stage as possible.

**The Chairperson:** OK. I agree with the point that Charlotte made in her introduction, which was that the service needs to be modernised, but we need to ensure that we are bringing people with us and that we are not excluding people who need the service.

**Ms McArdle:** Absolutely.

**The Chairperson:** OK. On behalf of the Committee, I thank you for the papers that you sent and brought today and for your presentations. They have been quite useful.

A presentation from the Department will follow this session, but, because this has been a long session and the room is very warm, we will suspend the meeting for 10 minutes, while we take a comfort break.