

Social Care in Northern Ireland

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This brief focuses on issues and policy developments relating to adult social care in Northern Ireland. It draws on published research evidence and the discussion at a Roundtable event organised by ARK and held on 17 September 2010. Roundtable participants included officials from a number of government departments, representatives from a range of NGOs and academics. The event was conducted under the anonymity of reporting allowed under the Chatham House Rule to encourage open debate.

Introduction

The White Paper, *Our Health, Our Care, Our Say* (DH, 2006) defined social care as: “The wide range of services designed to support people to maintain their independence; enable them to play a fuller part in society; protect them in vulnerable situations and manage complex relationships.” Although social care covers a range of client groups this

brief mainly focuses on how policy impacts on older people and people with physical disabilities.

The impact of rapid and expected demographic and social change, including an ageing population in many countries, including the UK and Ireland, has been well documented. While Northern Ireland has a younger population than the rest of the UK, the demand for long-term care is also linked to the health and well being of a population – factors which are likely to increase demand here (Bell, 2010). The urgency of the debate about social care, including the funding of long term care, has been increased by concern about growing levels of unmet need and the focus on intense or high level needs at the expense of relatively lesser needs (York Consulting, 2009; Age Concern, 2009; PAC (NI), 2008). Despite the urgency of the issues there has been less debate and policy attention in Northern Ireland than in other parts of the UK.

Differences in how social care

services are organised and delivered precede devolution. While in Britain local authorities are responsible for social care, albeit with increasing emphasis on joint working with health services, in Northern Ireland health and social care services are structurally integrated and care is organised through Health and Social Care Trusts.

Recent Policy Developments in England

In 2007, the Labour Government announced its intention to reform the system of funding and delivering social care. This followed the publication of a number of reports highlighting the shortcomings of the current system and the need for a fundamental rethink to address its unfairness, complexity and financial unsustainability (Wanless, 2006; Keen, 2008). A Green Paper ‘Shaping the Future of Care’ published in July 2009 set out a series of options for funding adult social care and support aimed at giving users more choice and control.

The subsequent White Paper, Building the National Care Service (HM Government, 2010), contained proposals to build a comprehensive National Care Service for all adults in England. In July 2010, the Coalition government set up a Commission on future funding of care and support to report in July 2011. It will make recommendations on an affordable and sustainable funding system for care and support, in the home and other settings, for all adults in England. It will also consider the interests of the devolved administrations where appropriate. The coalition government has indicated it favours the greater roll-out of personal budgets.

Where are we now in Northern Ireland and what are the issues for the future?

With regard to community care policy, Northern Ireland operates under the vision and principles set out in People First (1990) which includes enabling individuals to remain in their own home or in homely settings in the community. Social care is a devolved responsibility which means the DHSSPS is responsible for allocating budgets to Trusts for the provision of social care services.

As shown in Table 1 acute services attract a substantial proportion of health and social care funding. Since 2004 this Programme of Care has been consuming a rising percentage of all Trust expenditure in Northern Ireland, a point stressed by roundtable participants.

Long term care

The funding of long term care has been a source of much controversy and differences exist within and between devolved areas of the UK. Since 2002 the Scottish parliament has provided free personal as well as nursing care in home and residential settings, the only region of the UK to do so. This has been highly popular, with a strong political and public consensus; it has had a major impact on care provision in Scotland as shown in the Sutherland Review of free nursing and personal care in Scotland (Scottish Parliament, 2008). The Northern Ireland Assembly voted in favour of providing free personal care in 2007, followed by a review of the costs and benefits of it. The review concluded that a relatively small number of people would benefit and that it would be therefore difficult to justify the cost.

In May 2009, Minister McGimpsey ruled out the introduction of free personal care in Northern Ireland for cost reasons.

Progress in increasing and enhancing domiciliary care

Much of Northern Ireland's spending on social care continues to be on institutional care. In 2006/07, half the £191million expenditure in mental health services was for hospital settings (DHSSPS, 2008). Northern Ireland has the highest level of care home places per thousand population aged 65+ in the UK. In 2007/2008 expenditure in elderly

care totalled £644.9m. Nursing homes accounted for almost a quarter of this expenditure (DHSSPS, 2008).

This may be accounted for to some extent by higher levels of disability and therefore more high level need, but the Northern Ireland Audit Office (NIAO) (2008) and the Northern Ireland Public Accounts Committee (2008) have been critical of the failure to develop sufficient capacity in the domiciliary care sector.

Bamford (2006) reported that, in 2000, over one quarter of people with a learning disability in Northern Ireland lived in nursing homes while in 1997-8 in England and Wales, just 7% of people with a learning disability did so. There is no Public Services Agreement target for the development of supported living accommodation for people with disabilities of any kind. Although legislation to allow Direct Payments to people wishing to purchase their own care was introduced in 1996, take up here has been lower than in any other part of the UK and is low across all client groups. This is clear from the relevant Public Services Agreement target, which is an increase to 1,750 direct payment cases by March 2011.

In Scotland, the provision for free personal care appears to have added impetus to a process to shift the balance from residential to home care started prior to devolution. In Northern Ireland figures from the

NIAO show that the expenditure on domiciliary care services for older people increased by 40% in the four years from 2002-03 (£108.4m) to 2005-06 (£147.3m), however over the same four years the number of domiciliary care packages had increased by only 12. The NIAO concluded from this that resources are increasingly being directed towards those with the most severe needs and levels of dependency. This raises an important issue about creating future need for more residential or nursing care by a failure to meet lower level or intermediate needs. A shift towards domiciliary care in Northern Ireland, provided at the appropriate point, would not necessarily be more expensive – particularly if it contributed to prolonging independence and reduced the need for more intense intervention.

Community care and personalisation – what is the policy in Northern Ireland?

Personalisation is used broadly to mean increasing the take up of direct payments and the expansion of individual budgets as a way of giving people control over how their social services are designed and delivered. It is also seen by some as having the potential to achieve greater efficiencies. There is evidence from a range of studies on independent living and social care of fundamental challenges to the personalisation agenda, not least the requirement for

providers to change services and transform commissioning practices.

A number of roundtable participants referred to the DHSSPS commitment to promoting self directed care and the absence of strong direction on how this is to be progressed, including the implications of funding being tied into current services. Personalisation demands a massive cultural shift on the part of service providers and users. Evaluations in England show that users are often confused by the concept of personalisation, with much more needing to be done to inform users and carers and support them to engage in what is a complex process. It was pointed out that that personalisation requires a very different approach from health and social care staff who may see some choices users make as ‘risky’ or undesirable. The point was made that social workers are now seen as gatekeepers of resources with services linked to their assessments. The potential for these assessments to be subject to judicial review can lead to accountability. However, it was also seen as resulting in greater levels of caution on the part of social workers. The view was expressed that Trusts had become fearful of innovation. There is a fundamental challenge in achieving a balance between supporting and protecting vulnerable people and encouraging independence and choice.

The experience of Direct Payments in Northern Ireland was used by a number of participants to illustrate the

need for professionals, voluntary organisations and users to be well informed about policies. Take up of Direct Payments here is below other parts of the UK, due in part to a lack of knowledge and confidence of social work staff to inform and support users (Davey et al, 2007). Participants raised questions about how staff are being prepared for personalisation; whether policies at Departmental level are adequately developed to inform work on the ground; and how professionals (and society) view older people. There was criticism that too often older people are not listened to in relation to the support or services they want as opposed to what others feel they need.

An additional complicating factor in Northern Ireland was raised: while there is a considerable amount of recent policy and guidance, much of the legislation relating to social care in Northern Ireland is quite dated.

Northern Ireland does have the opportunity to learn from experiences and evaluations in Britain. An event bringing together service users and policymakers to feed into the Labour Government’s Green Paper Consultation in England found that the priorities for those present – in order of importance were:

- Greater user involvement: priorities include increased involvement for people who use services, more support for service user organisations, more service user

training and more user-controlled services;

- An improved workforce: priorities include improving the role, status, pay and conditions of workers and better training for workers;
- Improved and appropriate services - not all were supportive of individual budgets and some people stressed the need for them to be supported by an adequate infrastructure;
- More funding for social care: need for existing funding to be used better and differently and the damaging effects of inadequate funding recognised;
- Changing from a restricted to an accessible universal service: the removal of narrow eligibility criteria;
- Policy and provision based on rights and independent living;
- Policy and provision based on an holistic approach to people, instead of being based on a narrow idea of 'social care' needs, joining with the wide range of other policies that affect lives, like housing, health, benefits, education, planning, justice and so on. (Beresford and Hasler, 2009)

Of particular relevance to rural Northern Ireland may be a piece of research carried out by Shaping Our Lives (User-led group) with older people for Cumbria County Council and Cumbria PCT. It found there

were a range of common barriers that often prevented older people from being able to remain in their homes. These included: concerns over standard of care; lack of accessible, reliable and frequent appropriately-timed transport; lack of affordable and reliable services to help with house and garden maintenance and repairs, particularly small jobs; delays to adaptations to homes; and fear and isolation. If these barriers meant people could not stay in their own homes then they considered a move to what seemed to be more suitable 'mainstream' accommodation, such as a bungalow. For others it meant a move to a less rural and isolated location. It was only after these options had been explored that people thought they would start looking at housing options specifically for older people. Sheltered accommodation was the preferred option, though the need for nursing home care for some was recognised.

Workforce Issues

The social care workforce was the subject of much debate. Participants stressed that the quality of domiciliary care is closely linked to skilled staff. This was seen as a challenge in an environment where care is delivered by low paid workers employed in a range of sectors, some of which are not used to the level of regulation required to protect vulnerable individuals and ensure standards. Voluntary and private providers now supply 81 per cent of publicly funded

home care in England, compared with 5 per cent in 1993 - a much higher proportion than in Wales and Northern Ireland, where independent suppliers provide just over 52 per cent of state-funded home care. In Scotland, only 36 per cent of home care was supplied by independent providers in 2008, while a further 11 per cent of provision involved combined working by local authorities and the voluntary or private sectors.

Reference was made to how little is known about people working in the range of sectors which provides social care. In particular, it was felt there needs to be more focus on issues raised by the marketisation and personalisation agendas. These include the recruitment and retention of workers, skills and qualifications, professional development and prevention of abuse. Although the Regulation and Quality Improvement Authority has responsibility for regulating and inspecting all provision, concern was expressed about whether the fragmentation of the social care workforce affected the application of standards, codes of guidance and regulation. Does such fragmentation also make it more difficult to deliver care efficiently with little or no matching of clients and care providers/care workers at a local level? One initiative in County Louth in the Republic of Ireland is piloting organising care services and workers on a geographical basis in an attempt to rationalise services. Should such initiatives be considered

in Northern Ireland and how could this be managed?

The low value and low status attached to care work was perceived as a problem by many participants. It was felt by some that this was reflected in the minimal training and professional development support offered to workers. Fundamental questions about care workers include: how much we are willing to invest in high quality services and what values we feel, as a society, should underpin social care policy and provision? The value placed on social care work was a point returned to again and again by participants, particularly given the anticipated cuts to public spending. Demand for care is a market which is likely to grow but the resources to meet demands are becoming more constrained.

While the roundtable did not look specifically at unpaid care inevitably, given that the majority of care is provided by unpaid carers, there was quite a lot of discussion of the issues affecting carers. This included concern that a lack of resources resulted in pressure being put on families to care or implicit assumptions being made by professionals regarding how much care should or would be provided by families. There is a lack of data on the number of Carer's Assessments and the outcome of these.

Policy making and governance

Reference was made to a DHSSPS view that no decisions on future social care policy would be taken in Northern Ireland pending the outcome of the Coalition Government Commission on Long Term Care investigations, but this was felt by most participants to be inadequate. Northern Ireland will have little influence on the Commission and there was frustration that the opportunity for policy making created by devolution had not been well used. Reference was made to developments by the Scottish Executive, including the way in which that administration was addressing the contradictions of the overlap between social security and social care and was linking procurement policy to human rights issues.

A perceived barrier to progress in Northern Ireland was the unwillingness of politicians to take political leadership on social care issues and to make difficult and unpopular decisions. One participant defined the problem as 'institutions being perceived as services' - so the closure of a hospital or a nursing home was seen as a service cut rather than an opportunity to develop alternative and more progressive services in the community. An additional problem was argued to be the way in which the Programme for Government provides encouragement for departments to maintain a 'silo mentality'. This lack of co-

operation and joint working was perceived to go beyond government departments; lack of communication between Health and Social Care Trusts can mean that they operate in 'regional silos', limiting the sharing of good practice.

There has been considerable debate in Northern Ireland about the number of government departments and whether the resultant organisation of functions is a hindrance to effective policy making. Would the problem of 'departmental silos' be addressed by reducing the number of departments? Some participants argued this might not necessarily be the case. In Scotland for example Departments have been abolished and the focus has been on systems working together. However that may have been due more to a strong commitment to public services and to the promotion of equality and social justice than to structures.

Missing knowledge or 'evidence' about social care in Northern Ireland

There was a strong consensus among participants that policy development and discussion was hindered by a dearth of evidence on aspects of social care, including the impact of the integration of health and social care on social care provision. While in theory integration should have distinct advantages in terms of co-ordination of service planning and delivery, in practice social care is often felt to be in the

shadow of hospital services. Less money is spent on many aspects of social care than in other parts of the UK. Participants referred to the political difficulty of saying that Northern Ireland has too many hospitals or spends too much on acute care but argued that this is something that needs to be discussed much more openly. There was strong agreement about the need to adopt more long term vision and planning with regard to the development of social care.

Little is known about how the Commissioner/Provider structure is operating in Northern Ireland and whether it is working effectively. With regard to care provision, some participants warned about falling into

the ‘free market approach’ which could result in more limited resources and inequality in access to services.

There is an acknowledged lack of data and long-term evaluation of services in the devolved regions of the UK. What can we do in Northern Ireland to address this? Given the evidence from England about what users feel is necessary for genuine participation, are arrangements for public and user engagement in Northern Ireland sufficiently local and robust?

Little is known about what people in Northern Ireland want and how they feel about their own social care provision but public endorsement would be an important basis for

fundamental policy change and long term planning. Prior to the publication of the Green Paper on Social Care in England the Labour government commissioned research to explore public understanding of social care provision and aspirations and expectations for the future (IPPR and PWC, 2009). The findings point to a lack of awareness about how social care is funded and confusion about how it is delivered, with few people preparing or planning for the future. Findings from a set of questions on attitudes to social care included in the Northern Ireland Life and Times survey, which will be carried out between October 2010 and January 2011, will go some way to providing this information for Northern Ireland.

Table 1 Planned Expenditure by Programme of Care 2008/09 v 2009/10

Programme of Care	2008/09	2009/10	%change from previous year	2009/10 Programme of Care % Share
Acute Services	1,143	1,196	4.65	38.2
Elderly care	594	600	1.01	19.2
Family and Childcare	179	190	6.15	6.1
Health Promotion	56	98	75.00	3.1
Learning Disability	205	209	1.95	6.7
Maternity and Child Health	120	125	4.17	4.0
Mental Health	219	235	7.31	7.5
Physical and Sensory Disability	90	89	-1.11	2.8
Primary Health and Adult Community	99	111	12.12	3.5

Source: Strategic Resources Framework Health and Social Care Expenditure Plans for Northern Ireland by Programme of Care and Key Service, incorporating Selected Planned Activity 2009/10

Key points emerging from the roundtable

There was agreement that this was an overdue debate and that there were key areas which future discussions need to focus on:

Structural issues

These include upskilling the social care workforce, a serious discussion about the value of that workforce and how that value needs to translate into pay levels and continuing professional development opportunities. What about the impact of different funding models? Is there too much focus on driving down costs and not enough on quality and choice?. We need to know more about commissioning – how it is working in Northern Ireland and is this a model that is effective, suitable and efficient?

Technical issues

The effectiveness of models of delivery needs to be evaluated. This includes the differentiation between public and private providers and should involve analysis of rationale: Is it about pushing down costs? Are we doing what we think is best in terms of quality ? Given the emphasis on increasing personalisation in Britain how do policy makers sees future developments in Northern Ireland? How can the potential for the gap between aspiration for personalisation and the reality on the ground be addressed?

Values

In the past there has been a lack of holistic expression of values and the potential for tension: whose values – government, public, individual? There was much agreement that this debate also needs to be translated into issues of choice, personalization and a rights based agenda.

Funding

There is a critical need for an informed debate about future funding of social care. Given the need for long term planning, politicians need to look beyond the current economic climate. Glasby et al (2010) note *“many recent debates about the funding of long-term care have arguably dismissed various options too quickly as ‘unaffordable’. Although this is often portrayed as an economic argument, such statements are inherently political. Something is only ‘unaffordable’ if we are not willing to pay for it. If we genuinely wanted to fund a particular level of service for adult service users, then we could afford to do so tomorrow – as long as we did not fund other activities that we decided to value less.”* It would be useful for the debate in Northern Ireland to look beyond the UK to social care arrangements in other countries. The UK’s current social care arrangements are very different from many other developed countries. In particular, virtually no other country restricts access to publicly funded social care only to poorer people. Recent reforms in countries as diverse as Austria, Germany and Japan have increased rather than decreased the universal nature of their social care provision (Glendinning and Bell, 2008).

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