Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

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

12 March 2014

NORTHERN IRELAND ASSEMBLY

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

Witnesses:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr Gardiner: What areas are you locating those in?

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

Mr Gardiner: That will be for him.

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

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

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

Mr Gardiner: I wish you well.

Mrs McClements: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mrs Cunning: Yes; that is the point.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr Wells: Any advance on £200,000?

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

Mr Wells: Did you say £500 million?

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

Mr Wells: So you spend around £2 million?

Ms Heaney: Yes.

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

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

Mr Wells: By a process of deduction —

Mrs Cunning: It must be £1 million.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms Heaney: We provide the care and support.

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

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

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

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

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

Mr Dunne: Is it working?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Chairperson: But are there enough?

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

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

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

The Chairperson: That has cleared things up.

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

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

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

Mrs McClements: That would not look at it.

Mr Beggs: What is the cost?

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

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

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

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

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

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

Mrs Cunning: I am sorry; your question —

Mr Beggs: Why are they not listed?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Chairperson: I apologise for that.

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

The Chairperson: Thank you for that.