



Northern Ireland
Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Reform of Adult Social Care and 'Power to
People' Report: Department of Health

5 March 2020

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:

Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Sinéad Bradley
Ms Paula Bradshaw
Mr Gerry Carroll
Mr Alan Chambers
Ms Jemma Dolan
Mr Alex Easton
Ms Órlaithí Flynn

Witnesses:

Mr Seán Holland	Department of Health
Mr Mark Lee	Department of Health
Ms Jackie McIlroy	Department of Health

The Chairperson (Mr Gildernew): I welcome Mr Seán Holland, chief social worker; Ms Jackie McIlroy, deputy chief social worker; and Mr Mark Lee, director of mental health, disability and older people, all from the Department of Health.

I declare an interest in that I was previously a social worker in our trusts.

I invite you to brief the Committee.

Mr Seán Holland (Department of Health): Thank you very much, Chair. Good morning. Thank you all very much for the opportunity to brief you on the work that we are taking forward on the reform of adult social care. To elaborate, Mark Lee is the director with policy responsibility for adult social care; and Jackie McIlroy, who, as you said, Chair, is deputy chief social worker, has been leading on developing the response to the report by the expert panel 'Power to People'.

With your permission, I will make an opening statement and then we will endeavour to answer your questions. Please forgive us if we are a little bit out of practice. Hopefully, we will get into the swing quickly enough. If there are any questions that you have that we do not feel we can answer adequately, we will follow up as quickly as possible in writing with the information required.

The need to reform the healthcare system in Northern Ireland has been widely acknowledged for many years. For those of us who are old enough to remember, you can go all the way back to the Hayes review of nearly 20 years ago, through more recent proposals, and to the current proposals from Rafael Bengoa.

The need to address issues in adult social care is, in my view, just as pressing, but a wider appreciation of that need probably is more recent. One of the reasons for the current awareness of the need to reform adult social care has probably come from the growing understanding that the ability of the acute healthcare system — our hospitals — to function effectively is dependent on social care. Without good social care, patients who have completed their treatment but who still require support with activities of daily living cannot be safely discharged. That is certainly one of the reasons why we should value social care, but it is not its purpose. Its purpose is to support people with needs arising from their physical or mental abilities to lead lives as full and independent as possible. Social care promotes and protects the social well-being of people for whom it might be at risk of compromise.

I make the point not to be pedantic but to highlight that if we only focus our reforms, or the need for reform, on effective discharge from hospital, we will not address the totality of social care or the concerns and hopes of, literally, the tens of thousands of people who rely on social care and for whom hospital discharge is not relevant. It is important that we realise that, while there is an important relationship between social care and acute health care and there are interdependencies, the value of social care goes way beyond getting people out of hospital.

Why the need for reform? Probably the biggest single reason is rising demand. Members will be familiar, I am sure, with the changing demographics of our population. Our society is ageing. By 2028, older people will outnumber children for the first time in Northern Ireland and the pace of change is accelerating. The demographic shift that will happen in the eight years between 2015 and 2023 will be equal to the change in the 40 years prior to that. While adults of all ages use and rely on social care, the older population accounts for about 62% of adult social care expenditure. Assuming that we continue to respond to the need for social care in the same way that we do today, that would mean that, for example, the number of care packages would have to increase by 68% by 2037 compared with today.

In addition to demand, there are issues with the supply of social care that will also shape reform. Social care is delivered through a mixed economy of care, with health and social care trusts being providers of care directly and commissioners of care from for-profit and not-for-profit providers. It is important to secure the best value for public funds, but there are questions about the sustainability of social care associated with the price being paid for it. Much of the social care workforce is a minimum-wage workforce, and that has implications for the recruitment and retention of staff. It also contributes to the misconception that social care is a low-skill activity, which, I have to emphasise in the strongest terms, it is not. If we are to respond to demand, we will have to take whatever steps are necessary to secure a sustainable supply of social care.

A third driver for reform is the legitimate expectations that people using social care have of that care. Traditionally, social care was shaped by those who provided it: what providers thought people needed was what people got. An older generation, who maybe had memories of a pre-Bevan and pre-Beveridge world, tended to be unquestionably grateful for whatever help they received. Increasingly, and I believe rightly, rather than simply accepting what is on offer, many who use social care want tailor-made support and they want to do the tailoring. Although progress has been made in that area with the rise of self-directed support, more needs to be done to increase the flexibility and responsiveness of social care if we are to meet people's expectations.

A further reason for reform is the need to improve support for carers. Family and friends carers have always played a crucial role in supporting people with care needs, but, as more and more people live longer and survive medical conditions and situations that they, perhaps, previously would not have, the burden on carers has increased, as, indeed has the age of carers. The system, quite simply, could not function without the support provided by family and friends carers, and many feel that the pressure on them is eroding their health and social well-being to a significant degree.

Then there is money. Unlike healthcare, social care is not free to all at the point of delivery. Currently, it is not always understood that that is the case by those who require care, and the arrangements for who pays and what they pay for are thought by some to be unfair. Furthermore, regardless of who pays, the costs of adult social care are likely to rise significantly, and so sustainability will be a challenge.

Those are some of the main reasons — there are others — for needing to reform adult social care.

In December 2016, the then Health Minister, Michelle O'Neill, commissioned Des Kelly and John Kennedy to consider how those challenges might be responded to. Their report 'Power to People' was published in December 2017 and contained 16 proposals for change. In the absence of a Minister, the

permanent secretary directed his officials, including us, to establish a process to analyse the report and develop options for an incoming Minister to consider for implementation. In January 2018, the project board and project team began work and, over time, they have been supplemented by an independent carers' panel and a service users' engagement group. In addition, we have held a series of workshops and focus groups to consider issues such as the role of the community and voluntary sector and the needs of the workforce.

Building on the work of 'Power to People', the project team has aligned the 16 proposals from 'Power to People' into six major themes. Those are, first, staff who work in social care need to be valued, competent and resilient. Secondly, individuals who use social care should have as much choice and control as possible over the support that they receive. Thirdly, prevention and early intervention should support people to achieve their own social well-being whenever and for as long as possible. Fourthly, support should be provided to carers in their own right and not be subject to the assessed needs of the person they are caring for. Fifthly, all services should support the primacy of home, including those services where home is a managed care environment. We need to recognise that, while it may be staffed, it is still people's home and that should be the primary consideration in how it is run and regulated. Finally, a social care system needs to be delivered through a stable and sustainable system. Although the work on the reform of adult social care experienced significant delay as a result of staff being redeployed to support Brexit planning, we are now at an advanced stage, and the Minister hopes to bring forward an implementation plan in the coming months.

That is my opening statement. We will now try to answer your questions to the best of our abilities.

The Chairperson (Mr Gildernew): Thank you, Seán. You made reference to the importance of hospital discharge. It occurred to me that prevention of hospital admission is actually as significant and that perhaps more of the solutions lie there and that support should be given to carers and people. We know that health outcomes are significantly impacted by hospital admission and that it also creates additional costs in the system. That is an observation.

My question is: will the Department undertake to commission an independent true cost of care analysis to provide an informed basis to discuss the sustainability of adult social care? It is important to note that the information should provide a range of options and not just a one-model option. What is the position now on true cost of care?

Mr Holland: One of the recommendations of 'Power to People' was that we establish the true cost of care. Initially, we had planned to go about that in a particular way, commissioning an external institution to undertake a review. Unfortunately, at the time, the funding that we had allocated for it was reallocated. That does not mean that we have not been doing work on the true cost of care. We have been engaging with the independent healthcare providers who represent care providers on this issue. We have also been doing an internal analysis of the market.

We have also been looking at work that has been done in other parts of the UK that, we feel, could inform our deliberations on the true cost of care. However, I think that further work will need to be done to address the core issue of what a reasonable margin is for a provider to be sustainable and what that means for what we will have to pay for care on a day-to-day basis. That having been said, it is important to recognise that we have information available that indicates that the market for nursing and residential home care is relatively sustainable at the price being paid today. Domiciliary care, I would say, probably feels like something that is under more pressure than the nursing and home-care sector. However, those are things that we really need to have concrete information on rather than arguments from one side or the other or anecdotal evidence about.

I am looking to see whether my colleagues would like to supplement that answer.

Mr Mark Lee (Department of Health): We are aware of some of the work that the United Kingdom Homecare Association (UKHCA), for instance, has done to look at costs and what they believe will be a fair rate of hourly fees for domiciliary care. I am sure that we will look at some of that work as we go forward and consider it.

Mr Gildernew: Seán, you have noted the importance of it, so I wonder why it was reallocated and not proceeded with.

Mr Holland: I think that it was at a time when the return of an administration was not foreseeable. There were pressures and this was one of the things that, it was felt, we would push down the line. We

recognise that it still needs to be done. The information that we have in relation to what we pay for nursing and residential care is that we tend to be about mid-level for what is paid across the UK. However, for domiciliary care, we are paying very much towards the bottom end of the scale to the point that you could say that we are probably getting the most value out of any pound spent on health and social care for domiciliary care, but that is probably at the expense of sustainability.

The Chairperson (Mr Gildernew): It is very worrying that it was pushed down, because if we do not start to front-load these solutions we will keep doing the same things that we have always done. We have seen situations where learning disability budgets in several trusts are underspent, and it creates an impression that this is not seen as important, whereas it should be absolutely central.

Mr Holland: Chair, I have no disagreement with that whatsoever. For too many years, in the wider health and social care system, the prominence that social care required was not afforded it. Too often, pressures in other parts of the system were resolved by compromising on social care. That has now gone, and I do not think that it is a prevalent mindset in the system either at departmental, board or trust level.

The Chairperson (Mr Gildernew): One of the issues effecting social care is staffing and wages. We recognise that we have some of the best care staff and unpaid informal carers and that they are the foundation on which the entire system is largely based. How does the reform of social care address the issue of sleep-in staff receiving back pay? Does the social care compliance scheme apply here in the North?

Mr Holland: The thrust of the social care reform programme is not considering the specific issue of sleep-in payments, which has been a dispute between staff and employers throughout the UK. It is more about looking at how we can create a sustainable baseline for what people are paid and a career structure for them. I do not have an immediate answer for you on the specific query.

The Chairperson (Mr Gildernew): Can you come back to us with an answer on that, Seán?

Mr Holland: We will do that, certainly. Yes.

The Chairperson (Mr Gildernew): Finally, there are significant issues with coronavirus, but are there any plans or protocols in place to protect older people, especially care-home residents? Are there action plans to contain coronavirus in care homes?

Mr Holland: Chair, you will forgive me for this response, but it is really important in the current situation that we have a unified process for responding to coronavirus and communicating both with elected representatives and the public. My colleague, Michael McBride, is leading that process, and I know that you have had engagement with him on the issue.

Social care is represented in the forums. Work is certainly under way, but I prefer not to respond to queries about the virus outside those mechanisms. It is not that we will not respond to them; we will, absolutely. I can tell you that, yes, we are making plans about social care. It is really important for the public perception that there is a consistent face and method for communicating about coronavirus. Michael is leading the communication, and I would not want to muddy the waters.

I apologise for that. It is not an unwillingness to answer the question. Yes, we are making plans. Social care is certainly integrated in those plans, and specifically the needs of people in nursing and care homes are being considered. I would rather channel responses.

The Chairperson (Mr Gildernew): I accept that. I do understand that communication is very important and has been working reasonably well. People are keen to know that there is a plan.

Mr Holland: I am represented in the regional gold planning arrangements.

Mr Carroll: Thank you, Chair. Thank you, Seán, for the very detailed report. I went through the report yesterday, and there is a lot in it. The report mentioned the need to be radical, and I agree with that, but some of the proposals, whilst detailed, do not go far enough to tick the box of being radical.

First, there is nothing, from my understanding and recollection of the report, about moving to publicly owned care homes, and that is a debate that has kicked off in England and possibly in other places as

well. The figure of £900 million has been spent on adult social care, and my understanding is, although I am happy to be corrected, that more than 70% goes through private organisations via the trusts: payments to the trusts that then go to private companies.

In some of those organisations, although not all, there are concerns that people are overworked, not adequately trained, not adequately paid, there are problems with unions being allowed in to some of the homes, with staff being forced to pay their own travel costs and issues like that. That is one point that I would like to home in on. Have there been any conversations, when the Department is on the panel, about the move to publicly owned care homes? If there is a concern about cost and if we need to spend £1 billion or £2 billion on adult social care, we need to spend that, but my concern is that a lot of money is going to already well-remunerated and well-off organisations. I am concerned that some of those organisations may not be using best practice.

Has there been a conversation about the move towards publicly owned care homes?

Mr Holland: You raise a lot of points in your question, and I will try to address them in my answer. Yes, there has been discussion about the balance. We have what is described as a mixed economy of care. That was established in policy going back to the 1990s. It was recognised that the ideal model was to have a mixture of providers that included provision from the statutory sector alongside provision from the private sector and contributions from the voluntary and community sector. The mixed economy was established, but I do not think that it was managed. There was never a clear policy position on what the proportion should be. Roughly 30% of domiciliary care is retained in the statutory sector and 70% is in the private and independent sector. In nursing and care homes, the proportion is even greater towards the private sector.

There are reasons why that happened, particularly in the home sector. One of the key issues is that, as we introduced higher regulatory standards for the physical environment of care homes, we in the statutory sector had a lot of stock that was not of great quality. A lot of it had the classic problem for buildings from the 1950s, 1960s and 1970s: asbestos. The private sector was saying, "We have capital to invest. We will build homes to these new, very high standards", and they did. That was one of the driving forces towards the expansion of the private sector, particularly in the home sector.

Considering where we are now, it is appropriate for us to ask whether the balance is right. On occasion, we have seen issues arise with private providers in relation to their business models. We have managed and coped with those, but they certainly have made us wonder whether we have got the balance right. I am talking about Southern Cross and, latterly, Four Seasons. Southern Cross is an historical matter of record and the difficulties that Four Seasons has had are in the public domain. Those are big companies that have bases overseas. Given the centrality of having care-home beds and nursing-home beds to the operation of our system, a mix seems reasonable, but we have to consider whether our exposure to market forces is appropriate. We have, therefore, been having discussions about whether we need to redress the balance.

Recently, we had discussions about whether the time has come for trusts to expand their direct provision of homes. Those are ongoing discussions. There are financial questions as well. We have modelled what it would cost if we were to take all the domiciliary care back in-house. It is significant. The balance that we have, however, allows us to have the benefits of independent providers, such as their flexibility and innovation, while allowing the statutory sector to concentrate its work on providing care where needs are more complex or in areas where it is not commercially viable. For instance, we find the statutory sector emphasising its work in geographical areas where it is hard to recruit carers.

Where we will arrive at will, obviously, be a decision for Ministers, and it is a political decision. You asked whether there was discussion about the mix. Yes, there is.

Mr Carroll: I am glad that there is discussion, but, to be frank, I would like to see it advance more and to come into policy and be in position. You mentioned Beveridge and Bevan and the idea of the NHS being from the cradle to the grave. There is a concern that when you get closer to the grave, or get ill, you are reliant on and forced out to the private sector. That is something that I have been worried about. I appreciate the answer, but I would like to see the issue sped up and, ultimately, become Department policy.

Mr Holland: As I said, the discussion is ongoing, and it is being fed into the deliberations. However, they will be political decisions in the final instance.

Ms Dolan: Thank you very much for your presentation. You mentioned domiciliary care and the geographical problems. As the Committee is aware, I represent a very rural area of Fermanagh and South Tyrone. We are well aware of the problems with domiciliary care and how valuable it is to my constituents. What plans are there for the provision of an adult safeguarding Bill and carers' rights as part of the reforms to the legislation?

Mr Holland: There is active consideration of the development of an adult safeguarding Bill. You will be aware of the Commissioner for Older People's report on Dunmurry Manor and the recommendation that an adult safeguarding Bill be developed. We are looking at that and are developing options for consideration on adult safeguarding.

On domiciliary care in rural settings, we recognise that one of the phenomena of recent years has been — this goes back, to a certain extent, to Gerry's point — "hand backs", as they are called. We increasingly find that, although we have the money to pay companies for the care at a price that they have agreed to, and although we have people in need of that care, they are handing packages back, saying that they cannot find the people to deliver the care. That is central to the need for reform. That is why we are developing a major stream of work on the workforce not just in rural areas but everywhere. It is particularly relevant to rural areas that we have a system whereby people who are involved in social care see it not as a stopgap till they get something else or not as, "Well, I might get a job in retail, I might a job in hospitality, I might get a job in social care", but more, "I actually want a career in social care". That is why there is a workforce stream. Mark, do you want to add anything on adult safeguarding?

Mr Lee: No, I think that that covers it. Did you ask about carers?

Ms Dolan: Carers' rights.

Mr Holland: Carers are certainly referenced in 'Power to People'. There has been a work stream to look at the needs of carers, and carers have been represented on the project board. We have been hearing the voice of carers very strongly. Currently, the only right that a carer has in legislation is to an assessment. At the time, that was seen as a significant step forward. However, being assessed and being told that you need something and then having those needs met does not take you very far, so we are looking at how that might be developed. As I said, John and Des were very clear that they felt that carers needed to be identified as people having needs, completely independent of the person whom they are caring for, and that support needed to be provided to them. That is under active consideration in the work that we are undertaking.

Ms Jackie McIlroy (Department of Health): The workforce is also of economic value to rural areas, because people get jobs in the locality. It is for, the most part, a part-time workforce, and it is mostly females caring for children at the same time as working and supporting local people in their area. The economic value to an area is as important as the care that it is provided.

Mr Holland: I emphasise that point, because one of the most frustrating dynamics of the debate about social care is that people often frame it as a burden. Money spent on social care is not relieving a burden. It supports people, but it is also a sector of the economy and provides employment. There is good reason to believe that it may become an increasingly significant sector of employment. There are a lot of areas where jobs may go to artificial intelligence and automation in the coming years. Those developments will have a bearing on care, but we know that the thing that people value most from social care is the relationship with another person. It will be a long time before that is replaced by a robot. We need to recognise the value of social care in that it not only helps our healthcare system and supports individuals but is an important part of the economy.

Ms Dolan: One thing that might help with recruitment is becoming a living wage employer. Proposal 6 suggests that. Do we have any update on that? Where do we deal with it?

Mr Holland: We are developing options for our political masters to consider. Their considerations will be contingent on financial settlements. If you are asking me whether we are modelling different options for how we make the workforce more sustainable, including looking at remuneration, the answer is yes, we are.

The Chairperson (Mr Gildernew): I will follow up on Jemma's question, Seán. You mentioned that it will be part of adult social care reform, but the crisis in domiciliary care is on top of us now. What is

happening to try to address it? In some ways, it cannot wait. Already, people are staying unnecessarily in hospital as a result of domiciliary care not being available. What is happening right now to try to meet that demand?

Mr Holland: I urge a little caution on the narrative, which I hear frequently, that it is a major cause of discharge delay. Difficulties with discharge are being analysed. Sometimes, the absence of a care package is a factor in delaying discharge. However, although I am frequently told that it was a factor, on analysis, it was not always the crucial issue that people said that it was. We have to improve hospital processes to make sure that from the moment of someone's admission, active planning for their discharge is commenced. If it is not, there will be a delay, but I think that it would be wrong to characterise that as a delay that originates in a problem with social care.

Yes, work is ongoing. A regional discharge group, which is led by the board and the Public Health Agency, is analysing the issue of delays in discharge, including how we can ensure that the appropriate social care is available at the point of discharge. We are also doing things that address the big themes that I talked about. We are not waiting for the finalisation of the policy. We are, for example, trying to make social care and domiciliary care more attractive to young people as an area of employment. The Northern Ireland Social Care Council has been doing fantastic work in that area, reaching out to young people in schools and colleges and working with further education colleges on what vocational training and courses can be made available. Work is ongoing to address the challenge in social care. Some big shifts are needed, and those will require the delivery of this policy.

The Chairperson (Mr Gildernew): I agree that hospital discharge is not the only issue.

Mr Holland: I knew that you would, Chair.

The Chairperson (Mr Gildernew): Hospital admissions also happen as a result of trips and slips. People then deteriorate, potentially because the care is not available. There are other concerns.

Ms Bradshaw: Thank you for your presentation. I want to raise two separate issues. The first relates to care workers in my constituency of South Belfast and is probably more of a Belfast/urban issue as opposed to Jemma's question on a rural issue. I have tried to raise this in several ways but got nowhere. Some care workers, especially in the independent sector, really struggle to make their way around south Belfast because of the morning congestion. As you know, with conditions such as Parkinson's, medicine is needed in a timely manner. I wrote to the Department and to the health trust to see whether those staff could use bus lanes, but we got nowhere. The Belfast Health and Social Care Trust said that it allocated that facility to a certain number of staff but that it had never included the independent sector. Turning up late for appointments is a huge frustration.

Added to that is a new resident-only parking scheme in the Holylands area, which means that care workers drive around for ages and cannot park. I got a letter from the Department for Infrastructure yesterday. It said that it had now completed the analysis for resident-only parking schemes and will start rolling it out elsewhere, so it will become a bigger problem in south Belfast. Care workers cannot get there on time, and, when they do get there, they cannot park. These are issues when it comes to trying to make travelling between jobs easier for those staff. You do not necessarily need to comment on that, but please take it on board, because I am getting nowhere.

Mr Holland: If you will forgive me, I will comment on how it relates to us. I do not have an immediate answer for you on the very specific issues of bus lanes and residents' parking, but I will follow up with you on that. I think, however, that there is a general issue about care workers travelling from one client to another and, in particular, the practice that has happened whereby care workers have not been paid for travel, either in time or the cost of getting from one place to another. That is not sustainable. Des and John's report looked at how care can become more neighbourhood-based, and we are exploring that. One situation is that care workers drive quite some distance from one case to another. Des and John were interested in the possibility of more community-owned, very local providers of care so that the travel that they need to undertake is not as significant. The report said that we should explore that, and we are. That does not address the issues in somewhere like south Belfast. I understand that.

Ms Bradshaw: It is more about the frustration as opposed to the distance.

Mr Holland: It would be desirable to have care providers dealing with much more concentrated geographic areas. Our population density would probably allow care workers to walk from one client to another because they would be much closer together. Do you want to add anything, Jackie?

Ms McIlroy: I was just going to make that point. As you know, the Health and Social Care Board has developed a new model for domiciliary care that is based on that locality model. It is being tested in some of the trust areas, specifically the South Eastern Trust area. It is early days, but we hear good reports. We hope to move towards that kind of neighbourhood approach.

Mr Holland: We will specifically follow up on the bus lane and parking pass issues and come back to you directly.

Ms Bradshaw: I met representatives of the British Association of Social Workers yesterday, and I was pleased to hear that its members feed into the new encompass programme to allow records to become more streamlined. As you know, much of social workers' time is spent on bureaucracy. How will care workers be able to feed into that? I am conscious, as you said, that they are the ones who have the personal relationships. From day to day, they will see any deterioration, a change in somebody's behaviour, jaundice or whatever. Will they have a role in feeding information into that system? Will new technology or the encompass programme make their jobs easier?

Mr Holland: Three different angles to technology and social care come closest to answering your question. The first is that technology can provide more innovative and responsive booking systems, and a number of providers have invested in good software for that purpose. That software ensures that when considering how many slots have to be covered, they do not do that with a pen and paper, scribbling out names on a rota and what have you. Rather, they use software that can add efficiency. Many providers do that at present. We are encouraging that and looking at ways to ensure that they use information technology appropriately to enhance their overall management.

The second is that care workers are workers on the move, and their effectiveness can be increased with simple hand-held devices. If they can record the fact that they have completed a visit and, maybe, communicate information about that visit remotely, that delivers an efficiency. We are discussing that with the encompass team as well.

The third is how technology can enhance or support the delivery of care. I am not contradicting my earlier point about a human relationship being the most important thing, but, over the next number of years, we will see technological developments blending into care delivery. It is often assumed that older people are not very tech-savvy, but grandchildren change that quite rapidly, particularly when the grandparents' desire is to stay in touch with their grandchildren. I am sure that in your family, as in mine, you will have the phenomenon of grandparents Skyping their grandchildren and having that kind of interaction. Isolation and loneliness can be as big an issue as needing physical care support. We are looking at whether there are remote solutions that can help people to stay more in touch using technology that is already available.

Technology will be involved in the direct provision of care, but that is a bit further off. We have had some false dawns, but advances in artificial intelligence and robotics will support and enhance, rather than take over, the delivery of social care. Technology will play a role there.

The Chairperson (Mr Gildernew): As I noted previously, it will be vital that all areas have access to broadband to support that provision so that we do not open up further inequalities in access to technology and to care. That is very much a health issue.

Mr Holland: That point and Paula's point emphasise the need for joined-up planning in social care. One Department will not have all the answers.

Mrs Cameron: Thank you for your presentation. I have a couple of questions: one about measuring the extent of unmet need; the other about data collection issues. What mechanisms does the Department use to establish current and future levels of social care need at regional and local level? What information does the Department collect to establish that?

Mr Holland: Through this process, we have been doing an awful lot of work on projecting what we think the future needs will be. We use a variety of data sources. We use the data that the trusts hold about their current delivery of care, and we extrapolate that alongside other data. Demographic data is probably the most significant additional source that we look at. We have been using a methodology called systems dynamic modelling as one way of trying to identify what the future will look like. From the outset, I have to say that I do not understand it. There is not widespread capability in this, but we have access to some skills in that area. It is about taking lots of different data sources, modelling them and working out, if you vary a value in one of the data sets, what implications that has on other things.

If, for example, you change the rate that you pay care workers, what might that do to other things related to the supply of care workers, the churn in care workers or whatever? If you start investing in early intervention, what impact might that have on hospital admissions? We are doing some of that work. It is not an exact science; it is about predicting the future, but, as I said, we are drawing on a very wide range of data sources, from internal performance data to external sources such as demographic information.

Currently, the way in which we assess unmet need relates to waiting times for care packages. It is about how quickly you can meet a need that has been expressed to you. That is valuable information, but it is distorted slightly by what we have done in relation to thresholds over the past number of years. This is a phenomenon across many publicly funded services. When faced with rising demand and the constrained supply of a service to meet that demand, you introduce a threshold of eligibility before someone can access that service. It is incontrovertible to say that, over the past decade, we have raised the threshold. The level of need that you are now required to have before you can get a service is higher than previously. That has happened across the UK. It also happens in healthcare in some instances. The difficulty with using waiting times for assessing unmet need is that you assess unmet need at the high threshold that you established. However, you do not capture other kinds of needs that do not meet that threshold but which could, eventually, have an impact on your longer-term demand for services. That is the early intervention piece. If you do not provide an early intervention service, you do not assess the absence of one as being unmet need. The reality, however, is that, if you started providing one, you might impact on the need that is above that threshold. I am sorry if that is a bit convoluted, but we are exploring whether we have gone too far in shoehorning need into a high threshold. Mark, do you want to add anything?

Mr Lee: I just want to say that some people are waiting for care packages, but there will always be some churn as people who have been waiting are brought on to care packages. It is about understanding how much is natural churn and how much is the lack of capacity in the system.

Mr Holland: Generally, we do not have a massive problem with waiting times for care packages. We tend to have problems when people have very particular needs. Sometimes, where they live or the complexity of their care needs can result in an extended delay in meeting the demand. Broadly speaking, we have a reasonable flow of people being assessed as needing care to their receiving that care.

Mrs Cameron: I appreciate that. Many of us are involved in the all-party group (APG) on ageing/older people, and we have been looking at this issue. Will the encompass project — back to technology again — help with data collection? There are always issues. Every time we ask questions of the different trusts, we get different responses. There are different systems of collecting data, and it is very difficult for us to scrutinise and understand what is going on when the trusts do not seem to marry up.

Mr Holland: I fully agree with you. There are two problems. One is that, as you said, we have a number of trusts, each with variations in how they collect data. We continuously try to ensure that that is standardised. The other difficulty is real-time data. Currently, an awful lot of the information that we have on, say, domiciliary care, comes from an annual survey. We survey on a given date, once a year, and collect the information. That is valuable, and it gives us an awful lot of information, but it is not the same as real-time data. We do not have the ability currently to collect real-time data. That would be a big advance, and, hopefully, encompass will support it.

Mr Lee: The challenge that encompass *[Inaudible]* really improved was the consistency and availability of data across the board. In social care, we have to interface with private companies delivering care. Functionality within the provider system will support the encompass programme. We need to have further conversations about how that functionality is used and to what extent we can interface with or provide functionality to private providers and their systems. Some conversations are ongoing; others are yet to happen. An obvious part of making sure that the encompass programme is successful is making a judgement on which bits we start immediately and which bits we seek to exploit later. Discussions are ongoing on what the immediate functionality is and what we will seek to develop at later points.

Ms McIlroy: The point about data is really important. We get an awful lot of data in addition to encompass, but we do not always know how effective that data is in helping us to plan. Some of it is extremely effective. The Health and Social Care Board is looking at that data and thinking about how we move to a much more outcomes-focused approach. That will encourage us to streamline what we need and what is useful to us. In our early discussions with the encompass team, we were clear that,

rather than just putting everything on to the system, we need, at this stage, to be selective about what will help us in the future and what data we no longer need. Sometimes, as you know, we start something, and it just carries on without there being a real purpose for it. We will look at that.

Mr Holland: I will follow on from that really important point about the move to outcomes data. Currently, much of the debate on adult social care is framed in terms of beds or time. How many minutes or hours do you get in a domiciliary care package? Is a bed in a nursing home available for someone? That does not tell us about what I said the purpose of social care is: how we support someone's social well-being. We buy beds and we buy minutes. We would be very interested in looking to a situation whereby we bought outcomes or improvements in people's social well-being for a defined population.

That is not straightforward. We have been looking around for others who led the way in this field. After false starts, we find that they have not got as far as we thought, but we still want to pursue that. We want to get away from simple transactions, "We are buying you 20 minutes or half an hour" or "We are buying you a bed", to saying, "We are buying you the independence to be able to continue to go to your local leisure centre or go to the pub" or whatever. We need to start to shift towards outcomes. That is a challenge.

The Chairperson (Mr Gildernew): That speaks to a point raised earlier. We are creating business models around all this, whereas it is about care, and that is really what should be at the centre.

Mr Easton: Thanks for your presentation. A proposal in 'Power to People' is agreeing a concordat with the public to ensure:

"citizens are able to be well informed about their entitlements and rights as well as their responsibilities and duties."

What steps has the Department taken to develop a concordat to stimulate debate and agreement with the public about the future adult care and support system?

Mr Holland: As I mentioned in my opening remarks, there are fundamental differences between social care and healthcare. The most significant is that one is a universal service free at the point of delivery, and the other is paid for and subject to means-testing. That is not widely understood. Research suggests that, at the point when social care is needed, something like 66% of people are not aware that they will be means-tested — assessed for paying for it. Often, what causes the greatest resentment is not charging but the fact that people did not understand that they would be charged. Des and John felt that we had to be much more explicit about what the offer is and what support is available — it should not come as a surprise to people. They were very keen on what they described as a "concordat": a clear public statement about what the state's duties are, what you can expect to be provided to you and what you might have to pay for. We are looking at how a concordat would work. We are also doing other work in the same space, which is trying to raise the understanding of social care and trying to ensure that people have a greater appreciation of what it is and what is offered. Jackie, you have been involved in some of that.

Ms McIlroy: As a starting point, even if you look at our project board, you will see that we had a wide range of stakeholders involved in informing the work of the reform team. That, in itself, is a discussion that has started on how we take forward social care, how we reform it and what needs to be done. It will inform decisions that we will have to think about in the future: what is the role of the state in providing social care and what is the individual's responsibility? We are having those discussions.

We also had discussions in the Department on how we might do that in more creative ways. How, for instance, do we get young people at school to start thinking, "I am leaving school now, but, some day, I might need social care"? We all think of social care as being for older people, but things happen in life, and we might need social care at an earlier stage. We want young people to ask, "What is my responsibility in thinking about that? As a family, how would we pay for it? Will it be totally the responsibility of the state?". We must have those discussions and debates. We are looking at those issues and will put options before the Minister.

Mr Easton: When does the Department plan to evaluate the impact of the reform agenda? How does it plan to involve service users and their carers in the evaluation process? How frequently will evaluations take place?

Mr Holland: All policy should be subject to an evaluation of its impact. Policies that come forward through 'Power to People' will certainly be subject to that. We will look at what we consider to be the appropriate timeline, because it might be different for different aspects of the policy. For example, some measures that could be taken to create a sustainable workforce might be amenable to being evaluated fairly quickly, because you could see changes in the employment market relatively quickly, whereas, if we bring in early intervention and preventative measures, the evaluation of their impact may have to go on over several years. The answer is that it will be different for different aspects of the policy, but it will be subject to evaluation.

Re involving people in that evaluation, we mean to carry on as we started. Service users and carers are significantly involved in the development of the policy. Indeed, there is a draft paper on one of the work streams that looks at the needs of carers, and that paper, which we are working from, was, more or less, written by carers. We intend to continue in that vein. A term that has become very common in healthcare circles recently and which has been around in social care for a lot longer is "co-production". We recognise that, for the services to be the right fit for people, they have to be designed by those who will use them. That will extend to the evaluation.

Ms Flynn: Thank you, panel, for all your contributions. Seán, at the end of your briefing, you said that, hopefully, the Minister will bring forward the implementation plan in a number of months. Our briefing paper mentions that the development of the action plan was delayed in 2018. I am concerned about lost opportunities to develop proposals and work streams during the past three years, when there was no Minister in place. I am conscious that, before we heard your briefing, there was still no report or proposals before the Minister. My question is similar to the point that Colm made earlier: why did the reform of adult social care slip down the list of priorities? Is there one reason or a number of reasons for that?

My second question is for Mark. The briefing paper mentions the move from the mental health directorate to the Office of Social Services. Was any of that down to changes due to planning for Brexit? Was the mental health group disproportionately impacted on by that compared with other sections in the Health Department?

Mr Holland: Absolutely, Brexit was central to the delay. Originally, this work was being taken forward by Mark's predecessor. Mark's responsibilities include mental health, but they also include older people, learning disability and physical disability, so it is a broad portfolio. Within a very short period, the person doing Mark's job and nearly all of the team who were working on this were taken to do no-deal Brexit planning work.

We let that act as a halt for a period. After a while, however, we felt that it was not acceptable for that delay to continue. Therefore, I turned to Jackie, who, with no additional resource at that stage, took on the work of developing this policy. Of course, without additional resource, it did not move at the same pace as previously.

We are now moving at a good pace. I used the phrase, "in a few months", and I tried to use the phrase "before summer" with the Minister, and all I will say is that the Minister is very anxious. When talking to the three of us a couple of days ago, he expressed, in no short order, his expectation that the proposal would be with him very quickly.

Ms S Bradley: I will follow on from that because it is a very good point. There is so much in the document, and I would like to get into the detail. However, knowing that it is gaining pace and moving forward is critical. You aim to present an implementation plan, and I would like to understand better what will be in that? What are the proposals and costing? When do you anticipate moving towards this plan being implemented on the ground and affecting the people who are dependent on it?

Mr Holland: We need to take proposals to the Minister, who will then decide what goes into a final plan. The nature of the areas that we are considering will require public consultation, so there will be a consultation period.

The implementation will vary. I envisage being able to put some things into practice really quickly, as there are some things that you can start doing virtually straightaway. Some elements will be conditional on what financial resource is available, and we do not yet know what the settlement is. Other elements, by their definition, will take time. Earlier, reference was made to an adult safeguarding Bill. Legislation might flow from the plan, but, given the pressure on the legislative timetable, it would have to take its place within that.

That is not a very satisfactory answer: some things will be immediate, some will take a bit longer, and others will be defined by the nature of a legislative process.

Ms S Bradley: The plan includes supported living and shared housing, which are probably longer-term measures. At what point will you start to see implementation of measures with an earlier reach?

Mr Holland: We started some things because we did not feel that we needed to wait for a Minister to do them. I mean no disrespect to Ministers, but there are things that we can do without them. For example, Jackie mentioned earlier that we had been testing some models. We started that because we felt that a Minister would want to decide whether to roll out a model and would want to see the evaluation. We did not feel that we needed a Minister to develop and test a new model. That is the case with domiciliary care. In the South Eastern Trust, people have started to experience a different way of receiving domiciliary care. We did not wait to roll out that model, but whether it is one that will be rolled out more widely is subject to a Minister's consideration of the evaluation.

Ms McIlroy: I want to make the same point. Transformation is not just about waiting for reform work. On the workforce, as Seán said, the Northern Ireland Social Care Council has done significant work to promote social care as a valuable career. The council does lots of work in that space. We are looking at how we can promote the value of the workforce in a range of ways, such as career pathways etc. That work has commenced. We are not just waiting for the final paper to be produced. Where we have been able to start work, we have done so.

Mr Holland: I want to pick up on one point from that. I know that everyone wants to see change and that they can see deficits and where things need to be improved, but it is worth reflecting that the Assembly, in its previous incarnation, passed legislation to register social care workers that was at the leading edge of legislation in the UK. Before anyone else in the UK had done that, Northern Ireland led the way, and we now see Scotland and Wales following suit. It is important to realise that there has been progress in that area and that there was leading progress in the past.

Ms S Bradley: I welcome the content in the document and the spread of contributors. There is very rich information in it from the voluntary and community sector and organisations like Age NI, but it also includes a broader spectrum, such as younger people with deteriorating illnesses. It speaks to the wide breadth of social care.

Through my constituency work, I have found continual confusion about pathways from healthcare to social care. People do not know what point they leave healthcare and enter social care or, equally, when they leave healthcare or social care and enter palliative care. There can be a real breakdown in communication. What efforts will be made to ensure equality and clear communication to people who are dependent on those services?

Mr Holland: There are probably two elements to that. One goes back to Alex's earlier point about a concordat. There is a need for us to be much more explicit and transparent about what is available and what you can expect. There are also decisions to be made, because the line between healthcare and social care gets blurred in places. You mentioned palliative care, and that is a case in point. It is not the case that your need is social care today and palliative care tomorrow, but we have different funding arrangements for those, and there needs to be some more work done on that. Whatever the decision is, people should know what it is. That is the important thing. I very much take that point on board.

Ms S Bradley: I want to raise one point on that. I am trying to get more detail on it, but there has been an emphasis placed on things such as continuing assessments of need. Whether those are in place may dictate whether a person has to fund their future care. That does not appear to be consistent across trusts, and I am eager to know that the system will not repeat any errors that may exist.

Mr Holland: We certainly hope that that would be the case. If you have a specific issue that you want us to look into, we can respond to that.

Ms S Bradley: I appreciate that.

The Chairperson (Mr Gildernew): As to lines being blurred, Seán, in my experience as an MLA, I have heard that the lines are quite clear, in that most of the trusts are providing social care at level 4, which is critical need. That is when a person's health will significantly deteriorate or they will be

admitted to hospital. We have very clearly stripped it back to healthcare needs that have to be demonstrated by an allied health professional such as an occupational therapist (OT), a physio or someone like that. There may have been blurred lines in the past, but the point that we are working at now is essential critical care.

Mr Holland: You are absolutely right about that, and it goes back to the earlier point about thresholding. There are some areas where there is a degree of confusion about whether it is a healthcare or a social care need. You will be aware of that. It often arises in the case of support for people with dementia. People sometimes expect that, because their social care need is driven by illness, it should be healthcare, but it may be social care. That is an issue of ongoing consternation for a lot of people.

Mr Chambers: Over the years, having visited friends and family in nursing care and residential care, I have always found that the staff and management are very well intentioned and dedicated. They go the extra mile to provide excellent care to residents in a particularly stressful environment. We heard earlier that 30% of residential care homes are in the statutory sector and 70% are in the private sector. That worries me. We have to be realistic. The private sector exists to make money. That is just the reality. They make big investments in new properties, in furnishing them and everything else, so they have a right to make a profit. However, I have seen a situation in nursing homes where residents who needed the assistance of one or two care workers to go the bathroom have been told to wait 15 minutes before they could be taken to the bathroom. That is not a satisfactory situation, but it is, unfortunately, the reality in a lot of homes, if not all homes.

In the pursuit of profit, I wonder whether care, staff availability, quality of meals etc, is compromised by owners in the pursuit of enhanced profits. I know that a home can be inspected and everything may look fine on the surface, but subtle tweaks can be made in care packages to enhance profit margins. Do you have any accountancy systems in place to ensure that private-home owners are not going daft on profit-making at the expense of the care that they offer?

Mr Holland: The first thing to say is that the 70/30 split specifically related to domiciliary care. It is even greater in the private sector when it comes to nursing and residential homes. The statutory provision of that kind of residential accommodation is now very, very small. I suppose that goes back to the earlier debate about whether or not that should be expanded.

The regulatory standards of care that are applied are the same regardless of the provider. The minimum standards that are required should not differ in a private home versus a statutory home. From personal experience of having relatives in a statutory home — the old St John's House in Downpatrick — and other relatives who have been in private care homes, I cannot say, "statutory, good; private, bad". It is not like that. Whether the staff who deliver the care work in statutory homes or private homes, that is not what determines whether they are good staff or whether the care is good.

Interestingly, research indicates that that is the case. The key thing seems to be not whether it is a statutory home or a private home but the quality of the leadership in the home. There is a growing body of evidence that seems to suggest that the quality of care really turns on the home manager, and that can work both ways. The appointment of a strong leadership team can very quickly lead to an improvement in the quality of care, and the moving on of that team can very quickly see a deterioration in the quality of the care. One of the things that we are increasingly talking to our regulatory colleagues in the RQIA about is about how we can have more advance knowledge, intelligence and understanding about what is happening in a care home so that we can prevent situations where care has gone from being acceptable to not acceptable and that not being picked up on, and leadership seems to be a key feature.

On the broader point about profits, there is no regulatory mechanism to limit profit in the care home sector. We have talked about that. It is possible to look at social care almost like a national utility such as water or electricity. It is just as essential to the running of the country. There are specified margins of profit in the electricity and water sectors. We do not have that in the care sector. I am not sure if it would be feasible to introduce such a system, but it is something that we have discussed.

If you were having a presentation from the independent healthcare providers, they would tell you that there is no excessive profiteering in their sector; in fact, they would argue the opposite. I do not see evidence that excessive profit is being made. People are leaving the marketplace because, they say, the returns are not sufficient. We are not seeing huge gaps in provision as a result of that. Other providers seem to be willing to take on provision, but I do not think that there is excessive profit being

taken out of the care home system at the moment. The key issue around quality of care seems to relate to leadership rather than whether it is private or statutory.

Mr Chambers: I appreciate what you are saying about leadership, but a leader, with the best will in the world, will have their senior managers coming into the home, showing them the balance sheet and saying, "We have to make more profit. You're not making enough profit" —

Mr Holland: There is a regulatory flaw to that.

Mr Lee: The trusts are responsible for ensuring that the quality of care that they have commissioned is sufficient, and the RQIA has a regulatory function. I was with RQIA inspectors on a visit to a care home, a couple of weeks ago. They look at the care plans. They see that Mr Smith, or whoever, should be checked on every 50 minutes; they talk to the staff to make sure that that is being done; and they speak to residents, families and friends separately to see what the feeling is around the care. No system is perfect. There is a review going on at the minute in the Department around the regulation and how well that works and how we can continue to improve it. However, as Seán said, there is a system of regulation and a system of care management in place to ensure that we get the quality of care that we need, and to ensure that someone cannot reduce the quality of care in order to take excess profits.

The Chairperson (Mr Gildernew): Thank you for your presentations and answers. We are acutely aware that the adult social care element is one of the key issues that we need to address if we are going to create real transformation. I am glad that we have touched upon the community and voluntary sector and the contribution that it makes. We also touched on the massive contribution of carers. At the outset, Seán, you recognised that, as well as the fact that carers are getting significantly older, with their own complex health difficulties, mental health issues are a problem. We need to get better and more-tailored support earlier for carers, and we need better co-production with the community and voluntary sector for the people who are using the services.

A lot of the Committee share the view around the importance of having a properly valued domiciliary care workforce. It is important that their value is reflected in their pay, terms of conditions and career progression. That could assist with some of the other difficulties with regard to the workforce. We will be coming back to this issue, as we will with a lot of the areas that we have dealt with. We are dealing with a lot of inquiries around Dunmurry and Muckamore, and there are other issues. We will keep a close eye on the plan to bring this forward. We are keen, as is the Minister, that that is made a priority. The ground that has been lost in this area needs to be made up.

I thank you for your contributions. We will see you again, but good luck for now.

Mr Holland: Thank you. I will come back to you on the point on sleep-ins and the points you raised in relation to south Belfast. I am sure officials will remind us of any other points on which we have committed to returning.