Northern Ireland Assembly

Committee for Health, Social Services and Public Safety

OFFICIAL REPORT (Hansard)

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

9 April 2014

NORTHERN IRELAND ASSEMBLY

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

Witnesses:
Ms Claire Keatinge Commissioner for Older People

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

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

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

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

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

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

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

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

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

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

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

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

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

The Chairperson: Go ahead.

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

The Chairperson: You have a few minutes left.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms Keatinge: In what context?

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

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

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

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

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

Mr Gardiner: Senior citizens. They are senior citizens.

Ms Keatinge: What is your definition of senior citizen?

Mr Gardiner: It is your definition of old people.

Ms Keatinge: Those aged over 60.

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

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

Mr Gardiner: Yes.

Ms Keatinge: OK. Thank you.

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

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

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

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

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

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

Mr Gardiner: We are talking about human beings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms Keatinge: That is absolutely right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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