Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

Care and Support in Northern Ireland: DHSSPS Briefing

17 October 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Ms Sue Ramsey (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Mr Roy Beggs
Ms Paula Bradley
Mr Mickey Brady
Mr Samuel Gardiner
Mr Conall McDevitt

Witnesses:

Ms Christine Jendoubi	Department of Health, Social Services and Public Safety
Mr Dean Looney	Department of Health, Social Services and Public Safety
Mr Michael Sweeney	Department of Health, Social Services and Public Safety

The Chairperson: Good afternoon. I welcome Dean Looney, Christine Jendoubi and Michael Sweeney. We have your briefing paper before us. I will hand over straight away to you to make your presentation, and then we will open up the meeting to questions and comments from members.

Ms Christine Jendoubi (Department of Health, Social Services and Public Safety): Thank you very much, Chair. Members of the Committee will have received our discussion document and briefing paper. The Minister made a statement on 1 October and took questions. By your leave, Chair, I do not intend to trouble you too much by rehearsing what is in those documents. You will already be familiar with them.

I remind the Committee that this is the only part of the UK that has not had this debate on the future of adult social care. England, Wales and Scotland are considerably further down the track than we are. Even the Republic of Ireland (ROI) examined the funding aspects in 2008, and it is re-examining the revised system that it brought in then.

This is stage one of a three-stage process. Stage one is designed to help the Northern Ireland public understand what we mean when we talk about adult social care: what it is; who provides it; how much it costs; where the balance of provision sits now; and what the balance of responsibilities is between the individual, the state, the carers, the family and the voluntary sector — all the people who contribute to what we refer to as the care and support system. There will be a six-month consultation period. We are running 15 formal events throughout Northern Ireland, and you will have had details of those. We will also have a small number of bespoke stakeholder events for service users just to make sure that people who do not like formal assemblages where they have to speak into a microphone can get the opportunity to tell us what they really think.

The consultation will close on 15 March 2013. We will then take a period to analyse what we have been told. I should have said that there is an online consultation paper, and there is a consultation section at the back of the book. There is a variety of means of contacting the Department; we are happy to take written contributions, telephone contributions and contributions in any form. We will analyse all those, and we will do some financial modelling to make sure that whatever proposals we bring forward, again for consultation, will be affordable and sustainable. After that consultation period, we will bring forward final decisions on the future of adult social care.

I will say a word about how this consultation fits in with Transforming Your Care. The thrust of it is in entirely the same direction. The difference between the adult social care proposals being consulted on at the minute and 'Who Cares?', our consultation paper, is essentially in the term that we are talking about. Transforming Your Care is looking at a three- to five-year horizon. We are looking at a change to the way we provide and deliver adult social care that will be in place, hopefully, for the next 20 to 30 years. Also, Transforming Your Care is not looking at the funding arrangements for the model, and our consultation is. Through the consultation process, we have been trying to explain how the funding arrangement currently works, because a lot of people do not understand it, and that is part of the problem. They do not plan for their old age, and they do not feel that they have to. There is a range of views. When you ask people whether they think that the state should provide everything or whether people should be prepared to contribute to the cost of their care if they can afford to do so, which is the basis on which it is provided at the minute, you get very strong views on both sides, and we have already got that. We have had five events so far. One room was entirely in favour of people contributing to the cost of their care if they could afford to do so; another room was of the view, "I have paid for this care all my life through my taxes and I fail to see why I should have to sell my home and all my assets to pay for it when I do need it." The responses that you get depend on where you go around the country.

The important thing is that what we are looking at is a system that we hope will be in place for a long time and that we will be able to afford. In fact, that is one of the reasons why the Republic of Ireland is reviewing the reforms that it put in place in 2008: it is because the financial situation today is totally different from what it was when the system was designed. We are hoping that we will have arrangements in place that will be sustainable in 2025 when the over-85 population in Northern Ireland is almost twice what it is now and our over-65 population is almost 50% bigger than it is today.We hope that the pot of money we have to provide care for those people will be deployed in a way that means that, when people need care, we can afford to provide it. I am happy to take questions, Chair.

The Chairperson: Thank you for your paper, Christine. You mentioned in the introduction to your paper that adult care and support involves a wide range of services, including from the Department of Health, Social Services and Public Safety, benefits, and help with housing through DSD. Last week, the Minister for Social Development was up for questions in the House, just prior to the Health Minister making a statement on Transforming Your Care. What alarmed me was that, in his answer to a Member's question, the DSD Minister admitted that DSD was failing in its commitments under Bamford around providing supported housing. The Minister of Health, Social Services and Public Safety then made a statement on Transforming Your Care, one of the issues of which is to allow people to come out of institutional settings and go back more into the community. So, ten minutes before that statement was made, another Minister was admitting that the Housing Executive, the housing associations and DSD have failed in their commitments under Bamford: alarm bells went off with me right away.

Ms Jendoubi: This year and last year, there has been a problem with the Supporting People programme that has left the Department for Social Development with unspent money at the end of the year. That is the problem. It revolved around the fact that for DSD to be able to spend its capital budget on social housing for the Supporting People programme, it needs a commitment from the trusts as to the individuals they will be resettling from Muckamore and over what period. The Housing Executive needs to know today which individuals are going to be resettled in 18 months' time. The trusts are not always in a position to give that information and, indeed, are very reluctant to give any commitments for 18 months' time, when their budget only arrives with them year on year. That has been a particular problem for them because they were not able to commit so far in advance.

The Chairperson: The alarm bells go off with me because there are two Ministers who are both committed to providing a service under commitments that have been given under Bamford and who are both tied up to Transforming Your Care and, at this stage, there is still an admission that there has been a failure. If we are talking about the failure to meet the commitments under Bamford, which both

Departments support, how can you convince me that Transforming Your Care, which is about delivering a lot of this stuff in the community, will work?

Ms Jendoubi: The problem with the Supporting People budget, which I just mentioned, has been sorted out in so far as the Department for Social Development has agreed to give the Department of Health, Social Services and Public Safety £12 million in the form of £4 million, £4 million and £4 million over the remaining years of the CSR period. It is actually coming as £2 million, £4 million and £6 million because of the time of the year that we are getting this year's money. The Department for Social Development is giving us that from its capital budget so that we can spend it recurrently on providing the personal care that will allow it to build the houses that we can afford to support people in. Hopefully, that will help fully sort out the original problem, which was that DSD got its bid in the 2010 CSR and we did not. We made parallel bids for the same stock of population, and DSD got its bid, which gave it more capital than we had the revenue to support people in. It has made a transfer to us to even up the budgets. Hopefully, that is sorted.

As far as having both Departments signed up to Transforming Your Care is concerned, the Supporting People programme is hugely important to Transforming Your Care and the programme that the board has set out for the reduction in statutory residential care home places. Approximately 450 places will come online through the Supporting People programme over the next three to five years. That represents a real win for people who would prefer to live out their old age in their own homes rather than residential care. It is a step more support than living in your own home, but it is not an institution; you have your front door and you have a key. So, it is a good way for people to be provided with care rather than with residential care.

The Chairperson: That takes me to my second question. As you are aware, we went through the issues of domiciliary care, meals on wheels, and how some trusts were ignoring the Department's circulars. Hopefully, that is no longer the case, but on one hand the Committee is being told about the housing issue and DSD and on the other, over the past months, that some trusts were ignoring what the Department wants. Are you convinced that trusts cannot ignore a vision and policy from the Department, particularly around some of the adult social care services that are delivered through the board and trusts?

Ms Jendoubi: It is the Department's responsibility to work through the commissioners to ensure that that happens. We cannot afford to take our eyes off the ball with any of these services. We need to make sure that the commissioning plan direction clearly sets out exactly what we expect from the services that will support Transforming Your Care; that targets and indicators are in place; and that the services are managed through the commissioner.

The Chairperson: Finally, I hear that there are concerns or issues around direct payments. Will you provide us with a written brief on the exact issues with direct payments? Can new people apply to be involved in the direct payments scheme or has that been closed because of legal issues?

Ms Jendoubi: There is no issue with the legalities around the provision of direct payments. We know that they are unpopular with a lot of people because when they get their direct payment they usually want to spend that money on employing their own personal assistant. That brings with it all the responsibilities of becoming an employer, which many people do not want. So, the uptake of direct payments has not been as fast as we would have liked across a lot of the programmes of care.

There is a legal issue around the provision of direct payments to people who do not have the capacity to consent to receive a direct payment. For that reason, we have had to put interim extra-statutory arrangements in place to legalise the payments that we had been making until we found out that there was a problem. We discovered that through a 2011 judgement on a judicial review that was taken by a set of parents in the South Eastern Trust area. We are now taking steps to amend the primary legislation to allow for payments to be made to another person.

The Chairperson: Does that specific incident mean that there can be no new direct payment applicants until this is sorted?

Ms Jendoubi: The trust stopped taking on board new clients in the learning disability programme of care for a period until they got assurance from us and additional guidance on how to deal with new clients.

The Chairperson: When did that assurance —

Ms Jendoubi: That has gone out.

The Chairperson: Recently?

Ms Jendoubi: Yes; I think within the past month.

The Chairperson: OK; will you prepare a paper for us on that? I think that there is still a bit of confusion; I am dealing with a case at the minute, and some officials from a certain trust did not indicate to me that was sorted. So, we will get a paper on that. Thanks.

Mr McDevitt: I have a general question about where you see your direction of travel, obviously without prejudice to the consultation period. It seems to me that England and Wales are pitching themselves as taking a cost-cutting approach, saying that they need to find a way of doing this without having to spend a lot more money in the future, and therefore transferring the duty for care to the citizen and the individual and away from the state. That is as I read it, and Scotland appears to be taking a different approach, from what I can see. Where do you see us ending up? Where would the Department like us to end up?

Ms Jendoubi: That is very difficult to summarise.

Mr McDevitt: Let me ask you a question *[Inaudible.]* Do you see this as being the sort of place where the principal duty to care for the elderly will still lie with the state, or do you see it as a place where the principal duty for the care of an elderly person will lie with the citizen and their family?

Ms Jendoubi: I think the Minister made it clear when he took questions, even last week, on Transforming you Care, that he sees Northern Ireland being a place where, if you need care, you will get it. That does not mean that there will be no reliance on the family and the informal carer system, because there always will be. What we are trying to tease out in this consultation is whether that balance is currently right, whether we should expect more from the individual and whether what we are currently providing for the citizen is too much or too little. For example, at the moment I do not think we place enough emphasis on a person's responsibility to look after their own health for as long as possible. We need to do more on the prevention and early intervention so that we can put off for as long as possible the point at which state intervention actually becomes necessary.

Mr McDevitt: We were debating public health earlier, actually. That is a story in itself. One of the things that I find interesting and think is very commendable in our system is that it seems to encourage an older citizen to stay at home by always providing free domiciliary care. It seems to me that there is a strong encouragement and that, as long as a person stays at home, we will provide them with the support they need in the house. I presume that this is the direction of travel we would like to continue on and that we will always prefer people to be in their own homes than in any form of public or private institution.

Ms Jendoubi: The five events that we have had so far have been very different in some ways, but we have never had a room of people say, "See this supporting people to live at home business; we would far rather go into residential care".

Mr McDevitt: What do you mean? I do not want to misunderstand you.

Ms Jendoubi: They prefer to stay at home.

Mr McDevitt: Yes, absolutely. That would be my sense too.

Ms Jendoubi: Everybody is telling us that. However, they have said that there will be individuals who will reach a time in their lives when they do not want to live at home any longer. They suffer from isolation and loneliness, and the only person they see all day is the carer who comes in in the morning. They cannot and do not want to look after themselves at home any longer. There always has to be a residential care sector around for those people.

Mr McDevitt: Given that we already provide free domiciliary care, surely that would be the foundation on which we want to build.

Ms Jendoubi: Whether domiciliary care should remain free is a ministerial and political decision.

Mr Wells: A political decision?

Ms Jendoubi: For some Ministers.

The Chairperson: You did well there, Christine.

Mr McDevitt: Take the politics out of it for a second. I understand that this is ultimately a political decision, but if the direction of travel were to be that the overwhelming majority of citizens want to stay at home for as long as they possibly can, at the moment we are able to support them at home without having to ask them to pay. Therefore, it would seem like a logical next step that in the future we would not seek to charge them to stay at home because that could force them into false choices and force them out of their homes because they cannot afford to pay for the support to stay at home, even though everyone — the state, the citizen and society generally — wants them to stay at home. Do you not think that that is reasonable?

Ms Jendoubi: It is certainly an argument that is coming up through the consultation.

Mr Wells: There are interesting figures in the paper. Somebody clearly got their act together with the consultation. We are always complaining about areas of the Province being neglected, but this is as good a spread as I have seen throughout the country, so somebody in your section has a good sense of geography. People will be very pleased when they see that.

The paper states that the average stay in a nursing home costs £52,000, and it is £100,000 for a residential care home. If you dig a bit deeper and divide those figures by the average number of years, it is £22,317 for a nursing home and £22,173 for a residential home. That surprised me because I thought the level of care was higher in a nursing home because you had to have more experienced conditions nurses available than in a residential home. So, I am a bit surprised. Are those figures for the statutory sector alone or for statutory and private?

Mr Dean Looney (Department of Health, Social Services and Public Safety): The figures are from a study by Queen's University. As far as I am aware, they are across the statutory and independent sectors. The cost of nursing homes is lower because the length of stay is shorter.

Mr Wells: It is an average of 2·33 years as opposed to an average of 4·51 years in residential. However, if you divide £52,000 by 2·33, that gives you the £22,317 figure, and if you divide £100,000 by 4·51, you get £22,173. So, there is next to nothing between them, yet I would have thought, given that the level of care is higher in a nursing home, it should be more expensive.

Mr Looney: The cost differential between residential and nursing homes tends to be around £100 per week. Trusts pay that. The individual never pays that; it is not a cost to them.

Mr Wells: OK, that is a good point. That explains it. Under Compton, we are proposing to close at least half of all residential homes. Given these figure, that will free up a very large sum of money. Could that not provide the option to make what individual residents are left to pay less onerous? Do we know what it will save, because it is £100,000 a time, multiplied by the number of residents in the 56 residential homes in Northern Ireland? I am not saying whether I support it; I am just saying that an awful lot of money is involved.

Mr Looney: As part of Transforming Your Care, the trust implementation plans outlined savings year by year in relation to social care in recognition that some of the changes that the programme wants to bring about will have to be financed by savings within the trusts themselves. There are savings linked to the closure of statutory homes, and those are being used as a contribution towards, for example, a move towards early intervention, preventative services, self-directed support and individual budgets.

Mr Wells: That windfall is all taken care of already.

Mr Looney: Yes.

Mr Wells: There was a famous story that George Best spent all his money on wild women, parties and gambling. He spent 80% of it on wild women, parties and gambling, and the rest he wasted. A lot of elderly people may take the same approach to life, because those who saved hard for their old age suddenly find that they may as well not have bothered because it will all be snaffled up in their care charges.

The one thing I find universally unpopular is the inclusion of the home as part of savings. If I were Conall McDevitt, were very successful in life and retired at 65 on a vast income and pension, it would be reasonable that I would be expected to make a significant contribution to whatever nursing or residential home I end up in. Surely, if part of that contribution is a family home, there would be logic in saying, "Cash, yes, but the home cannot be touched." I know that the home is not touched if a husband, wife or elderly relative is still left there. However, do we know whether we could afford to eliminate the most unpopular aspect of the present policy? What would it cost if the house were ignored as far as the assessment is concerned?

Mr Looney: We looked at that back in 2007, as part of the work linked to free personal care. The cost at the time was just over £44 million, and the then Minister made the decision that the money was not available to proceed with it.

Mr Wells: So it is a very significant amount of money. I was hoping that you were going to knock a nought off that, but unfortunately, we cannot afford £44 million. I can assure you of that.

The other issue is that, in England and Wales, Dilnot carried out a report which has received a very significant amount of publicity. Have we any idea what it would cost us to implement Dilnot here?

Ms Jendoubi: No. That is one of the reasons why we are going to do financial modelling. We need to insert Northern Ireland statistics into that type of model. The only thing that we can do is to take Dilnot's £1·7 billion and divide it by 40, as we are one fortieth of the size of England.

Mr Wells: That is still about £60 million, so we are still in figures where we would be struggling, to put it mildly. Finally, to go down the statistics road again, do we know what it will cost us in 25 years' time, if we continue on the way we are going? Have you any idea what we are facing, financially, if we do nothing? In other words, is it affordable to continue on the way we are going? What will it cost us in 10 years' time, or whatever?

Ms Jendoubi: We do not have those figures because we have never assumed that that kind of limitless pot would be available to us. That is why we are doing this exercise now. We have no indication that we are getting any more money for social care. I do not know what we will get in the next spending round, but we are certainly not getting anything before it. So, it is not a matter of, "If we keep on doing what we always did, it is going to cost us x"; it is a matter of, "If we keep on doing what we always did, we will not be able to afford to provide care for people who are currently getting care." We would have to set the care thresholds higher and higher, and some people who would be in need would not be getting that care.

Mr Michael Sweeney (Department of Health, Social Services and Public Safety): If it helps, I should mention that we had a look at the increase in government expenditure in this area. Since the financial year 2005-06 until 2010-11, that is over five years, it increased by over 30%.

Mr Wells: That is in five years? That is an extraordinary growth. The number of people who are availing of the services cannot be growing at that rate. Is it that the cost of the service is rising, as well as the numbers of people availing of it?

Mr Sweeney: It must be a mixture.

Mr Looney: You asked a question about the shortfall. The Department of Health in England said that by 2027, there would be a shortfall of £6 billion; so again, if we divide by 40, we are looking at a figure in the region of £150 million.

Mr Wells: These are all cricket scores. These figures are extremely worrying. I wish I had not asked those questions.

The Chairperson: Minister — sorry Jim *[Laughter.]*

Mr Gardiner: I want to ask about contribution to healthcare on page 149, or, in your small print version, page 5. What provision has been made to adjust for inflation and increase the proposed £35,000 cap on the amount that a person pays towards lifetime care costs, and to increase for inflation the £100,000 level of assets and savings that a person can have, above which the state does not help with care costs?

Ms Jendoubi: Those are the Dilnot proposals; that you do not pay anything if your assets are worth less than £100,000. If that is the case, you will keep them all. If you have assets of worth more than £100,000 you pay a maximum of £35,000 towards the cost of your care.

I am not sure what calculations they have done, or what assumptions they have made, about inflation in those figures. At the minute, they cannot find the money to meet that in the first place, much less inflate it. I am sorry, that is not a very helpful answer.

Mr Gardiner: This document came from the Minister himself. It is dated 12 October.

The Chairperson: What you are talking about, Sam, on page 149 of our papers, is what they are talking about in England.

Mr Gardiner: Yes, but what is happening here?

The Chairperson: At the minute, there is no recommendation.

Ms Jendoubi: *[Inaudible.]*

Mr Gardiner: It looks as though you have not looked at the papers then.

Ms Jendoubi: That is the situation in England.

Mr Gardiner: I know that this is about what is happening in England, but surely it will come here? What England has, we follow in some instances.

Mr Sweeney: In this case, we are not making proposals, and we are fully aware of what the Dilnot Commission said. As Christine said earlier, the second stage of the process will involve significant financial modelling, and the modelling in England and Wales is not suitable for here. There is no off-the-peg model that we could use. We will have to use health economists and other experts to do a bespoke model of what different proposals would mean, how much they would cost and what they would mean to people.

Mr Gardiner: Nothing is said in the letter that was sent from the Minister to the Chairperson. It is in our documents today, and I am asking questions about it. Maybe I am jumping the gun a wee bit for we are not that far advanced.

Ms Jendoubi: No, we are not.

Mr Gardiner: We have to catch up rather than leave it too late. We need not come shouting on the last day.

Ms Jendoubi: It has to be remembered also that the £100,000 threshold and £35,000 cap are simply Dilnot proposals. The Government in England have not yet said that those are acceptable. There are all kinds of variations around the edges.

Mr Gardiner: I want to know if they are happening here. So, nothing is happening here at present?

Ms Jendoubi: Not at this stage.

Mr Gardiner: When will we catch up?

Ms Jendoubi: We reckon that the financial modelling period will probably take at least a year.

Mr Gardiner: OK.

The Chairperson: Some of Sam's points are relevant. People are hearing what is happening, proposed or suggested in England and they are automatically thinking that it will have an impact here. We have seen that happening recently. I know that you are carrying out the consultation exercise and are going out to constituencies, and that is a good thing. Are you targeting people for those exercises, and is the community and voluntary sector involved to ensure that people are attending them?

It is important that the views of the community are being sought, because there is genuine concern that a cost will be brought in for people's care when they are at that time in life. That is part of the point, and you hear headlines about what is happening. It may only be a proposal and suggestion that might never be implemented, but there is a fear factor out there.

Ms Jendoubi: We involved Age NI and Mencap in drafting the consultation paper and advertising the stakeholder events. We will hold a small number of events in care homes and day centres so that we can talk to people and their carers about what matters to them. The voluntary organisations have been advertising those events through their websites with their clientele.

The Chairperson: That is good; fair play on that.

Mr Beggs: I will follow on from what Sam asked. You mentioned bespoke modelling in England. Are you making the necessary adjustment so that there will be modelling here and that we will have an understanding of such implications here?

Ms Jendoubi: Yes, our modelling will be bespoke to Northern Ireland.

Mr Beggs: What issues are significantly different? I am curious about that.

Ms Jendoubi: Our proportions of elderly people and people with various disabilities are different.

The Chairperson: Health inequalities.

Ms Jendoubi: Yes.

Mr Beggs: Fine. In the area of adult social care and the push towards increasing domiciliary care, I have not heard talk about the need to constantly review the situation when people are in their own homes. Circumstances can change. I came across a constituency issue with a pensioner who was looking after her disabled adult son. A significant change had occurred over a two-year period, but there was no change in the assessment even though increased support should have been given. That ultimately resulted in hospitalisation for a considerable period of time and additional cost to the health service. How are you ensuring that, if increasing numbers of people remain in the community, there is appropriate monitoring and a change in the level of support to meet any changing circumstances?

Ms Jendoubi: That issue is coming up in public engagement events. One thing that people are vociferous about is the lack of support for carers. They feel that there is not enough support for all carers, not just elderly carers. When the trusts talk about respite, they are talking about a fortnight a month, which is not what most carers need. They want a bespoke number of hours in the week.

To get back to your question; I think that the issue is about how the existing system should work. Carers, especially elderly carers, have a right to an assessment of their own, and when they have needs, those needs should be met. Your elderly parent carer has got a right to ring up the trust and ask for an assessment of her own needs to be done. As well as her son's needs, she has rights of her own to services and she has to have her needs fully explored and assessed.

Mr Beggs: There is a huge danger that by moving people with infirmity out into the community, there could easily end up being hidden issues. Yes, there are savings to be had, but those savings can come at great cost. There must be proper systems, if that is the direction of travel, to ensure that there is the necessary support as circumstances change.

Mr Brady: Thank you for your presentation. It is interesting to read about the commission being set up in England in 2010 to deal with all of this. I went to a meeting in Belfast around 12 years ago — Keith Vaz was the visiting Minister — and the issue that Jim raised about housing and people having to sell or give up their houses to pay for care was supposed to have been dealt with. I would not necessarily have the confidence that they will deal with it again, because they have been talking about it for a long time. That royal commission never materialised.

I have a couple of other points. The outworkings of welfare reform through under-occupancy will probably impact on older people. There is no doubt that it will impact on those who have had a family and whose family have gone and so they are now only using one or two bedrooms. They may eventually decide that they will have to go into care because they might be the only person left in the house that they have paid for. I wonder whether that may have to be factored in.

The meeting that you had in Newry was held in Dromantine, which is not that easily accessible for people from the city itself. I am not saying it is very far out, but for a lot of older people who you might want to have attended, public transport is virtually non-existent. There are plenty of venues centrally that presumably you could have used. I am not sure who organised that one, but I just wanted to make the point. It may be something to remember for the future.

Ms Jendoubi: We were aware of the public transport issue when we were looking at venues We were also aware of cost. Dromantine is a terrific conference venue, but you are right, it is not exactly on the bus route.

The Chairperson: I am glad that Mickey raised that. I was going to raise a point earlier about the venues for meetings. You have two in Belfast, but you are not going to get many people from where I live in Belfast, which is on the border with Lisburn, who will go into Belfast city centre for a meeting.

Ms Jendoubi: There is one in Lisburn as well.

The Chairperson: They will not go to Lisburn. They are more affiliated with Belfast than they are Lisburn. So, it might be an idea to do something through the community infrastructure. I am glad that you are talking to Age NI. What about the older person's commissioner? Is there any involvement there?

Ms Jendoubi: Yes, indeed. Age NI came in and spoke to the Minister about this.

The Chairperson: That is good. I do not want to sound negative, because you have put the effort into going into areas to try to carry out consultations, and it is not very often that that happens, so fair play on that. However, if there is anything that we can do through our offices, you should factor us in as well. Thank you very much for your presentation. Christine, will you send that paper on direct payments?

Ms Jendoubi: Yes.

The Chairperson: Thank you.