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Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Adult Social Care

23 November 2011

NORTHERN IRELAND ASSEMBLY

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Adult Social Care

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Members present for all or part of the proceedings:

Ms Michelle Gildernew (Chairperson)

Mr Jim Wells (Deputy Chairperson)

Ms Michaela Boyle

Ms Paula Bradley

Mr Mickey Brady

Mr Gordon Dunne

Mr Mark H Durkan

Mr Sam Gardiner

Ms Pam Lewis

Mr John McCallister

Mr Kieran McCarthy

Witnesses:

Ms Patricia Higgins) Northern Ireland Social Care Council

Mr Brendan Johnston)

Ms Judith Cross)

Mr Duane Farrell) Age NI

Ms Anne O'Reilly)

The Chairperson:

I welcome Brendan Johnston and Patricia Higgins from the Northern Ireland Social Care Council (NISCC). Tá fáilte romhaibh. I have just asked members to be succinct with their questions, so I will also ask you to be succinct with your answers. We know that you have an awful lot to say; we accept that, and we need to hear it. However, we are just trying to get the

best value for money from the time that we have today. I am sorry, Brendan, you did not think that you were coming here for a lecture.

Mr Brendan Johnston (Northern Ireland Social Care Council):

It is no problem at all.

The Chairperson:

It is lovely to see you again. I saw you at Monday's event in the Long Gallery.

Mr Johnston:

Thank you, Chair. In order to press on, we have given people a submission, which, I assume, has been circulated to some extent. Rather than say very much about the background of the Social Care Council, I will note that it has policy objectives that are about protecting people who use services, raising standards of practice and strengthening and supporting the professionalism of the workforce. We do that by registering the workforce and holding them to account for their practice. We regulate social work training and the two universities that provide that training in Northern Ireland. We also have a role in workforce development and training for the broader social care workforce. We develop qualification frameworks and national occupational standards and we promote quality training.

I will focus on the part of our submission that relates to adult social care. First, we need to look at the need for adult social care. Although many people will live full and independent lives in the community without support from the care system, the need for some form of social care support tends to increase with age. As people live longer, they tend to require more care, and as medical interventions improve the ability of people with disabilities and long-term mental or physical ill health to live in the community, the demand for social care services to support that increases. Consequently, the number of people who require various forms of social care support and intervention will increase as the demographics of the population change and, in particular, as the older population increases.

Traditionally, care services are defined as care provided in an individual's home, which we call domiciliary care or home help. There is also a quite considerable amount of day care provision, whereby people attend a variety of day centres where they will receive a series of interventions, whether in the form of general support, care, therapy or rehabilitation. In addition, of course, residential and nursing home care is a major part of social care. Services are generally provided following a professional assessment of need by a social worker or a care manager employed by a trust. Although a small number of people purchase their own

care, the bulk of social care is provided by trusts and purchased by the public purse. Some services are means-tested, and some people pay contributions to their care costs. However, although trusts assess need and commission services, a very high proportion of services are provided by the independent sector. The majority of residential and nursing home care is provided by the private sector, and a large number of innovative and community-based services are provided by the voluntary sector. Social enterprises are also beginning to provide and develop a range of very responsive community-based services.

We can talk about domiciliary care and residential and nursing home care, but it is also important to remember that social care is broader than those traditional services. There is a growing range of innovative approaches to the provision of care. Consideration of service provision should not be restricted to traditional approaches. A great deal of work has been done, particularly in other parts of the UK, to develop more personalised approaches to care provision, which is often referred to as the personalisation agenda. They suggest that providing more flexible approaches to care and giving people greater control over how care is provided is more effective in meeting needs and maintaining people in the community. When we talk about personalisation, it should not be restricted to a concept of direct payments. Although direct payments are fine, a lot of people do not wish to become employers and take on the responsibilities that go with that. Personalisation is giving people some personal control over the package of care delivered to them at the end of the day.

A great deal of work has been done on what are described as “re-ablement services” — forgive the terminology — which provide more intensive support to people at an early stage to enable them to regain the functions that they may have lost, either through a stroke or ill health. The idea is that if you invest heavily in that and get people functioning again, you can, ultimately, save on traditional long-term care services. Those approaches to care should be borne in mind, and we should not just think about domiciliary care and nursing home care.

I will now look at the funding of adult social care. Clearly, there are challenges, and you will have heard about many of those challenges. They arise from a combination of factors: people are living longer; there is a reduction in the percentage of younger people in the community, and the percentage of older people is increasing; and improved medical interventions and technical innovation mean that people with disabilities and long-term health problems are able to lead fuller and more active lives in the community as long as they have proper support services. There will be major changes in the demographic profile of the population of Northern Ireland, and we have included some headline figures in our submission. The number of people over 65 is projected to increase by 42% by 2025; the

population aged 85 and over is expected to represent 4% of the entire population by 2033; and the number of people living with dementia is expected to increase from 19,000 to an estimated 60,000 by 2051.

There are also changes in society's attitudes. Society focuses much more on a rights-based approach to older and disabled people, and it has expectations of high-quality care and support that will allow people to live relatively independently in the community. Meeting those expectations will present major problems for the health and social care system, and the recognition of the rights and needs of carers means that it cannot be left solely to family and friends to pick up the care needs of their relatives. All that will result in greater demands on health and social care, both in Northern Ireland and in the UK. There are many difficult considerations as to how we deal with that increasing demand. I suppose I should say upfront that there are a number of important reports. The health and social care review, which you will be looking at, will be an important development, and the Dilnot commission in England, which looked at the overall funding of social care, is another important contribution.

The Social Care Council does not have the economic expertise to be able to give you advice on how to solve those complex economic questions. We need to restrict our evidence to those bits where we have some professional knowledge and expertise. However, any consideration of the funding of adult social care needs to take account of the fact that it is not a stand-alone issue. Social care is provided by an integrated health and social care system, and health and social care needs are very often closely intertwined. Effective healthcare provision often depends on the availability of high-quality social care. Furthermore, effective and timely provision of social care can also prevent the need for more expensive forms of healthcare intervention from arising at a later date.

As well as looking at the costs of providing social care, we should look at the costs of not providing social care. The obvious costs are the social costs associated with that. At its most severe, this will take the form of increasing human suffering and misery for people who cannot look after themselves. It will place major burdens on carers, who themselves are often elderly and disabled. It will mean that many people will not be able to remain in the workforce. They will have to stay at home to care for dependent relatives. At the very least, it will mean a loss of human dignity and independence for many. I am sure that there will be lots of evidence about that, and you do not need us to go on about it too much.

As well as the social costs, there are economic costs. There is a debate about how funding should be provided and whether there is a balance to be struck between contributions from the

state and the individual, which Dilnot has addressed. There is the extent of means-testing — whether to cap individual contributions, etc. All those sorts of issues are complex and difficult. However, I think that significant economic costs will be incurred if we do not invest in social care services.

As I said, effective healthcare provision depends on people receiving social care in order to remain in the community. The lack of such provision is likely to place greater demand on more expensive, often hospital-based services that are free at the point of delivery. By that, I simply mean that it is a lot less expensive to have someone live in a nursing home and attend hospital for care and treatment than having that person stay in a geriatric ward in an acute hospital.

More importantly, as well as that side-by-side stuff, there is increasing evidence that high-quality social care is effective in preventing the need for other, more expensive services. If provided at the right time, at the right level and to the right quality, it can mean that people will not need to go on to require more expensive health services. In preparation for the Committee, we made a limited review of the evidence base and the knowledge base, and in our evidence, we quote some of the findings that illustrate my point. I will not go through the evidence in detail but some of it suggests that for every pound invested in adult social care, there can be equivalent savings in the health side of between £1.20 and £2.65.

A particularly good piece of research was done on evaluating partnership for older people projects, which shows — again, in an illustrative way — that £1 invested in social care can save £1.20, particularly in emergency beds. A recent study by the Nuffield Trust suggests that the balance of spend towards the end of life tends to be on the social care as opposed to the health side. It also indicates that if we reduce investment on the social care side, a lot of those costs will drift towards the health and acute sector.

The important point that we want to make is that funding social care can save money in the round. That is the really important point that we are putting forward. However, if social care services are to be successful in preventing the need for more expensive hospital and residential services, it is essential that they be effective and of high quality.

Although research from, for example, the Centre for Policy on Ageing, shows that older people want and value low-level support, which we often describe as “that bit of help”, the help must reflect the needs of the individual. Services must be needs-led. There is no evidence to suggest that salami-slicing approaches to care provision, which spread the level of

service thinner and thinner, are effective. The 15-minute home help slot does not prevent anything.

Similarly, there needs to be a recognition that the provision of support and care is not just a technical activity and not a matter of just bringing the care to the person. Many important benefits to the health and well-being of the individual stem as much from the quality of the way in which the service is provided as from the service itself. Social contact and stimulation through the human interaction with the care worker can have an important impact on the individual's psychological and social well-being. Having a positive attitude to the circumstances of one's life is really important.

Of particular importance, I think, is the fact that a lot of social care is about providing intimate care. The way in which intimate care is provided can make a difference between people feeling that they are passive and helpless dependents on services and feeling that they are valued human beings who are being provided for with respect and treated with dignity at a time when they need help. That is really very important and has a huge impact on people's well-being.

What I am saying, therefore, is that the provision of care is a skilled activity that requires proper induction, training and personal and professional development of skilled workers. It is too often regarded as a low-skill, low-wage activity that can be undertaken by anyone. The effectiveness of social care provision is heavily dependent on having a skilled and appropriately qualified workforce.

We have done a lot in developing occupational standards for social care workers. We have also done a great deal of work with our sister organisations in the UK to ensure that a proper qualification framework is in place for the sector. However, it is important that the training and development of the workforce is seen as a high priority issue and that the debate on funding of social care takes that into account.

In summary, there is an inescapable need for social care and that need will grow. Consideration of what constitutes social care should not be restricted to traditional residential and domiciliary care services. Innovative approaches to personalisation and re-ablement offer the promise of really effective outcomes for people. Consideration of funding social care costs should not be seen in isolation but in the wider context of expenditure on health and social care. Social care can offer cost-effective, preventative alternatives to more expensive forms of health care.

To be cost effective, services have to be effective and deliver on outcomes. That requires a provision that responds to need, rather than one that is constrained by budgets and eligibility criteria, and that is delivered by a skilled workforce that knows what it is doing and does it well.

The Chairperson:

Thanks a million, Brendan. I remind members to keep their questions short and witnesses to keep their answers short. I agree with you 100% about skills. Unfortunately, the Department will be listening to this and saying that there are finite resources and that it has to work within its budget. However, early, quality intervention does not have to cost the earth, and quite a number of providers are already showing that that is the case. It is important that the workforce is skilled because we do not want the people who go into care to think that they are not valued.

I was impressed, Brendan, by the number of times you used the word “dignity”, and that you talked about human suffering and misery. Those are not words that we hear very often, and it is where we have to keep the focus. Generally, we hear about the bottom line. This Committee is committed to prevention. The reason why we are running so late today is that we got carried away talking about community meals. So, what you said struck a chord with all of us.

Mr Wells:

The greatest bugbear for most MLAs is the issue of social care packages for the elderly, not complaints about the quality of the package. So, the regulation seems to have done a good job in that most elderly people really appreciate that it does an excellent job. However, you already alluded to the 15 minutes. In one part of my constituency, the ladies, and they are all ladies in this case, get out of the minibus in their running shoes — I call them gutties, which really shows my age — and they literally run to the door, do their 15 minutes and then run to the next door and do their 15 minutes, and the bus is waiting for them at the end to pick them up to do the same as they go around.

There is that concern, and the concern about the turnover of carers. Gone are the days when Sadie or Siobhan would come to spend half an hour with you and she was with you for years. I know that I will be shot down by the Chairman for saying so, but they are all females in my constituency, every one of them.

Can you not intervene, as the regulator, and say, from your professional point of view, that that does not constitute provision of an adequate level of care? That would force the hand of the Department and the trusts to ensure the basic minimum half hour — even that is a significant cut from my early days in this Building when it was well over that — and continuity of cover. Do you not have the power to intervene to stop this happening? Obviously, you are aware of it like everybody else. If we could crack this, there is not an awful lot wrong with the model of provision, as long as there are resources to keep funding the hours.

Mr Johnston:

The honest answer is that we do not have the power to require anybody to provide a certain level of service. We have the power to ensure that the social workers who make those assessments and the social care workers who provide the service perform their tasks in a professional way that is informed by evidence.

If there are issues — for example, where professional staff are aware that the resources are not meeting the needs — those should be brought to the attention of their employers.

Mr Wells:

How can the needs of anyone be met if a visit lasts for 15 minutes?

Mr Johnston:

I agree. It is just not doable. I would not attempt to defend that.

Ms P Bradley:

Thank you very much. I want to bang the table and shout “hear, hear” at the top of my voice. I agree with 99% of what has been said.

I will pick up on Jim's point about visits lasting for 15 minutes. I put packages of care together for people day and daily, and 15 minutes might be allocated for a lunch call or perhaps a toileting call. It would be much longer than that if it were for personal care. I query why they have to do so much in 15 minutes. It does not seem as though correct assessments are being made.

I want to flag up the point of re-ablement. The Northern Trust has been using it for some time, and I would like to know whether you have had any feedback on how it is working. I think that it is a much better idea and that people should be told from the beginning that the

service is a re-ablement service, not one that they will have for the rest of their lives, and that it can change. We have created a very dependent society in which people think that if they are given a package of care, it is theirs for life. I agree with re-ablement and I agree that we should encourage people, where possible, to become more able and independent in their homes. Have you received any feedback from social workers or care staff as to how that is working? Is it working? Is it freeing up services to be used by other people?

Mr Johnston:

First, the personal feedback that I have got through talking to people suggests that there is great enthusiasm among social workers and social care staff for re-ablement. There is no doubt that there is commitment to it. Evidence from studies elsewhere shows that re-ablement is very effective. However, it is a very skilled activity. It is very hands-off and is not about doing things for people. It is about waiting and having the patience and skill to help people to learn to do things for themselves. That is quite difficult and quite challenging. Again, it goes back to the work that we are talking about, which is skilled work. It is not just work that anybody can do.

The evidence suggests that it is not just effective, it is cost effective. It saves money. To invest intensively at the beginning of an issue saves an awful lot of money in the lifetime costs of providing care to people who have not been able to regain their functionality.

Mr Gardiner:

Do you have continuity? I see elderly people whose carers may see them one week and then not for a fortnight. I think that you have to consider that and try to build up continuity for the good of those who are receiving the treatment. Also, how often are you caught out with respect to people going into patients' homes and interfering with something there or taking money? I am aware of such a case in my constituency at the moment. The police are investigating the matter and have taken fingerprints, etc. It is upsetting for the elderly person, whom I have seen time and again. That is not good service.

Mr Johnston:

I could not agree more about continuity. It is often the relationship between the social care worker and the individual that can make the big difference in the longer term. Continuity is very important. However, there are real difficulties because of issues that we are trying to address, such as staff turnover. There has been a reduction in staff turnover over the past five or six years, but the level is still too high. I accept that. Patricia will speak about referrals.

Ms Patricia Higgins (Northern Ireland Social Care Council):

We regulate social workers and social care workers and, unfortunately, we have seen an increase in referrals about the latter. You referred to dishonesty. As the regulator, we have to deal with that issue. Equally, we have to deal with issues relating to abuse and negligent behaviour, but dishonesty is an issue.

Mr Gardiner:

It does not leave patients with great confidence. Patients view all social care workers in the same way by asking: are they all like that? They are not all like that, and I want to put that on record. There are some excellent members of staff.

Ms Higgins:

We have taken action against people who have committed such offences.

Mr Durkan:

Thank you, Patricia and Brendan. I apologise that I missed the event on Monday. I had been invited, but I was not here on Monday. I think that we all agree on the value of social care and have done so for the past few months. It is the preferred option of the care recipient, and it is the preferred option of the Department because it is, allegedly, the cheaper option. However, I think that we have to stop seeing it as cheaper and start looking at it as the more cost-effective option. Given the change in demography and greater demand, there is going to be more emphasis on it.

In conversations that we have had with the Minister and in questions that we have put to him, we can see that, up to now, he is cognisant of the savings that can be made in social care if interventions, early detection and prevention are done properly. Although, ultimately, it will yield savings, I have a concern that not enough is being invested in social care. A couple of weeks ago, we had the launch of a dementia strategy. The Minister says that he would like to have £8 million to spend on that over the next couple of years but that we have to work better with what we have and find that £8 million. It was a case of: “money's too tight dementia”.

The Chairperson:

Stop it.

Mr Durkan:

My worry is that transition to the model that we are talking about, and which sounds great, is

not going to happen as quickly as the savings that will be made elsewhere to invest in social care. Basically and bluntly, is there a ballpark figure for how much funding you think social care should be getting? Dare I ask the question: is it being underfunded at the moment?

Mr Johnston:

Not being an economist, I cannot give you a ballpark figure on that, but there is some interesting work in the Appleby and McKinsey reports, among others, that could do so. When I speak to social workers and social care workers, I sense the feeling that they need to get ahead of the curve and that they are always behind the curve. Instead of providing services to meet people's needs, they feel that they are looking at a constrained budget and asking whether eligibility criteria are being met. We need some sort of investment that gets us ahead of the curve.

The problem that you face, and which will be a problem for the Administration to face, is the fact that the savings that you generate through investment in social care now will probably not be realised until some way down the line. For instance, investing in my mobility services now may prevent me going into hospital later, but if you do not have the money to invest in maintaining my mobility now, where does that leave you? That is an issue, and I am sure you will be discussing it with Mr Compton. There is a real need to look at reducing our dependence on the acute sector by developing services in primary care, which will allow that to happen, and by making sure that we invest in social care and other community care services to ensure that people are prevented from entering the system. That is the equation, but it probably requires some form of bridging investment and upfront investment to allow the benefits to be realised further down the line.

Ms Higgins:

We are saying that there needs to be a change. Brendan talked about a change from the traditional social care model. We have to think about this more as a continuum of care and look at prevention methods. As you said, this is not a package for life, and it is about beginning to achieve that. That is a bit of a culture shift from how we provide social care now. So, it is that coupled with looking at the resources needed and how they can be reconfigured to support the provision. It is also about looking at social care as part of the totality of the health and social care profession so that professional care is provided from healthcare through to social care.

Mr Durkan:

I wonder where that initial investment is going to come from, since the budgets have been

allocated already. It will not come for another few years, although one imagines that some decisions on the acute side will be made in the interim, but the savings will not be realised.

The Chairperson:

The difficulty is that because the prevention strategy and care have not been put in earlier, there is still a need for acute services at this time. It is about what comes first. If there is a plan to reduce acute services significantly and without having put the building blocks in place, you will end up with people not having access to acute services. We have to look at the demographics as well as the geography. So, I accept that this is very difficult but, to me, it makes sense. The Committee is very committed to preventative care and to putting solid building blocks in place for further down the line. However, it will take strong leadership to make future savings now when you might not get the credit for it.

Mr Durkan:

I am concerned that they might get caught betwixt and between. Funding has been reduced in certain areas but has not necessarily been increased accordingly in others.

The Chairperson:

If members are content, I will guillotine the session at this stage and bring in Age NI. Gordon will be the last person to speak, unless anybody has a burning question for Brendan or Patricia. This is a very good paper, Brendan. It is the kind of information that we need, and although your session might be slightly shorter than you had planned for, the fact that you are in before John Compton and his team is probably a big advantage. Gordon, you will have the last word on this.

Mr Dunne:

Thanks for the presentation. During a recent visit in the north Down area, I was informed of a problem with sheltered housing in a Fold care facility. There are vacancies in that building, which had never occurred before. The facilities were always in very high demand. However, the trust is not making the referrals that it had made before. Are you aware of such issues?

Mr Johnston:

I am afraid that I am not aware of those issues. I find it surprising because I would have expected there to be an increasing demand for services.

Mr Dunne:

My understanding is that there is a demand but that the trust is not putting forward the

referrals and is cutting back on budgets. You are not aware of the issue?

Mr Johnston:

I am sorry, no.

Mr Dunne:

That is grand.

The Chairperson:

Brendan and Patricia, thanks a million for a very useful evidence session. We look forward to hearing from you again. I have no doubt that we will do so because I know that you are keen on the quality element, the skills of people, accreditation, and on giving workers the recognition that their skills are valued. We have discussed that in the past, and I will want to talk to you about it again. Thank you.

We are now joined by the witnesses from Age NI. I remind members to keep their questions short and remind the panel to be succinct in their answers. Anne, you are very welcome. It is good to see you again, Judith and Duane. We are very pushed for time. We have heavy agenda, so I ask you to go right ahead. Failte romhaibh. You are all very welcome to the Health Committee, and you have provided a very weighty document in advance, which is welcome.

Ms Anne O'Reilly (Age NI):

Good afternoon everyone. Thank you for giving us the opportunity to be here. I will not go through the paper. We had the benefit of listening to what Brendan had to say. So, we can start by saying that the good news is that we all seem to be going in the same direction. We are seeing the importance of prevention as a key intervention tool to try to make the changes that need to happen in the system. Age NI is very strong in that desire and it works with older people themselves. If the Committee drives that agenda through, it will receive a lot of support from Age NI, and older people will welcome it.

We want to log some key things with the Committee about social care and about the whole investment in prevention. We feel that that is the lynchpin around which the system needs to be adjusted. We recognise that the Compton review is looking at acute care, primary care and social care. We think that social care needs to be brought further up the political and policy agenda and we look to strong political leadership and public debate on that. Why do I say this? It is because I was fascinated by the questions that you were asking and the information

that you were seeking. In that sense, I draw your attention to the back page of our document. An inquiry into what is meant by social care would probably help us to find some of the solutions.

Chairperson, I know that you are very keen to think about solutions to the challenges that you face. If you were minded to work towards seeing social care as a preventative tool and teasing that out through an inquiry approach by this Committee, you could ask two questions. Is the objective to have older people receive personal safety, security, practical care, feeding or washing? Is that the outcome that we want for older people or do we want to achieve the objective of maintaining independence, social inclusion, participation with a strong purpose and participation in life? That is what the Wanless review was challenging us all to ask ourselves. The answers to those questions will drive the resources required to see through the changes that we want to be made.

As far as I understand it, you have £4.3 billion in your budget. You have unmet need that is emerging, so what do you do with that £4.3 billion? Around £600 million is going into social care. If social care, prevention and early intervention are the drivers, the resources are not following that direction sufficiently. The questions are these: where do you disinvest, and how do you plan transition so that you can drive what you need to do on acute and primary care and also strengthen social care? Our suggestion is that you need to find a way to pump-prime social care. I will give you a practical and tangible example of that. Brendan mentioned POPPs — the partnership for older people projects. The outcomes and solutions achieved there included a 47% reduction in A&E, a strong reduction in overnight beds and around £2,500 in savings in the sort of bill associated with individuals using the system. As he mentioned, there were corresponding savings of something between £1.20 and £2.65 in emergency beds. What made the difference was the scale of the investment. It was £60 million to 29 public authorities, and it was a strong invest to save policy direction.

That is the radical nature of the transformation needed in social care. We have to stop thinking about social care as being domiciliary care, meals on wheels, residential care and nursing home care, because that is not where older people want the investment to be. We have matched residential care, nursing care and hospital care to a loneliness rating. Some 60% of people who access that type of care tell us that it is a lonely experience. They feel excluded and do not feel that they are participating fully. If we were driving a more outcome-based way of delivery and measuring our success based on that grading, I think that we would be doing things differently for ourselves and older people.

This is about a real momentum for change. I have been around for a long time. I was a social worker responsible for health and social care. The questions that you are asking are the very ones that have been asked for years and years. I think that we have a policy opportunity and an unstoppable momentum to try to do things differently. As regards our responsibility for older people as citizens in Northern Ireland is concerned, they expect a level of debate and political leadership that will change the course of how social care is delivered. This is the lynchpin. It is the key prevention tool and has to be on the basis of early intervention. The evidence to support this is strong, and Age NI is very willing to play its part in ensuring that that information and intelligence is brought to bear. We ask you to consider seriously an inquiry route for social care as a prevention tool.

The Chairperson:

Thanks very much for that, Anne, and for keeping below the 10 minutes.

Mr McCarthy:

Thank you very much, Anne and your colleagues. I congratulate you on the presentation that you gave the other day in the Long Gallery. I am sure that you will get 100% support from the Committee for the work that you are doing. You said that you had been around for a long time. I agree with that. *[Laughter.]* I have been around for as long as you and I know the work that you have all been doing and continue to do and you have my 100% support.

I will ask the question that I was not allowed to ask during the earlier session. That was thanks to our Chairperson — in case you thought that I had been dumbfounded. It was to be a question to the previous witnesses on item number 31 in the Dilnot report. Will you comment further on the impact on social care in Northern Ireland of, for example, the capping of costs and the increasing of means-test thresholds, including on how possible read-across from the Dilnot report ties in with your recommendation that a fundamental review of social care in Northern Ireland should be carried out? In other words, should we, in Northern Ireland, be afraid of what the Dilnot commission is saying?

Mr Duane Farrell (Age NI):

First, Dilnot was one piece in a framework of pieces in GB. The Department of Health consulted on a new vision for adult social care and on an outcomes framework for adult social care. At the same time, the Law Commission looked at the plethora of legislation that was on the books, with a view to introducing a single statute to govern adult social care. Dilnot was the funding piece. There was a broad architecture of pieces, of which Dilnot was one.

We are concerned about any talk about means-testing. There is an established principle of parity, and one of our concerns is that Dilnot could be brought in through the back door by tampering with the benefits system. It might read across, and we would lose the opportunity to make those decisions for ourselves in Northern Ireland. That is one of the dangers, and we are calling for political leadership on that so that we have the opportunity to make those decisions for older people in Northern Ireland.

The Chairperson:

Is that it, Kieran — one question?

Mr McCarthy:

I can go on if you want me to.

The Chairperson:

It is not like you. I will give you the chance to ask another, seeing as I got such a —

Mr McCarthy:

In your documents, ‘Agenda for Later Life’ and ‘Would you have sandwiches for your tea every night?’, you refer to the decreasing numbers of older people who receive domiciliary care and meals on wheels. We talk about that every week on this Committee. You refer to focus groups in which older people describe 15-minute visits, the fact that different members of staff come in and out, the lack of time for that little bit of extra, and lack of assistance for people with lower-level needs. All that ties with the emphasis in your presentation today on prevention as a tool. We have been talking about that. Will you comment on the current levels of preventative social care initiatives in Northern Ireland and how you envisage the required profile of such interventions, including good training of the workforce in the future?

Ms Judith Cross (Age NI):

We do not have the data or the statistics, because the Department does not collect them. The trusts are in the process of developing all the models, and so forth. Each has its own database, so you will not be able to compare like with like. It will be difficult to do that.

Mr Farrell:

The reality is that social care is not being deployed as a preventative tool. In fact, the evidence tells us that, increasingly, social care services are being rationed for older people. This is a strategic opportunity to fundamentally change what social care delivers. The direct answer to your question is that it is not happening. It is difficult to make estimates about what

the profile might look like moving forward.

Ms O'Reilly:

We are actually getting the unintended consequences of the disinvestment in social care as a prevention tool, so you have to stop that slide. You are actually getting the 15 minutes because the resources are being constrained. There are rationing and access issues, and you are storing up trouble for the future. I refer to a piece of research in Canada. When they reduced home care, they found that the healthcare costs increased overall because they took the decision to disinvest in social care. What has happened with the tighter squeeze — and it makes sense — is that people are focusing on the more acute, at-risk side because that is where the worry is for now. The trusts have the wisdom of Solomon. If you have a certain budget, you will drive your resources to the more acute and at-risk areas. You are perpetuating the system that we do not want. The radical shift of that system is needed to adjust it.

Mr Brady:

Thanks very much for the presentation and for your paper, which is very comprehensive. The paper states:

“It is vital that a coherent strategic policy direction for social care is undertaken”.

That is because ‘People First’ is an old document. At the time, it seemed that that was the way forward but, obviously, it is now outdated. Something else needs to replace it. I think that everybody agrees that care of the elderly is one of the main challenges that faces the health service, certainly now and in the future.

You have said:

“It is important that the focus is on older people remaining independent and that the emphasis is on the outcomes that they want for themselves, instead of a list of pre-determined services.”

That seems very sensible. You also say:

“the language of care should shift from one of services to one of rights, needs and outcomes. This means that assessments should be a consideration of a person’s social care needs and the outcomes they wish to achieve and should not focus on the person’s suitability for a particular service.”

Again, that makes sense. Part of the argument for the appointment of a Commissioner for Older People was that he or she should be at the heart of policy, consultation, and so on. What is your view on the role that the Commissioner for Older People should and could have in formulating a proper sustainable policy for older people? It seems to me that that should be one of her main priorities and functions.

Mr Farrell:

From our experience of going through the commissioner campaign, the commissioner will have a range of strategic powers, from formal investigation powers through to awareness-raising and issuing guidance and best practice in the area. We will meet the commissioner to look strategically at how those powers can be used to identify where it is going wrong. We are very clear that this is a new policy development issue. It is about bringing new thinking to this. There may be other ways in which Claire can deploy her powers to this issue.

Mr Brady:

There is no doubt that she will deal with problems that may arise, but my argument is that she should be inclusive in the policymaking. That would help to resolve problems that may or may not arise in future. She should be at the heart of that kind of policymaking, rather than being just an adjunct that deals with fallout from the policy. She should be part of the policymaking structure. Otherwise, it seems that she will just turn into another area of complaint or ombudsman-type figure, when she should have a much more predetermined and functional role in the context of policymaking for older people.

Ms O'Reilly:

The policymaking can be of an integrated nature. People's lives are not segmented by social care. There are links of transport and housing. It is an integrated approach to what we mean by creating independence and value. The commissioner could act in a more integrated way.

Mr Brady:

I have just one more point. It has been mentioned in previous presentations that welfare reform is coming down the road very quickly. That will have a huge detrimental effect, particularly on older people, who are probably the most vulnerable. With the replacement of disability living allowance with personal independence payments, it is how you cope rather than how you are affected. Surely the coping mechanism will be bolstered, if you like, by the degree of social care that is available. That will be a huge issue. Money will be cut, we are going to go into universal credit, pensions will be affected and we already have the meanest pension system in the developed world. How will all that figure? You obviously have views on that, and we probably do not have time to go into all of them today, but the so-called welfare reform needs to be factored in.

Mr Farrell:

That is something that we are hugely conscious of for the future. There is a huge link between poverty and poor health. The impact on older people's level of income will have knock-on

determinates on the health that they enjoy or do not enjoy and their need for services. We have huge concerns about that whole agenda.

Ms O'Reilly:

To put it into sharp focus: if you are at the top of the pile, seven years of health inequality; if you are at the lower income level, 17 years of health inequality. We have to bring the poverty and health inequality agenda to bear. There is no doubt about that.

Ms Boyle:

Mickey just asked my question.

Mr Brady:

Sorry about that.

Ms Boyle:

You are all right.

My question was on your report. Thank you for your report and my thanks also go to Brendan and Patricia for their earlier report. Just on what Mickey was saying, families and carers are now being forced to take on that additional role. In your report, you estimate that the Department of Health saves £4.4 billion each year. Because of the welfare reforms, a lot of people will be forced to leave work to look after elderly parents, or whoever it may be, in the family setting. My other point was that at one of our stakeholder events, the Committee met — apologies, I cannot remember his name.

The Chairperson:

Professor Peter Passmore.

Ms Boyle:

Yes, Peter Passmore. He told us about the importance of people who have dementia getting a visit during the day to help to stimulate their brains. As a result of speaking to people in my area who get home help visits for 15 minutes, I know that that goes way beyond the expectations of individuals who need that care for more than 15 minutes. Mickey always says that even if someone is just coming to change a light bulb, they have that experience of sitting down and talking to the individual, and at least it lets them know that there is someone coming in. I just wanted to make that point. Thank you for the report.

Mr McCallister:

Following on from the conversation, I think that we are all agreed that we seem to be firefighting rather than doing enough preventative work. That is true of social work and the main health system. I put it to you that that will be one of the biggest challenges for John Compton's review, whatever form it takes. If, as we are led to believe, he wants to move very much towards community care, one of the biggest challenges will be in getting that whole sea change and attitude change in how we deliver this on the ground. The work that organisations such as yours do in pushing and campaigning for that will definitely be critical. Of course, as we heard from Brendan's presentation, the funding of that, in the short term, could potentially be difficult. It is a difficult time to look for money.

I take it from your answer to Kieran that you would like to see something that suits Northern Ireland's needs, maybe not like what Dilnot is suggesting for England, but perhaps a commission like that could be set up to look at how we fund the issues around care, particularly given that our older population will continue to grow.

Mr Farrell:

We are not specifically saying that there needs to be a commission. It is about processes like this and about having a public debate. As Anne said, it is about driving forward political leadership and public debate on the issue. There have been different experiences in GB, but they have been having that debate for 10 years now, so they come at it from an informed point of view. In Northern Ireland, people tend to come to social care at a time of crisis, when they have not necessarily thought about it and are then forced to make decisions. This is an opportunity to get the public debate happening and to involve people in Northern Ireland in that debate.

Mr McCallister:

It is a difficult one because it involves very emotive issues. If you are looking at an element of charging, how do you fund that? Who funds the personal care element, for example? I know that many people are supportive of going down the road of providing free personal care, but how do you pay for and deliver that? What is appropriate? Is it fair that someone who has worked hard and saved all their life is suddenly charged for that?

Ms O'Reilly:

I think that it is about the process of public debate. In a way, it goes back to those two questions. What type of social care do we want for the future? Is it just about the lowest common denominator or is it about a wider inclusion agenda? If the public are engaged with

that, there is much more of a political mandate to maybe make the transformational changes that are needed. What is absolutely clear is that — going back to the definition of “insanity” — if we keep doing the same things and expect a different result, it just will not happen. In a way, we need a much more fundamental debate than we have. The Compton review is, quite rightly, focusing on acute care and primary care. We need to be much clearer in our public engagement about what we mean by “social care”. We need to use it as the key prevention tool, to build momentum around that and for it to be the linchpin in the way that we have said. We are absolutely convinced that we are on the right track. We all seem to be of one mind on this. It is what we put in behind that as a set of actions and processes to make sure that it happens. It will not happen overnight but, at least, let us set out a course of action that will take us there over the years to come.

Mr McCallister:

And the standard that we want to achieve.

Ms O'Reilly:

And the standard that we want to achieve.

Mr Farrell:

We were lucky enough to have one of the Dilnot commissioners in Northern Ireland to do a seminar. The very interesting point was made that the public debate could get swallowed up by the idea of additional resources. Actually, the resources are there, but it is about priorities. We need to think about it in those terms. It is about prioritising social care in the medium to long term and saying that we will save the system money rather than taking an additional investment approach.

Mr Gardiner:

A wee correction: I would appreciate it if you did not refer to people as “old people” or “older people”. Will you try to refer to them as “senior citizens”, as Translink does on its bus passes, smart cards and things like that? Do not pull those people down. Even if they are 100 years old, they do not want to be referred to as “old”. They are senior citizens.

Ms O'Reilly:

We would not call anyone “old”. Nor would we call —

Mr Gardiner:

You talk about services for older people here.

Ms O'Reilly:

That is based on what people are comfortable with being described as. It is a descriptor.

Mr Gardiner:

I think that you have to try to change that and refer to them as "senior citizens".

Ms O'Reilly:

We have tested that. It is interesting, because there are mixed views on "senior citizens". As long as they are not called "the elderly" — I think that that is as far as we got.

Mr Gardiner:

They are called "the elderly" and "old people". We hear references to "old people's homes".

Ms O'Reilly:

We should probably ban references to "old people's homes" and "the elderly".

Mr Gardiner:

It is "senior citizens" from here on in.

The Chairperson:

That just shows you how vexed the complexities of our language are.

Mr Gardiner:

From speaking to some people, I know that they do not like to be called that. They resent being referred to as "old" and references to "old people's homes".

Ms P Bradley:

Mickey, how do you feel about that?

Mr Brady:

I have no problems at all.

The Chairperson:

You are a very youthful senior citizen, Mickey.

I said earlier about Brendan's use of the word "dignity". Anne, your use of the word

“loneliness” struck a chord with me. Father Brian D’Arcy, whom many of you know, had a family bereavement recently. He wrote in the paper that if the Irish wake did not already exist, we would have to invent it. He felt that being able to talk to people during the days of the wake was the best help that he could imagine. We are dealing with a situation where our most vulnerable and loneliest people are maybe getting only a 10- or 15-minute package from someone who might be the only person whom they see in a 24-hour period.

I have said this before to John Compton and senior departmental officials: it is the Department with responsibility for health and social care. We have to recognise that the social needs of our most vulnerable have to be taken into consideration as well. So, I am glad that you used that word, Anne. I think that its use was timely. I am glad that we had this session with you, Brendan and Patricia in advance of the team coming in to talk about the review. Thanks a million for that and for your patience.

Ms O’Reilly:

Thank you for your time.