

### 3.5 Personal Social services

Personal social services incorporate a broad range of activity, from residential and nursing home care, to domiciliary care and day care, meals on wheels as well as field social care services. Social services differ fundamentally from the rest of the health & social care system in that they are delivered through a collaborative combination of statutory, voluntary and private sector organisations. In addition, informal carers provide a crucial input into the system which is often taken for granted. Demographic trends mean that carers will require more support in the future as they themselves become increasingly elderly whilst policies for dealing with young carers remain underdeveloped.

Spending on personal social services in 2003/04 accounted for around a quarter of total HPSS spend (£680m). Of this, services for the elderly accounted for just over half (52%), with around 30% devoted to mental health services and 18% to family and childcare services. The main areas of expenditure related to the elderly in terms of nursing home places (£144m), domiciliary care (£92m) and residential home places (£68m). In comparison, the main spend category for childcare was social work (£41m) whilst residential homes (£34m) was the main area of spend on services for those with a learning disability.

In comparison with England, per capita spending on personal social services has been on average 15% higher in Northern Ireland over the past five years<sup>62</sup>. This is close to the estimated need for spending of 13% higher than England based on HM Treasury NAS methodology but considerably less than the figure of 44% implied by the Northern Ireland Executive revisions to the Treasury model.

In terms of outcome based measures of performance, whilst the community services target set out in the DHSSPS Public Service Agreement covering the period 2003-2006 focused on the number of care packages<sup>63</sup> delivered, the main emphasis subsequently has been on increasing the proportion of support delivered in people's own homes to 40%<sup>64</sup>. In terms of children's services, the main focus has been on increasing the adoption rate for children in need to 7%.

The 40% target is interesting because although only 38% of care packages are currently delivered in a domiciliary setting, there appears to have been a downward trend over the past decade with 50% of care packages in 1995 being delivered in a domiciliary setting. Whilst the number of domiciliary care packages has increased over time, the growth in the generally more expensive alternatives (nursing and residential care) has been greater. There is also significant variation between Northern Ireland trusts, with the largest provider of care packages, Homefirst, also having the lowest proportion (22%) of care packages delivered in a domiciliary setting - if removed, the Northern Ireland average rises to 41% and the target is met.

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<sup>62</sup> HM Treasury Public Expenditure Statistical Analysis .

<sup>63</sup> A care package is the main form of care that has been recommended for a client through the care management process. Care packages are provided in the form of places in nursing and residential homes as well as domiciliary care in persons own home. Separate services are also provided in terms of Home Help and Meals on Wheels as well as places at Day Care Centres.

<sup>64</sup> A 1999 study entitled "Attitudes and Aspirations of Older People: A Review of the Literature" for the Department of Work and Pensions found that 80% of older people would prefer to remain in their own home as long as possible.

Whilst the integration of personal social services is often perceived as being a key strength of the Northern Ireland system, this was not necessarily the view of those we consulted in the course of this Review<sup>65</sup>. In particular, it was felt that funding for social services was often diverted to shore up the acute sector. There was concern that this was creating longer term pressures as insufficient funding of social services would lead to delayed discharges from hospitals creating further problems in the acute sector.

These views are in line with the consultation responses detailed in the First Report of the Review of Community Care<sup>66</sup>. Whilst there was widespread commitment to the aspirations set out in the strategy “People First: Community Care in Northern Ireland for the 1990s”<sup>67</sup>, which was introduced in 1993, there was concern regarding implementation. In addition, reservations were expressed regarding the considerable variations in service delivery across Northern Ireland whilst there were instances where the transition between hospital and care home was not as seamless as would be expected in an integrated system. Further, the decreasing share of domiciliary care was viewed as being the result of a perverse incentive as some of the cost of residential and nursing home packages can be offset by accessing social security benefits -which is not the case for domiciliary care<sup>68</sup>.

The Review of Community Care highlighted that there were many good working examples of new and innovative practices in the area of community care. However, too much of this work was developed in isolation, and staff expressed frustration at the lack of collaboration between trusts. Fears were also expressed regarding the amount of resources available to community care - in particular, the fees paid to independent nursing homes.

The second phase of the Review of Community Care was to involve a number of projects taken forward on the basis of the “People First” objectives. In the three years since the publication of the first phase there appears to have been a significant amount of analysis and review carried out into particular aspects of the community care system. To date, however, with the exception of increasing the rate of payment to independent care homes, there also appears to have been few developments in terms of how services are actually provided. In addition, there is little to suggest that this position will change in the near future.

Given the variety of providers supplying personal social care, it might be expected that a degree of competitive pressure exists in the system. In practice, however, there is concern that the public sector is crowding out the independent sector. For example, although independent/voluntary providers are able to tender for contracts to deliver care packages, they have difficulty in recruiting sufficient amounts of staff because of the higher salaries and greater certainty of employment offered by statutory providers. Therefore, even where independent provision may be preferable

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<sup>65</sup> Views ranged from those who argued that any additional funds tended to go to the acute sector to those who suggested that funds were actually taken from social services.

<sup>66</sup> DHSSPS, 2002

<sup>67</sup> Objectives included, the development of services to enable people to live in their own homes wherever possible, provision of practical support for carers, proper assessment and good case management, promotion of the independent sector alongside good quality public services, clear delineation of the responsibilities of agencies, and securing better value for taxpayers money.

<sup>68</sup> In the UK, local authorities levy a charge for domiciliary care so there is less of an incentive to use the more costly care home alternative.

in terms of service and cost, the contract may be lost due to staffing shortages. There was also resentment expressed that independent providers incur the expense of training staff who then move to the more highly paid public sector.

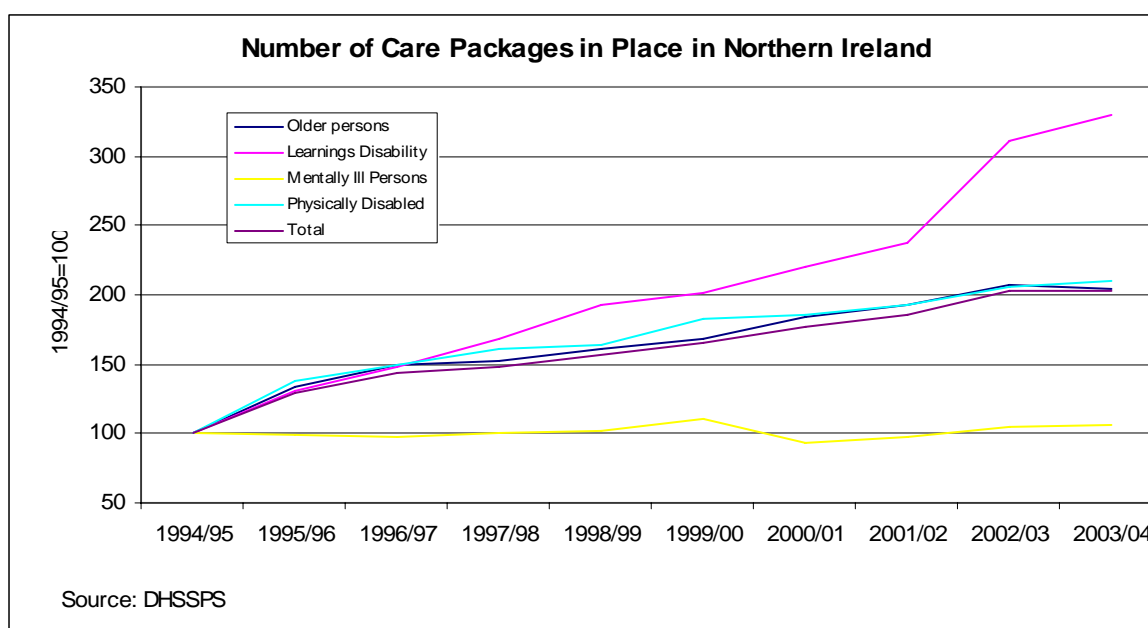
Assessing the efficiency of the delivery of social services is more difficult than for health care because the public sector is not the only provider, so inputs are less easily related to outputs. In addition, the comparability of data between jurisdictions is even more difficult than for healthcare. Therefore the analysis set out below is necessarily more tentative than in previous sections.

### 3.5.1 Adult Services

Adult services cover a wide range of service provision by trusts to a range of client groups, although services to the elderly dominates, accounting for three quarters of all care packages. Each trust decides the mechanisms for the delivery of social care. As at December 2004 there were 19,654 community care packages in effect, 38% of which were in nursing homes, 24% in residential homes and the remainder in the form of domiciliary care. The private sector provides the overwhelming bulk of nursing home packages (94%) and nearly half (47%) of residential home places. Over the past five years, whilst the number of care packages has increased by 29% overall, nursing and residential home packages have increased by over 40% whilst domiciliary packages have increased by only 12%.

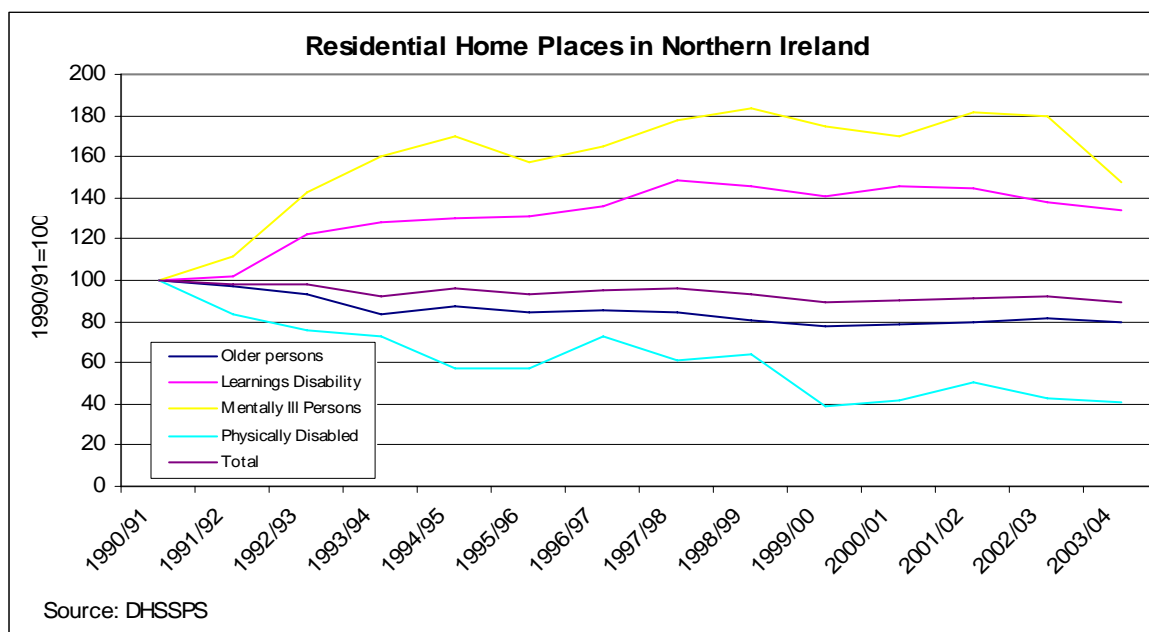
Figure 3.20 shows that over the longer term there has been even greater growth in the number of care packages provided with the exception of mental health where the level of provision has remained broadly stable over time. This is in line with the views those whom we spoke to representing mental health services who were concerned that mental health services were being left behind.

**Figure 3.20: The number of care packages has more than doubled over the past ten years.**



Although the number of residential care packages has risen over time, the number of places in residential homes has fallen as shown in figure 3.21:

**Figure 3.21: There has been a 11% fall in the residential home places in Northern Ireland since 1990/91**



The number of available places in residential homes in Northern Ireland has been on a gradual downward trend since 1990/91, and now stands at 6,282 (2003/04). Three quarters of places are in homes for older persons whilst places for persons with a learning disability account for 18% of the total. Figure 3.21 shows that the largest growth in places was in homes for the mentally ill and the greatest decline was in homes for physically disabled persons.

In comparison with other parts of the UK, there are 12.4 places in residential and nursing homes per 1,000 adult population in Northern Ireland compared to 13.8 in England, 12.0 in Scotland and 12.8 in Wales. However, given that the main client group for residential and nursing homes places are the elderly, the 2002 Needs and Effectiveness Evaluation quoted figures in terms of the population aged 65 and over which implied that there was 10% greater provision in Northern Ireland than England, whilst the 2002 Review of Community Care presented comparisons in terms of those aged 75 and over which implied that there were 15% more places in Northern Ireland than in England.

In terms of non-residential care, as of March 2004, 26,400 people in Northern Ireland were receiving home help, 4,650 meals on wheels services and 10,300 were registered at day care facilities. However, there is a downward trend in the numbers receiving home help, whilst numbers receiving meals on wheels and registered at day care facilities has risen over time. There are also significant variations between trusts with, for example, 59% of people aged 75 and over in the Armagh & Dungannon Trust receiving home help services compared to only 22% in the Ulster Community and Hospital Trust.

Those involved in mental health services raised a number of concerns with this Review that this form of care had a low priority in terms of resources, despite the

pressures that mental health problems have on patients and their families - it is only when a major incident occurs that mental health is considered. There was also difficulty in getting someone to take responsibility for a particular mental health issue as delivery of mental health services is spread across a range of organisations - this was a general point made by those representing the other forms of social services provision too.

In addition, despite the policy aim that long-term care should no longer take place in psychiatric hospital environments, the view of those we spoke to was that resources had not yet been transferred to the community sector to the same extent as in England. Although some progress has been made - with spend on the provision of mental health services in a community setting increasing at a faster rate than for psychiatric hospitals - the community share of mental health spend is still lower than was the case for England in 1999/00.

**The Review of Mental Health and Learning Disability** published a draft report in June 2004 and highlighted the higher level of need for mental health services in Northern Ireland (linked to social deprivation and political conflict). The draft report sets out a new **Strategic Framework for Adult Mental Health Services** for the next 15-20 years. Highlighting that there is insufficient investment in community services, leading to an inappropriate over-reliance on hospital services, the draft report makes recommendations covering the need for:

- better community and primary care for people presenting with a mental health problem;
- improved team working in community mental health services;
- improved services for those experiencing a crisis, with these services acting as a gatekeeper to hospital services;
- the location and quality of hospital provision;
- promotion of recovery and rehabilitation services to ensure people do not remain in hospital unnecessarily; and
- assertive outreach teams for those who remain vulnerable in the community.

Many of the themes expressed in terms of mental health can also be applied to learning disability and physical & sensory disability, in particular, the lack of progress in transferring provision from a hospital to community setting. Demand for services for the disabled is increasing due to rising survival rates of those with profound and multiple disabilities, whilst legislative requirements also have significant - in some cases disproportionate - resource implications. In addition, as with other social services, the view of those we spoke to was that policy initiatives in England were not being replicated in Northern Ireland.

The only significant indicator of the extent to which social services are delivered efficiently is unit costs. However, whilst variation in unit costs between trusts may provide an indication of relative efficiency, it may also reflect differences in underlying costs and quality of service. Overall, there appeared to be a significant variation in unit costs between trusts, for example, the cost of social work for the elderly in the North & West Belfast Trust was 220% higher than the Northern Ireland average whilst the cost of care homes for the elderly was significantly higher in the Causeway Trust.

### 3.5.2 Children's Services

Social services provided to children include child protection, care of looked after children (including fostering and residential care services), adoption services and day care facilities. Social work accounts for just over a third of total spend on children's services, with a fifth spent on residential homes and 15% on fostering and adoption services.

The key issue with respect to children's services is the level of funding relative to England. In particular, concern was raised with this Review that funding is to be terminated for the projects under the Children's Fund established by the Northern Ireland Executive. In addition, the perception was that policy decisions take longer to reach and implement than in England, with the result that service provision is often years behind in Northern Ireland - again, similar views were expressed in respect of the other social services.

However, from the activity statistics and evidence presented in the Needs and Effectiveness Evaluation, it appears that service provision is broadly similar Northern Ireland and England in terms of the proportion of children looked after by local authorities or on the child protection register - although it could be argued that that provision should be higher given deprivation levels in Northern Ireland.

Therefore, the main reason for the relative level of spend is lower unit cost of provision. Lower unit costs may reflect lower quality of provision or it may be that social services for children in Northern Ireland are provided more efficiently than in England. To the extent that the latter is the case, this raises questions as to whether similar levels of efficiency could not be derived for other parts of the health & social care sector.

There are currently around 2,500 looked after children in Northern Ireland (in the sense that a trust has parental responsibility for them). This is equivalent to 5.7 children per 1,000 population aged under 18 compared to 5.5 for England and 5.4 in Wales. Around 61% of children looked after are in foster care, 13% in residential care and the remainder placed with their families or elsewhere - the split in provision is similar to that in the rest of the UK. There are around 1,400 children on the child protection register - mainly as the result of neglect or physical abuse. A greater proportion of the population aged under 18 are on the child protection register in Northern Ireland (0.32%) compared to England (0.23%).

The quality of provision appears slightly better in Northern Ireland, with looked after children and young people experiencing more placement stability than in England or Wales, whilst in 2001/02 the proportion of young people aged 16 or over leaving care with at least one GCSE or a GNVQ was slightly higher in Northern Ireland (44%) than in England (41%)<sup>69</sup>.

As with adult services however, there are significant variations across trusts in the level and type of provision. For example, there was a 124% higher rate of looked after children and 446% more children on the child protection register in the North &

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<sup>69</sup> Five per cent of looked after children in NI had 3 or more separate placements during 2001/02 compared to 13% in Wales and 15% in England.

West Belfast Trust than the Craigavon & Banbridge Trust, whilst there were 137% more day care places in the South & East Belfast Trust than in Foyle. Such variations are largely explained by variations in need. However, there were also marked difference in the unit costs of residential care. For example if the unit cost of provision achieved by the South & East Belfast Trust was replicated across Northern Ireland, then the overall cost would fall by almost a quarter.

## **Conclusion**

The main issue raised by those we consulted during this Review with regard to both adult and children's social services was a perception of too little funding, and, in the opinion of many, in large part due to resources being diverted to the acute sector. Whilst the evidence was mixed in terms of funding, the available data does not tend to suggest that there is a significantly lower level of social services *provision* in Northern Ireland relative to England. That is not to say that there are specific areas where there are insufficient resources or that a case could be made for a higher level of provision given relative levels of deprivation.

In addition, innovative projects tend to be resourced through non-recurrent funding so that they are more likely to be terminated in the face of overall funding pressures. There needs to be a more rigorous approach taken to ensure that if projects are discontinued, it is on the basis of relative effectiveness.

The funding issue was directly linked to the integrated nature of the service. Northern Ireland appears currently to be mid-position between full integration - where responsibility for both hospital and social services is shared - and the position in the rest of the UK where services are split. The findings of the Community Care Review would suggest that it is not only funding but also the movement of patients between services where the link is less than seamless. This Review has not been able to come to a conclusion as to whether the answer is to have greater integration or to formally split health and social services - whilst the link was considered worth maintaining by those to whom we spoke, in light of the associated problems it was not entirely clear why this was the case.

The above has been only a brief overview of the key issues associated with the provision of social services in Northern Ireland which, given the issues highlighted, merits a more fundamental consideration, with a focus on the services delivered and in particular the equity of provision between different parts of Northern Ireland.

**Recommendation 19: the integration of health & social services should be re-examined with an initial first stage being the ring fencing of funding for social services from the acute sector. There should however be scope for financial sanctions when inefficiency in one part of the system impacts negatively on another e.g. lack of social services provision causing delayed discharge from hospital.**

**Recommendation 20: the contracting of services from independent/voluntary organisations should be reviewed to consider whether it can be placed on a more strategic basis.**