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Social Care in Northern Ireland

A better future for us all

November 2011
Final Report

PwC report prepared on behalf of Independent Health and Care Providers (IHCP)

Contents

Foreword

"We are in a situation without parallel in the history of humanity."

UN (2007) *Report on World Population Ageing*

"The ageing of the population is a significant success for many countries, and one which should be celebrated. The fact that people are living longer is a welcome one, and stands as testament to the advances we have made in technology, living standards and treatment of medical conditions. However, it also requires the development of a range of policies to address the opportunities and challenges presented by this phenomenon. Nowhere is this fact clearer than in the area of social care. The social care system in Northern Ireland is broken and fundamental reform must now be a priority for the Minister for Health, Social Services and Public Safety along with his Executive colleagues. The current system is no longer sustainable, and it's not capable of meeting the needs of today's generation of older people or indeed future generations. That's what hundreds of older people, their family friends and carers have been telling us over the last number of years.

Age NI has received nearly 23,000 calls to our advice service over the last 18 months, approximately 15% of which have been on issues of community care. On these calls, older people have been telling us that they are struggling to access that little bit of help which could help them to remain independent, and that rationing of services and increasing levels of unmet need are all characteristics of their engagement with social care in Northern Ireland. This report suggests that the pressures on our system are likely to intensify over the coming years as our population ages and we witness a 50% increase in the numbers of people who are 85+, the people who are most likely to require some form of care.

Looking forward, social care must become the linchpin in supporting older people to remain independent and out of hospital. The right system of social care could reap significant rewards for us all as we age. The right system of care means that older people could enjoy better health for longer, remain in their homes for longer and only go to hospital or residential or nursing care when it is the most appropriate place to access the care that they require – meaning better value for money for us all. Evidence from Great Britain demonstrates that using social care as a preventative tool works, saving money in the system and providing better outcomes for older people. As we all age, we all have an interest in securing a high quality, integrated social care system that recognises the rights, aspirations and diversity of us all, and which is based on the right to live with dignity, independence, security and choice.

This report is a welcome contribution to the debate on where our system of social care needs to travel in order to meet the needs of us all as we age. This report pulls together local and national evidence on social care and older people together with a broader view of what other countries are doing to address the social care needs of older people. The knowledge contained in this report must be used to underpin the ongoing Health and Social Care Review and any work which DHSSPS undertakes to move forward the outcomes of this Review."

By Anne O'Reilly, Chief Executive, Age NI.

Executive Summary

Introduction

PricewaterhouseCoopers LLP (PwC) was commissioned by the Independent Health and Care Providers (IHCP) in September 2011 to prepare a research report to inform the IHCP consultation response to the Review of the Provision of Health and Social Care Services, announced by the Health Minister in June 2011.

The preparation of this report was assisted by a Steering Group comprising representatives of IHCP, Age NI and other sector stakeholders.

In preparing this report, PwC undertook desk research of recent and relevant literature including research by the Joseph Rowntree Foundation and research undertaken as part of the Dilnot Commission on social care in England and Wales. A review of available demographic data was undertaken to inform the current need and future demand for social care services for older people in Northern Ireland (NI). In addition, PwC completed a high level review of good practice in other countries.

This report presents the key findings from that research into social care with respect to ageing and, in particular, it considers the social care system in NI. It does this by considering the structure of the system, the principles which should underlie the system and the pressures it currently faces. The report also considers good practice models from elsewhere, how to balance value for money with financial sustainability and finally it provides some areas for consideration for the future social care system in NI.

The principles that should underlie a better social care system in NI

It is widely accepted in the literature, and indeed it is our view, that these principles should include the maintenance of the dignity and independence of individuals in older age. Alongside this, a reduction in social isolation would be very desirable.

The system should also maximise choice between care options, providing a more than adequate provision whilst still encouraging and facilitating incentives for self-responsibility. The system should also be able to cope with the fact that for any individual, lifetime care costs are largely unpredictable and will, for some individuals, be substantial. Given this, it would be desirable if those who could afford to do so were given the option of insuring themselves against the potential future cost of social care.

However, any real world social care system has to grapple with inherent trade-offs between such desirable principles. For example, if on the one hand government increases the extent to which assistance is means tested, this increases the perception of unfairness on the part of individuals who have made provision for their future through savings or other means. On the other hand, if the extent of means testing is decreased (i.e. the benefit and assistance given is made more universal), this increases the public expenditure cost of the system.

Key points

- There is broad agreement that an improved social care system would deliver high quality care in order to recognise principles such as **independence, choice and flexibility, affordability and equity.**

- There may, however, be **tensions or trade-offs** between some of these desirable principles and the dilemma for policy makers, stakeholders and the

public lies in the choices which then have to be made between these principles and solutions.

The pressures on the social care system in NI

Our analysis of the data shows that there are a wide range of pressures on the social care system in NI, many of which are likely to intensify over the course of the coming decade. Some of these pressures are demographic, some social and some economic.

One of the difficulties in the current situation is that whilst lifetime care costs can be very substantial for some individuals, a large proportion of the public imagine (wrongly) that such social care is provided free by the state. In the absence of a substantial change in the extent to which the public are informed, there is the threat that in the future some individuals could be facing bills that they are in no way prepared for.

Key points

- According to Appleby (2011)[1] there is likely to be a **real reduction in spending on social care** by the Department (DHSSPS) of 7% under the NI Budget, through to 2014-15.

- **Rising expectations** are tending to push up demand for increased spending on social care.

- **NI's population is ageing**, itself a testament to the success of health and social care in NI and the impact of this is concentrated outside of Belfast. Indeed, it is ageing more rapidly than England.

- Ageing is paralleled by the **growth of some chronic conditions** of ill health, e.g. mental illness and dementia.

- Generally depressed economic conditions (increased indebtedness and less favourable pensions and valuations of domestic property) have **constrained individuals' ability to pay** for social care themselves.

- Such **constrained individual budgets matter** because for some individuals, lifetime social care costs are substantial. If individuals were charged the cost of domiciliary care (currently provided free) this could represent at least £10-15 per hour. Some individuals do currently pay the full rate for care homes (in some cases more than £500 per week). The Dilnot Commission suggested a cap on lifetime payments for social care of £35,000.

- There has been a significant **inflation in the costs of provision of social care**. Hence, when the general labour market is more buoyant, difficulties in maintaining an adequate supply and quality of labour into the sector are likely to become apparent. In the absence of some workforce planning, future labour force demands may well outstrip supply.

- Social change and economic pressure may **reduce** the extent to which we can continue to rely on **informal care**.

[1] Appleby, J (March 2011) *Rapid Review of Northern Ireland's Health and Social Care Funding Needs and the Productivity Challenge 2011/12-2013/14*. Report to Department of Health, Social Services and Public Safety: Belfast.

- The increasing complexity of the market, alongside the development of a small number of large providers of independent care homes, may be leading NI (like England) towards a situation where some of the care **providers are perceived as "too big to fail"**. However, it should be noted that this only relates to the residential and nursing home sector as domiciliary care providers tend to be much smaller in size and each serve less than 10% of the market.

The current social care system in NI

The NI social care system for older people, at least in formal terms, consists of two main parts: domiciliary care (i.e. assistance provided to help maintain people in their own homes) and residential and nursing care homes (i.e. a residential home is one which will provide personal care only whilst a nursing home also has qualified nursing staff on duty to provide nursing care). However, it is also important to note that a significant amount of care is provided informally (and at no or little direct cost to the state) by friends and family members.

Domiciliary care packages are provided by the Health and Social Care Trusts (HSC Trusts) without charge to the client. About 230,000 hours are provided weekly equivalent to an average of about ten hours per client. About two thirds of this provision commissioned by the HSC Trusts is provided by the independent sector. The HSC Trusts have found it increasingly difficult to fund a level of domiciliary care equal to the demand especially in a situation where the service is provided free.

There is now an element of unmet demand, and rationing in terms of both quantity and quality is occurring, suggested by the large decrease in the number of care packages agreed during 2008-10. This situation has negative implications from the point of view of DHSSPS. For example, if some extra domiciliary care funding meant that certain individuals were able to stay in their own homes for longer, then the "gain" in terms of reduced spending on hospital care or care homes might exceed that outlay. If further reductions in social care budgets occur, such wider gains are likely to be foregone.

The HSC Trusts provide means tested assistance to individuals staying in either residential or nursing care homes. Individuals and/or their family become liable for the full cost of care once their level of assets (including the value of their home) passes £23,250. So, it is often felt that the extent of assistance is ungenerous and the extent of means testing is severe with the consequence of potential inequities or disincentive effects. Even where individuals get full or part assistance from the state, their families may have to make additional third party, top-up payments to the care home.

The current system of social care - the combination of statutory and independent providers together with informal care and support provided within families - achieves a great deal. At the same time, there are strong indications of growing and substantial levels of unmet need. Despite some improvements from 2005 to around late 2010, the available indications suggest fees paid by the DHSSPS to independent providers, especially of care homes, remain lower than costs.

Key points

- The amount of **public funding** devoted to the social care system for older people in NI is **substantial,** at about £442m in 2009/10, which represented 10% of the total DHSSPS spend of £4.4bn.

- The available evidence suggests the use of **independent providers represents a lower cost option** for the HSC Trusts as compared to in-house (statutory) provision.

- Domiciliary care packages are provided free at the point of use. There are indications of **increased rationing and hence unmet demand**.

- **Residential** and **nursing home** provision consists of a **mixture of statutory** and **independent** providers.

- During 2005/06 - 2009/10, there has been a **downward trend** in the total number of **residential homes** and bed spaces (especially on the statutory side).

- **The state** provides **limited, means tested** assistance to pay for stays in homes. Even where this assistance is provided, third party **(or top-up) fees** often occur.

Good practice: looking at what is done elsewhere

As part of the research we considered a number of examples of social care provision outside NI including:

- **State funded universal provision** (as in **Denmark**). This can lead to high universal standards of care provision. A disadvantage is the need to pay for this out of general taxation. This option is unlikely to be adopted elsewhere in the UK. In any case, NI has limited scope, as a devolved region[2], to opt for higher social care spending funded by regional variation in taxation.

- **Compulsory social insurance** (as in **Germany**). This can also lead to high universal standards of provision. A major disadvantage is the need to pay for this out of relatively high insurance charges (e.g. on employment).

- The **mixed funding model** proposed for **England** by the Dilnot Commission. Some, though not all, commentators think this strikes a reasonably fair balance between some (but a limited and capped) contribution by individuals alongside assistance from government. Whether NI opts for Dilnot depends partly on whether Westminster opts for this approach for England (and this is still unclear). Adoption of such policies in NI could cost up to about £80m per annum in terms of additional public funding[3].

- **Social Impact Bonds** represent an innovative approach (now being **piloted** in **England**), based on the ability of private/voluntary sector providers to realise cashable savings in service delivery compared to in-house public sector provision (they are paid back a dividend out of any such cashable savings which are realised).

- **Healthcare villages** (as in the **US** and **England**). These are an attempt to strike a balance between individuals' desire for some degree of independent living in retirement alongside some safety and supervision. They also provide a possibly less onerous way of tapping into the equity of retiring property owners (as compared to what happens at present when some individuals find they must sell the family home in order to pay for a stay in a care home). However, villages

[2] Probably less scope than Scotland for example.
[3] The public spending cost of Dilnot in England could be about £1.7bn. Allowing for the relative number of older people in NI compared to England, the cost in NI could be 3-4% of that total.

are not an option for the less well off. Also, it is unclear how far people in NI would wish to live in communities of older people and, consequently, it is unclear if sufficient scale could be realised.

Key points

- Every case is unique. External models cannot be readily transferred, but **much can be learned** by NI from elsewhere.
- Other European countries (e.g. Denmark or Germany) have opted for high quality, universal provision funded either from public spending or social insurance. It is **unclear whether there is an appetite in NI** (or elsewhere in the UK) for a **higher level of taxation or insurance** contributions to fund such systems.
- The **Dilnot proposals** (especially if adopted in England) may provide a **more manageable balancing** of responsibilities between the taxpayer and the individual.
- **Social Impact Bonds** could perhaps be **applied** in NI, especially to the provision of domiciliary care.
- Based on the existing evidence, it is **unclear** how far **healthcare villages** could be developed in NI.

Achieving greater value for money and a financially sustainable sector in NI

Policy makers have to strike a balance between ensuring value for money from the use of public funds, while also promoting the sustainability of private providers of social care. However, financial sustainability may be becoming more precarious.

Previous studies by PwC and the Joseph Rowntree Foundation indicate that current costs of providing a bed space in the independent care homes sector surpass the fees being paid by the Department. This conclusion is further supported by a consideration of the inflation of costs between 2004 and 2011 relative to the increase in fees paid by the Department. Some, but not all, of this shortfall was closed as the Department upgraded the fee payments for residential and nursing homes. Similarly, it can be questioned as to how far current fee payments to domiciliary providers are sufficiently high relative to costs to ensure longer term sustainability of provision by independent providers.

Key points

- There may be opportunities to improve value for money through developing **more efficient procurement/commissioning** arrangements.
- The available evidence suggests that care home spaces can be provided at a **lower cost in the independent sector** compared to the statutory sector.
- The available evidence suggests that in the mid 2000s there was a **substantial shortfall in the tariff paid by the DHSSPS** compared to the cost of provision per bed space by an independent provider. That shortfall narrowed after 2004/5 but was probably not closed completely, notwithstanding an increase in DHSSPS Trust fees. Indeed, the available indicators suggest that the shortfall is now widening again.

Points for further consideration regarding the future of social care in NI

A system which is already showing signs of fragility is likely, over the coming years, to become even more unsustainable. This is partly because demographic pressures alongside rising expectations are tending to increase demand, while less public money is likely to be available from the HSC Trusts. One outcome will be increasing difficulty in maintaining standards of quality of care.

Nevertheless, and notwithstanding the tightness of the NI Budget through to 2015, from the point of view of the DHSSPS and, indeed, the NI Budget, spending to save through enhanced social care should be an increasingly attractive option. Leaving aside any considerations of improvements to individuals' quality of life, the budgetary attraction of spending on social care is that some of that spending can be considered preventative.

If a relatively small amount of spending now (say on preventative care or rehabilitation) keeps an individual in their own home for longer, and out of hospital, this should represent a saving for the DHSSPS budget overall. There is an imperative to act soon with respect to such spending to save; delay is likely to reduce the payback. An element of long term stability would be valuable, especially with respect to workforce planning.

Key points

- A **fundamental review** of the social care system in NI is **necessary**.
- The evidence we have reviewed suggests the **current system is not sustainable**, given the combination of rising demands (ageing and expectations) alongside ongoing funding pressures.
- These **pressures** are likely to **intensify**.
- **Failure to reform now** implies a **missed opportunity.** That opportunity is not only to enhance the **quality of life** of older people, but also to **spend to save** within what is likely to be a fairly fixed total DHSSPS budget through better preventative care.

1. The principles that should underlie a better social care system in NI

Introduction

This section considers the principles which we would ideally like a social care system to reflect. With social care now higher on the political agenda than it has been for many years and an economic climate of austerity in public finances, there is a pressing need for all interested stakeholders to collaborate to design and deliver high quality social care provision for those who need it[4].

This section of the report attempts to describe what an "ideal" social care system might look like to allow comparisons to be made between the ideal system and the current social care model. Whilst the following paragraphs describe an "ideal" model, we should attempt to design a system which incorporates as many of these features as possible. However, as this report identifies, the desirable objectives often conflict.

The social care system should…

Be one that promotes positive ageing through quality care. As such, we should be able to celebrate longevity and ageing as benefits, rather than fear them as burdens. In order to get to such a position, the social care system should provide individuals and their families with as much certainty as possible so that they can make their own financial and care plans for old age to the extent that they can afford to do so. The Dilnot Commission[5] suggests that instead of being fearful about the financial consequences of needing care, we need a new system that allows people to plan and prepare for the future. Such a more understandable and transparent system would also facilitate the development of products by the financial markets to allow those who can afford to do so to part insure themselves against future care costs.

Maintain independence

The ideal social care system would also provide a more than adequate provision to protect the health, wellbeing and dignity of older people. However, it would do so without discouraging individuals and families from making their own provision for the future. In short, it would foster responsibility and independence, without also encouraging social isolation[6]. According to Age UK (2011)[7] loneliness increases as people become less able to undertake the activities of daily living and they are inhibited from keeping up with their family and friends. Recent estimates from Age Concern and Help the Aged in 2009 suggest that over one million over 65s in the UK are lonely or experience social isolation. In addition, Age UK report that recent studies have shown that nearly 200,000 older people in the UK have no help to get out of the house. For these reasons, an ideal social care system would provide adequate care for older people whilst maintaining a level of their independence.

[4] PwC (2010) *Funding tomorrow's care: Practical implications of the Dilnot Commission proposals*. PricewaterhouseCoopers LLP: London.
[5] Dilnot Commission (2011) *Fairer Care Funding: The Report of the Commission on Funding of Care and Support*. Dilnot Commission: London.
[6] Age UK Oxfordshire (2011) *Safeguarding the Convoy: A Call to Action for the Campaign to End Loneliness*. Age UK: Oxford.
[7] Ibid

Provide choice and flexibility

In addition to promoting positive ageing and maintaining independence, the ideal social care system would provide reasonable choice to individuals and their families, without creating large amounts of unused capacity. Where appropriate, state assistance could be provided in the form of cash or individualised "budgets", rather than in kind[8]. Choice to the individual/families implies diversity in the provision of supply of care. Part and parcel of the "market" in social care is likely to be a churn (or entry and exit) of providers but it is important that this turnover occurs without disruption to the individuals receiving care, whether domiciliary or care homes. Domiciliary care in particular, along with respite provisions, should enable individuals, where they wish to do so, to live for as long as possible in their own homes[9]. The system would also recognise the value, and needs, of informal carers.

Be affordable

In the ideal system, social care would be affordable, both from the point of view of individuals or families and the point of view of taxpayers and the state. The lifetime costs of social care are potentially very large, compared to some household incomes, and also very unpredictable. A substantial percentage of individuals may end up paying almost nothing over their lifetime but, conversely, for a significant percentage the cost will be equivalent to more than £100,000[10]. According to the Dilnot Commission (2011)[11], in England, one in four can expect to need little or no formal social care. However 50% will need to spend at least £20,000 and one in ten will spend more than £100,000. The ideal system would cope with these features by pooling risk, either through adequate private insurance, in so far as private markets are desirable or feasible[12], or by compulsory social insurance.

Be equitable

Finally, the ideal system would be equitable in the sense of both supporting those from a low income background but without penalising those in the "middle", especially those who through a lifetime of work and savings have, by retirement, built up a moderate level of assets. Equity would also entail reasonably equal treatment of individuals who have broadly similar care needs without drawing sometimes arbitrary distinctions e.g. between nursing and personal care.

Key findings

- There is broad agreement in the literature, and indeed it is our view, that an improved social care system would deliver high quality care in order to achieve objectives such as independence, choice and flexibility, affordability and equity.
- There may, however, be certain tensions between some of these desirable principles and the dilemma for policy makers, stakeholders and the public lies in the choices which then have to be made between these objectives.

[8] Department of Health (2010) *A Vision for Adult Social Care: Capable Communities and Active Citizens*. Department of Health: London.
[9] Joseph Rowntree Foundation (2005) *The older people's inquiry: That little bit of help*. Joseph Rowntree Trust: York.
[10] Dilnot Commission (2011) *The Report of the Commission on Funding of Care and Support - Fairer Care Funding*. London.
[11] Ibid
[12] PwC (2011) *Funding Tomorrow's Care Practical Implications of the Dilnot Commission Proposals Talking Points*. PricewaterhouseCoopers LLP: London.

2. *The pressures on the social care system in NI*

Introduction

This section considers current and likely future pressures on the social care system. The current social care model is facing a host of economic, social and demographic pressures, both in the short and long term. This section of the report aims to highlight some of these pressures, such as:

- Spending cuts (and the associated impacts/constraints of this on individual and family budgets).
- Ageing population.
- Expectations and willingness to pay.
- Issues around service provision.

Whist some of these pressures are impacting on the current social care model, the ageing population and increasing costs of provision will continue to impact on social care well into the future.

Public sector spending cuts

The NI public sector as a whole is facing a challenge in terms of forthcoming spending cuts. These are on a scale which has not been seen for at least a generation; the real level of funding available for the 12 Stormont Departments in total is planned to be £1.1bn less in 2014-15 compared to 2010-11. In addition to this, there is a particular spending pressure relating to the DHSSPS. The Department's Spending Plan (February 2011) forecast that by 2014-15, based on current trends, total spending demands (based on expectations, prices, demography and disease profiles) would be £828m higher than the available level of funding. The McKinsey report (2010)[13] estimated that if health and social care continues to be provided in the same way, an additional £5.4bn of funding will be required by 2014/15 to cope with the combination of growing demand for care and inflating costs.

As things are, the Budget agreed through to 2014-15 is likely to imply substantial reduction in the real level of spending on social care by 2014-15 compared to 2010-11 see Table 2.1. The reduction in NI exceeds that in England, although it is smaller than that planned for Wales.

Table 2.1: The real reduction in social care and health spending comparing 2014-15 to 2010-11 (% decline)

	NI	England	Wales	Scotland
Health only	-1.5	-0.25	-7.7	-2.9
Social Care only	-7.2	-5.5	-15.5	n.a.
Health & Social care combined	-2.7	-1.25	-7.9	n.a.

Source: Appleby (March 2011) Rapid Review of Northern Ireland's Health and Social Care Funding Needs and the Productivity Challenge 2011/12-2013/14.

In fact, the Budget situation could be even worse than this given various "inescapable" funding demands might be imposed on Stormont during the next four years or events in either the world or UK economies could force a further round of spending cuts. Hitherto, the Executive, like the coalition government in London, has attempted to shield health spending against the real terms spending cuts imposed on other departments but it is not clear how far that policy could be maintained throughout 2010-11/2014-15.

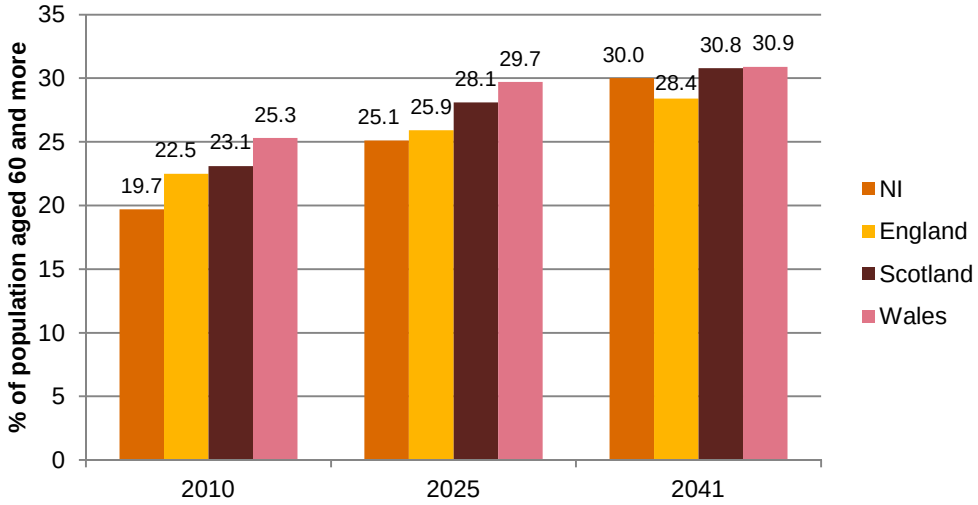
[13] McKinsey (2010) *Reshaping the System: Implications for Northern Ireland's Health and Social Care Services of the 2010 Spending Review*. Department of Health, Social Services and Public Safety: Belfast.

Demographics – an ageing population

The changing demography in NI represents a further pressure on the social care model. We have an ageing population, especially of the very oldest, and the proportion of the population aged 60 and over in NI is growing at a faster rate than in England, Scotland and Wales. Between 2010 and 2041, the percentage of over 60's in NI is forecast to increase by 10.3%, compared to 5.9% in England, 7.7% in Scotland and 5.6% in Wales.

Figure 2.1 below highlights this increase and, based on population projections from the Office for National Statistics, the percentage of over 60s in NI will reach a high of 30% in 2041, 1.6% above England.

Figure 2.1: Demographic change in NI compared to England, Scotland and Wales 2010-41



Source: Office for National Statistics.

Whilst the overall demographic in NI is an ageing population, Table 2.2 illustrate that there are some marked regional variations within NI. The Belfast HSC Trust is forecast to have the smallest increase in its older population (over 65). In contrast, in the Northern, Western and South Eastern Trusts the percentage of the population aged more than 65 could increase by about 3.5 percentage points during 2011-21.

Table 2.2: Population over 65 by HSC Trust (%) – 2011 compared to 2021

HSC Trust	% population over 65			% population over 85		
	2011 %	2021 %	% increase	2011 %	2021 %	% increase
Belfast	15.5	16.6	1.1	2.0	2.5	0.5
Northern	15.4	18.8	3.4	1.8	2.7	0.9
South Eastern	15.9	19.7	3.8	2.0	2.9	0.9
Southern	13.2	15.5	2.3	1.5	2.2	0.7
Western	13.1	17.1	4.0	1.4	2.2	0.8
Northern Ireland	**14.7**	**17.6**	**2.9**	**1.7**	**2.5**	**0.8**

Source: Northern Ireland Statistics and Research Agency.

It is worth noting from the table above that, whilst the percentage of population over 65 is forecast to increase by 2.9% percentage points and the over 85 age band by 0.8% percentage points, it is this older group that will put the greatest pressure on HSC budgets due to the level of need, particularly as age tends to be associated with an increasing prevalence of chronic ill health conditions such as hypertension, diabetes, obesity and asthma (the actual number of over 85s is forecast to grow by almost a half by 2021).

In addition to this, in examining population pyramids for each of the five Trusts (see Appendix 1) it can be inferred that family structures are changing with a smaller number of "working age" individuals and young people to support older relatives. This means that older people are less often able to rely on their family to provide "free" care, therefore creating a greater dependency on care homes.

Table 2.3 illustrates that some of the local government areas are likely to have significantly above average percentages of the population aged above 65 and 85 in 2021. The table has identified the top five districts with the greatest percentage of over 65s and over 85s for both 2011 and 2021. In addition, the top five districts with the greatest percentage change between 2011 and 2021 have been highlighted. Appendix 2 of this report provides a comparison of all 26 Council areas in Northern Ireland.

Table 2.3: % of population over 65 and 85 by Council area (top five only) – 2011 compared to 2021

2011		2021		% change between 2011 and 2021	
Top 5 Councils	**%**	**Top 5 Councils**	**%**	**Top 5 Councils**	**%**
% population over 65					
North Down	19.1	North Down	24.1	Coleraine	5.8
Castlereagh	18.3	Coleraine	23.8	Limavady	5.4
Coleraine	18.0	Castlereagh	22.0	North Down	5.0
Larne	17.2	Ards	21.9	Carrickfergus	4.9
Ards	17.1	Larne	21.4	Ards	4.8
Northern Ireland	**14.7**	**Northern Ireland**	**17.6**	**Northern Ireland**	**2.9**
% population over 85					
North Down	2.8	North Down	3.8	Coleraine	1.3
Castlereagh	2.4	Castlereagh	3.6	Carrickfergus	1.2
Coleraine	2.3	Coleraine	3.6	Castlereagh	1.2
Ballymena	2.2	Ballymena	3.3	Ards	1.1
Belfast	2.1	Carrickfergus	3.2	North Down	1.0
Northern Ireland	**1.7**	**Northern Ireland**	**2.5**	**Northern Ireland**	**0.8**

Source: Northern Ireland Statistics and Research Agency.

Demography could imply that there will be greater demands on health and social care spending for age related reasons. Added to this, there are rising expectations regarding the levels and standards of care which people demand. In particular many people want to be enabled to stay in their own homes for as long as possible.

Expectations and willingness to pay

It is possible that sometimes public and political expectations and attitudes are characterised by short term thinking and inconsistency, e.g. thinking the "NHS free at point of use" model does, or should, apply to all aspects of social care, but yet would be reluctant to accept either higher taxes or a social insurance model[14]. One Joseph Rowntree Report summarised the position in England by saying that general public attitudes were more supportive of greater state support for social care than governments had been hitherto (though this does beg the question whether the public would really be willing to back up a stated preference through paying higher taxes)[15].

According to the Northern Ireland Life and Times Survey (2010)[16], 80% of people surveyed indicated that it would be 'quite or very unfair' if everyone had to pay for their own social care by either selling their own home or taking out an insurance policy for care expenses, however 76% of people felt that a fairer system would be for the government to provide totally free personal care to everyone by having a special tax similar to national insurance that you pay over your lifetime until you need care. In the same survey, 66% of people indicated that it would be 'quite or very unfair' if everyone received a basic level of care from the government but had to pay the rest themselves.

An important additional pressure on the current system is the constraint on individual/family budgets. In the short and medium term this is driven by such factors as the impact of the 2007-09 downturn and the very weak recovery since then with falling real incomes, rising unemployment and falling house prices. Over the next few years this may manifest itself via a greater number of individuals who struggle to find the means to pay for any bills associated with social care. Importantly, and worryingly, such constraints on individual/family budgets are also likely to exist over a much longer term period. For example, changes in housing and pension markets allied to increases in student and graduate debt may mean that those retiring in, say, the 2050s may well be less asset rich than those retiring in the 2030s[17]. The cost of social care in Northern Ireland could have a huge impact on many individuals and households. By implication, greater focus and thought therefore needs to be given towards preparing people for the potentially very high costs of social care.

Issues around service provision

Increased Health and Safety and other (legal) standards have, and this is likely to continue to impose rapidly rising costs on providers of social care. Alongside this, past experience, especially during the middle years of the previous decade when NI was close to full employment, suggests we cannot be complacent about ensuring an adequate supply of labour into the social care sector. Hitherto this sector has been perceived as (or sometimes actually is) a low wage/semi or unskilled sector[18]. Rates of labour turnover are high[19] and also the extent of dependence on migrant workers. DHSSPS did publish a review of social services workforce supply in March

[14] Lloyd, J. (2011) *Gone for Good? Pre-funded Insurance for Long-term Care*. Strategic Society Centre: London.
[15] Glendinning, C., Davies, B., Pickard, L. and Corras-Herrera, A. (2004) *Funding Long-Term Care for Older People Lessons from Other Countries*. University of York. Social Policy Research Unit: York.
[16] Northern Ireland Life and Times Survey (2010) *Social Care for Older People 2010 module*. NILT: Belfast [online] Available at http://www.ark.ac.uk/nilt/2010/Social_Care_for_Older_People/BASICPC.html Accessed on 16th November 2011.
[17] PwC (2011) *How will the wealth of the baby bust generation compare with that of the baby boomers?* PricewaterhouseCoopers LLP: London.
[18] KPMG (2007) *Audit of Statutory Residential Homes for Older People*. KPMG: Belfast.
[19] Rates of sickness related absenteeism; according to KPMG (2007) *ibid* in 2005 in NI statutory homes the rate was 9.6% (about double the public sector average).

2011[20]. That review claimed it sought to address *"...issues for the overall social services workforce, including professionally qualified social workers, vocationally qualified care workers and unqualified staff in the Domiciliary, Day Care, Residential and Fieldwork settings across Programmes of Care"*. However, in practice, the focus was mainly on providing adequate labour supply to the statutory providers.

In NI, as elsewhere in the UK, the social care market has become a complex one. It may require an element of oversight, partly to maintain quality standards and partly to mitigate the "too big to fail" problem which may have developed in England. This could exist when a single private residential home owner holds a significant share of the market[21].

Key findings

- According to Appleby (2011) there is likely to be a real reduction in spending on social care by the Department (DHSSPS) of 7% under the NI Budget through to 2014-15.
- Rising expectations are tending to push up demand for increased spending on social care.
- NI's population is ageing (indeed, ageing more rapidly than England), itself a testament to the success of health and social care in NI and the impact of this is concentrated outside of Belfast.
- Ageing is paralleled by the growth of some chronic conditions of ill health, e.g. mental illness and dementia.
- Generally depressed economic conditions (increased indebtedness, and less favourable pensions and valuations of domestic property) have constrained individuals' ability to pay for social care themselves.
- Such constrained individual budgets matter especially because for some individuals lifetime social care costs are substantial. The cost of social care in NI could have a huge impact on many individuals and households. Greater focus and thought therefore needs to be given towards preparing people for the potentially very high costs of social care. If individuals were charged the cost of domiciliary care (currently provided free) this could represent at least £10-15 per hour. Some individuals do currently pay the full rate for care homes (in some cases more than £500 per week). The Dilnot Commission suggested a cap on lifetime payments for social care of £35,000.
- There has been a significant inflation in the costs of provision of social care. Hence, when the general labour market is more buoyant, difficulties in maintaining an adequate supply and quality of labour into the sector are likely to become apparent. In the absence of some workforce planning, future labour force demands may well outstrip supply.
- Social change and economic pressure may reduce the extent to which we can continue to rely on informal care.

[20] Department of Health, Social Services and Public Safety (2011) *Review of the Social Services Workforce 2011*. DHSSPS: Belfast.
[21] In 2010 the four largest residential providers represented 24% of the market in England. On this issue see: NAO (2011) *Oversight of User Choice and Provider Competition in the Care Market*. National Audit Office: London.

- The increasing complexity of the market, alongside the development of a small number of large providers of independent care homes, may be leading NI (like England) towards a situation where some of the care providers are “too big to fail”. However, it should be noted that this only relates to the residential and nursing home sector as domiciliary care providers tend to be much smaller in size and each serve less than 10% of the market.

3. The current social care system

Introduction

This section provides an overview of how social care is currently being provided in Northern Ireland. The current model of care provision consists of two main parts:

- *Domiciliary care* – provision of support for personal care and aspects of daily living in the client's own home.

- *Residential and nursing home care* – provision of support to clients who require 24 hour care or support.

Before considering each of the above domiciliary care and care homes parts of the sector, we summarise the significant level of public expenditure which is involved. The DHSSPS spent over £860m per year on personal social services in 2009/10, which represented 19.5% of the total DHSSPS spend of £4.4bn in 2010. Of the total £860m spent on personal social services, £442m of this was spent on the Programme of Care for older people. Approximately 60% (£265m) of expenditure on older people's care was spent on institutional care which includes both residential care homes and nursing care homes.

Within each of the domiciliary and residential and nursing home types of care, the following points are covered, as far as the data allows:

- Background and regulation.
- Number of care providers.
- Current delivery model.
- Costs of care and the current workforce.
- Sustainability of current care model.

Domiciliary care

Domiciliary care for older people is defined as the provision of services in their own homes for people who, by reason of illness, infirmity or disability, are unable to provide for themselves without assistance or support. It can include a range of personal, nursing and domestic care services such as personal hygiene, continence management, problems of immobility, food and diet, simple treatments, personal assistance, cleaning and laundry[22].

Background and regulation

In Northern Ireland, domiciliary care services are provided or commissioned by the five Health and Social Care Trusts (HSC Trusts). Domiciliary care packages are provided largely to older people (aged 65+), although a smaller number of packages (15%) are available to those with physical or sensory disabilities or mental health needs. The responsibility for domiciliary care packages sits within the Programme of Care for the Elderly, within each of the five HSC trusts.

Currently, staff within HSC Trusts in Northern Ireland, carry out care management assessments to identify a person's social care needs and determine the form of care that best meets those needs. When domiciliary care is identified as the form of care required, their HSC Trust is responsible for organising the delivery of this care. The Trusts will then either arrange for a statutory provider to provide care or contract an independent provider to do so. Statutory providers are those operated by HSC Trusts whilst independent providers can be found either in the voluntary sector or private sector. Significantly, the HSC Trusts provide these packages free.

[22] Northern Ireland Audit Office (2007) *Older People and Domiciliary Care*. NIAO: Belfast. [Online] Available at http://www.niauditoffice.gov.uk/pubs/DOMICILIARYCARE/FullReport.pdf Accessed 31 October 2011.

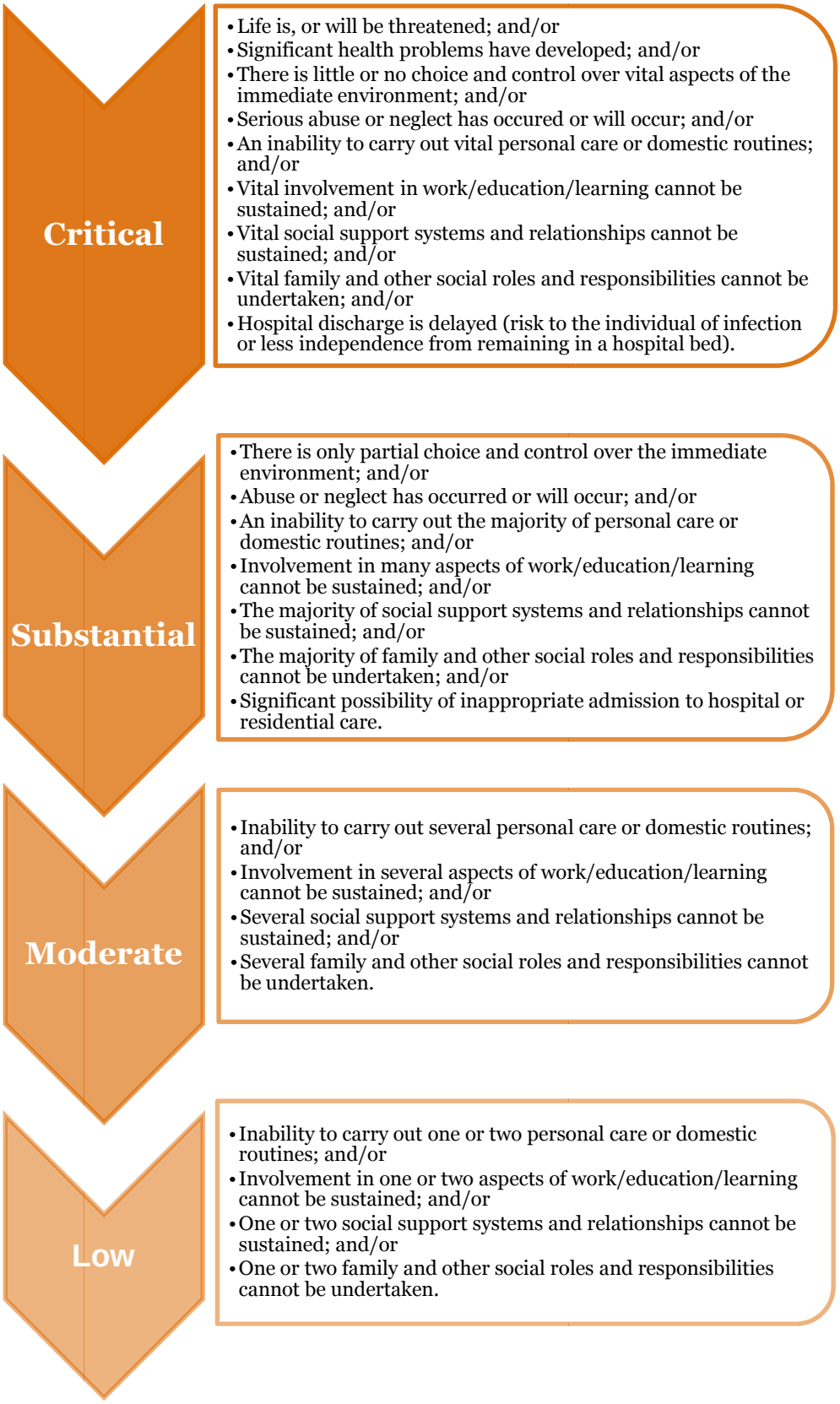
At the same time HSC Trusts have a duty to provide the option of direct payments to allow people with an assessed need for community services to choose who provides such services. People with an assessed need will include a disabled person, an older person, a carer, or parent of a disabled child. A person using a direct payment has to arrange the services they require, however an individual can choose not to accept a direct payment and have the services arranged by the Trust. According to the DHSSPS[23], the total amount of direct payments made during 2010 was £12.3m.

Presently, due to the ageing population and the requirement for HSC Trusts to make efficiency savings, the provision of domiciliary care packages to those most in need is becoming increasingly difficult. It is worth emphasising that whilst these packages are provided free at the point of delivery, budgetary restrictions have led to increased rationing of care packages. It is unclear whether service quality can be delivered in the prescribed fifteen minute slots. In the absence of a charge, definitions of need are effectively used as rationing devices[24].

Domiciliary care packages have been given the aim of enabling an individual to meet their basic needs in their own home with the focus mainly on the 'personal care' element. In 2008, the DHSSPS introduced Regional Access Criteria for Domiciliary Care to promote a collective approach across the HSC Trusts. The criteria are set out in Figure 3.1.

[23] Department of Health, Social Services and Public Safety (2011) *Direct payment statistics*. DHSSPS: Belfast [Online] Available at http://www.dhsspsni.gov.uk/index/stats_research/stats-cib/statistics_and_research-cib-guide/statistics_and_research-cib-direct-payment.htm Accessed on 16th November 2011.
[24] Evandrou, M. et al. (2011) *Measuring unmet need for social care amongst older people*. Office for National Statistics: Population Trends (45) [Online] Available at: http://onstest.landmarkgovernment.co.uk/ons/rel/population-trends-rd/population-trends/no--145--autumn-2011/ard-pt145-unmet-social-care-need.pdf Accessed 31 October 2011.

Figure 3.1: Regional Access Criteria



Source: DHSSPS (2008).

It is obviously very important to understand whether or not common standards are actually being achieved across the HSC Trusts. It is not clear whether this is in fact the case and some commentators have expressed doubts[25]. The more traditional 'home help' services such as fire lighting, collecting groceries and cleaning[26] are being reduced with new clients only receiving this service in exceptional circumstances. In 2008, Northern Ireland homecare providers were regulated and inspected for the first time by the Regulation and Quality Improvement Authority (RQIA). The RQIA is responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland including domiciliary care agencies.

Number of providers

According to data provided by RQIA, there were 282 'traditional' domiciliary care agencies in October 2011[27].

Based on a survey conducted by DHSSPS in 2008[28], approximately two thirds (64%) of providers said they had up to 50 service users each ("small provider"), whilst the other third (36%) said they had 51 or more service users ("large providers). Approximately 84% of voluntary providers and 59% of statutory providers were classified as small however 62% of private providers served more than 50 users (large providers). At present however, there is no dominant provider of domiciliary care, as the largest provides only 5-6% of the market.

The Community Information Branch within the DHSSPS has been collecting data on domiciliary care services since 2008. Some of this is presented in the tables below.

Table 3.1: Domiciliary care data, 2008-10

	2010	2009	2008
Domiciliary care contact hours (per week)	233,273	235,559	222,393
Average contact hours per client	10.0	10.1	9.4
Independent sector (% of total care provision)			
Within normal working hours	68	71	70
"Out of hours"	63	64	64
Overnight, live-in & 24 hour services	96	95	97
Number of clients in receipt of domiciliary care	23,389	23,377	23,553
Of which number of clients aged 65+	-	-	18,142
Of which % intensive domiciliary care	39	28	30
Clients in receipt of less than five hours of care per week (%)	45	49	43

Source: Community Information Branch – DHSSPS.

[25] Cross, J. (2011) *Update Paper for Trustees on People First.* Age NI: Belfast.
[26] Department of Health, Social Services and Public Safety (2011) *Circular HSS (SS) 1/80. The Future Provision of the Home Help Service in Northern Ireland.* DHSSPS: Belfast [Online] Available at http://www.dhsspsni.gov.uk/eccu_home_help_circular_-_2011.pdf Accessed 20 October 2011.
[27] The Regulation and Quality Improvement Authority http://www.rqia.org.uk/what_we_do/registration__inspection_and_reviews/service_provider_directory.cfm Accessed 18th October 2011.
[28] Department of Health, Social Services and Public Safety (2008) *Survey of Domiciliary Care Providers Northern Ireland.* DHSSPS: Belfast [Online] Available at: http://www.dhsspsni.gov.uk/survey_of_domiciliary_care_providers_northern_ireland__2008_final2.pdf Accessed 28th October 2011.

Table 3.1 above details the number of domiciliary care contact hours provided between 2008 and 2010. Table 3.2 below shows that in 2010, a total of 233,273 domiciliary care contact hours were provided per week, of which 42% were provided via the statutory sector and 58% by the independent sector. Since 2008, the majority of domiciliary care has been provided by the independent sector, increasing from 51% in 2008 to 58% in 2010.

Table 3.2: Domiciliary care data, 2008-10, by sector

	Statutory			Independent			All Sectors		
	2010	2009	2008	2010	2009	2008	2010	2009	2008
Number of providers	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	282	257	n.a.
Domiciliary care contact hours	98,678	109,764	109,622	134,595	125,795	112,771	233,273	235,559	222,393
Number of clients receiving domiciliary care	14,927	15,882	17,606	11,482	10,590	9,803	23,389	23,377	23,060
Average contact hours per client	6.6	6.9	6.2	11.7	11.9	11.5	10.0	10.1	9.4

Source: Community Information Branch – DHSSPS.

The table above shows that the number of people receiving domiciliary care packages has increased by 1.4% percentage points from 2008, however the total number of clients receiving domiciliary care in all sectors has remained fairly constant between 2009 and 2010 (23,377 and 23,389 respectively). This suggests that despite an ageing population, increasing need and government policy aiming to support older people at home for longer, the number of people actually receiving domiciliary care has remained largely unchanged.

It is interesting to note that the number of people receiving domiciliary care in 2010 is greater in the statutory sector (14,927) than the independent sector (11,482) yet the independent sector provides a greater number of contact hours. This means that the average contact hours per client is greater in the independent sector, with an average of 11.7 hours per client compared to 6.6 hours per client in the statutory sector.

Provision of domiciliary care across Trusts

In 2010, a total of 233,273 contact hours were provided by HSC Trusts per week in Northern Ireland, a 1% (2,286 hours) reduction relative to 2009. Table 3.3 provides a breakdown of these contact hours by sector and HSC Trust in 2010 and also shows the percentage change on the previous year (2009).

Table 3.3: Estimated number of domiciliary care contact hours provided, by Sector and HSC Trust in 2010

HSC Trust	Statutory			Independent			Total	
	No.	%	% change 2009-10	No.	%	% change 2009-10	No.	% change 2009-10
Belfast	21,458	38	-7	35,492	62	-2	56,950	-4
Northern	30,165	69	-18	13,296	31	+75	43,461	-2
South Eastern	10,315	22	+24	36,488	78	+7.5	46,803	+11
Southern	22,495	46	-8	26,465	54	+14	48,960	+3
Western	14,245	38	-16	22,854	62	-8	37,099	-11
Northern Ireland	**98,678**	**42**	**-10**	**134,595**	**58**	**+7**	**233,273**	**-1**

Source: Department of Health, Social Services and Public Safety (2010) Domiciliary Care Services for Adults in Northern Ireland. DHSSPS: Belfast.

Since 2009, each of the Trusts, with the exception of the South Eastern HSC Trust, has decreased the number of statutory domiciliary contact hours. The majority of Trusts have, however, increased the number of contact hours provided by the independent sector, with the exception of Belfast and the Western Trusts. Overall, however, three of the five Trusts have decreased the number of domiciliary contact hours, most notably in the Western Trust (-11%). There is currently no evidence to explain why the total number of domiciliary contact hours has reduced.

Historically, the Northern HSC Trust has had a much lower proportion of domiciliary care contact hours provided by the independent sector compared to other trusts. In 2009, the Northern Trust only provided 7,584 contact hours per week through independent providers, however this number increased by 75% in 2010 to 13,296 contact hours. In their *"Reconfiguration of Domiciliary Care Services"*[29] the Northern HSC Trust, whilst not explaining why their delivery via the independent sector has historically been low, has revealed plans to shift their provision more towards the independent sector in line with other HSC Trusts. Therefore we may expect the number of contact hours to continue to increase in this sector.

Current delivery model

Domiciliary care providers within Northern Ireland are heavily reliant on HSC Trusts as their main source of business. In a 2008 survey of statutory, voluntary and independent sector providers, of those who responded, 94% were either statutory services or provided care under contract to the HSC Trusts. In the same survey, more than nine out of ten (92%) voluntary and private providers said they had provided domiciliary care services under a contract for the HSC Trusts in the seven days prior to the survey, indicating the heavy reliance on HSC Trusts for business[30].

This is supported in a presentation from the Care Show in London in October 2011 where the United Kingdom Home Care Association (UKHCA) provided a check list

[29] Northern Health and Social Care Trust (2009) *Reconfiguration of domiciliary care services* [Online] Available at: http://www.northerntrust.hscni.net/pdf/Reconfiguration_of_Domiciliary_care_services.pdf Accessed 20 October 2011.

[30] Department of Health, Social Services and Public Safety data published in United Kingdom Home Care Association (2011) *An Overview of the UK Domiciliary Care Sector* [Online] Available at: www.ukhca.co.uk/pdfs/domiciliarycaresectoroverview.pdf

for providers to assist them in continuing to provide services to statutory commissioners during a time of public spending constraints[31]. Key elements of the checklist included:

- *Reviewing the business model* – not being dependent on high volume contracts or public sector contracts and evaluating the potential of private purchase.
- *Cost management* – jointly tendering and sharing back office costs with other providers.
- *Keep track of what's happening in the sector* – joining a professional representative association and understanding fully how the HSC Trust commissions homecare provision.
- *Regulation* – regular RQIA inspections.
- *Prepare for private purchase* – get on to local approved provider lists, review marketing materials, train office staff to deal with private purchase.

Cost of care

In 2008, the cost to the Trusts of using the independent sector was reported as an average of £9.84 per hour, while in-house services were estimated to cost £11.81 per hour[32]. Based on these 2008 costs, it appears more cost effective for HSC Trusts to commission independent providers rather than provide domiciliary care in-house. This conclusion is reinforced by figures relating to English local authorities[33] where the average cost per hour for independent providers of domiciliary care was £15.10 and £30.85 for in-house (the large discrepancy relative to the NI figures may be because the NI figures appear to be marginal costs).

In 2010, 58% of domiciliary care in Northern Ireland was provided by independent providers, which supports the assumption that this is the most cost effective option for the HSC Trusts. However, the independent sector has found that contract prices offered by the Trusts often fail to keep pace with inflation and other statutory burdens on employers[34].

In order to modernise homecare commissioning, contracting and service delivery, a number of HSC Trusts are planning or implementing a brokerage system for domiciliary care. The brokerage function is characterised by the following:

- A single point of contact for all domiciliary care provision, whether from the statutory, private or independent sector, within the HSC Trusts.
- Streamlined, efficient, cost-effective and equitable sourcing of homecare packages from providers by HSC Trusts.
- Improved, efficient, robust and standardised invoicing arrangements.

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[31] United Kingdom Home Care Association (2011) *Homecare agencies: Securing business during challenging commissioning* [Online] Available at: http://www.ukhca.co.uk/pdfs/PresentationCareShowLondon2011.pdf Accessed 21 October 2011.
[32] Department of Health, Social Services and Public Safety data published in United Kingdom Home Care Association (2011) *An Overview of the UK Domiciliary Care Sector* [Online] Available at: www.ukhca.co.uk/pdfs/domiciliarycaresectoroverview.pdf Accessed on 21 October 2011.
[33] Department of Health, Social Services and Public Safety data published in United Kingdom Home Care Association (2011) *An Overview of the UK Domiciliary Care Sector* [Online] Available at: www.ukhca.co.uk/pdfs/domiciliarycaresectoroverview.pdf Accessed on 4th November 2011
[34] United Kingdom Home Care Association (2011) *An Overview of the UK Domiciliary Care Sector* [Online] Available at: www.ukhca.co.uk/pdfs/domiciliarycaresectoroverview.pdf Accessed on 31 October 2011.

- Comprehensive and timely corporate information on domiciliary care to aid reporting, decision making and completion of DHSSPS data returns.

A VFM audit is forthcoming which should provide increased clarity on the true costs of domiciliary care.

Current workforce

A report by the Northern Ireland Audit Office[35] in 2007 estimated that approximately 11,774 people are in paid employment in the provision of domiciliary care, of which 64% are employed by the Trusts and 36% by the private or voluntary sector. Despite independent providers being the main source of domiciliary care, fewer people are employed by this part of the sector. According to the survey of domiciliary care providers in 2008, half of the independent providers said that they employed fewer than 20 employees whilst only 19% said they had more than 100 employees[36].

The Appleby Review[37] in 2005 reported that independent and voluntary providers experience difficulty in recruiting sufficient numbers of staff in part due to the higher salaries and greater certainty of employment offered by statutory providers. This is further hindered by the use of "spot contracting" by Trusts which prevents independent providers from predicting demand from week to week. Trusts use a range of contractual agreements for the delivery of different types of service or packages of care. The types of contracts offered to independent providers include:

- *Block contracts* – give great certainty in respect of continuity and consistency. Useful in stimulating and giving direction for market growth as well as providing the possibility for economies of scale. However, they can fail to provide flexibility in response to changing need, can be seen to restrict user choice and the lack of competition can lead to concerns over value for money[38].

- *Cost and volume contracts* – highly flexible which can bring the benefits of economies of scale, encourage partnerships between purchasers and a limited number of providers and aid market planning.

- *Cost per case/spot* – particularly attractive in stimulating competition and promoting choice and flexibility in response to changing needs. However, they are not beneficial to market stability as the lack of guarantee offered to providers can be detrimental to service consistency and continuity. These spot contracts are limited as a planning tool to both providers and purchasers.

[35] Northern Ireland Audit Office (2007) *Older People and Domiciliary Care*. NIAO: Belfast [Online] Available at: *http://www.niauditoffice.gov.uk/pubs/DOMICILIARYCARE/FullReport.pdf* Accessed on 31 October 2011.
[36] Department of Health, Social Services and Public Safety (2008) *Survey of Domiciliary Care Providers Northern Ireland*. DHSSPS: Belfast [Online] Available at*:* http://www.dhsspsni.gov.uk/survey_of_domiciliary_care_providers_northern_ireland__2008_final2.pdf Accessed on 31 October 2011.
[37] Appleby, J. (2005) *Independent Review of Health and Social Care Services in Northern Ireland*. King's Fund: London.
[38] Allen, I., Bourke Dowling, S. and Perkins, L. (1995) *Marking it work: The practicalities of working with the independent sector* p.80 [Online] Available at: http://www.psi.org.uk/publications/SCHS/Makitwrk.htm Accessed 21 October 2011.

Sustainability of domiciliary care

Given that the supply of domiciliary care funded by the HSC Trusts is increasingly being rationed by quantity and quality, there is likely to be growing unmet demand, suggested by the large decrease in the number of care packages agreed during 2008-10. According to Age NI (2011)[39] HSC Trusts are increasingly rationing services by only offering support to people with very high levels of social care needs. As a result, people with fewer needs, who might once have received a few hours of 'home help', usually get nothing. In addition, for those who are entitled to help, the level of support on offer is often inadequate as older people living in their own homes may only have short, 15 minute visits to help dress and wash.

In comparing the third quarter of 2010 with the third quarter of 2008 the number of domiciliary care packages agreed across Northern Ireland dropped by about half[40]. Currently there are no figures for unmet demand recorded regionally by the DHSSPS, but it is estimated that by 2015 there will be an additional 55,000 domiciliary care hours required[41], indicating that within the current system, unmet demand will increase. Quite apart from the emotional impact on individuals and their families who find it increasingly difficult to gain the care assistance which would allow them to prolong a measure of independent living, all this has broader budgetary implications for DHSSPS. If an inadequate provision of domiciliary care implies a more rapid entry into the care home sector or into hospital, then it is likely total levels of spending in the DHSSPS will be higher than they might otherwise have been if there had been more domiciliary care[42].

Residential and nursing care homes

A residential home is one which will provide personal care only, i.e. help with washing, dressing and giving medication. A nursing care home will provide the same personal care but will also have qualified nursing staff on duty to carry out nursing tasks. These homes are for people who are physically or mentally frail or people who need regular nursing attention.

Background and regulation

The DHSSPS spent approximately £442m on the Programme of Care for the Elderly in 2009/10, with around 60% of this expenditure (£265m) going toward institutional care in residential and nursing care homes[43]. This expenditure is allocated to the five HSC Trusts who have a duty to assess older people's care needs and ensure that these are met within the resources available to them[44].

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[39] Age NI (2011) *Future Direction and Funding of Adult Social Care: The current system and how this could be improved: A Briefing Paper for the HSSPS Committee*. Age NI: Belfast.
[40] Cross, J. (2011) *Update Paper for Trustees on People First*. Age NI: Belfast.
[41] NICON (2011) *Building on progress: Rising to the challenge, Election Briefing, Areas for Action for Health and Social Care in Northern Ireland 2011-2015*. [Online] Available at: http://www.nhsconfed.org/Documents/NICON_Election_Briefing_Summary_Building_on_Progress_Feb2011.pdf Accessed 31 October 2011.
[42] "Lower level" services such as shopping, cleaning, community meals, lunch clubs and other social events, many of which are or could be delivered through the community or voluntary sector are also important in this regard.
[43] Northern Ireland Audit Office (2010) *Arrangements for Ensuring the Quality of Care in Homes for Older People*. NIAO: Belfast. [Online] Available at: http://www.niauditoffice.gov.uk/pubs/ArrangementsforEnsuringtheQualityofCareinHomesforOlderPeople/Arrangements-for-Ensuring-the-Quality-of-Care-in-Homes-for-Older-People.pdf Accessed on 27 October 2011.
[44] NI Direct. *Introduction to residential care and nursing homes*. [Online] Available at: http://www.nidirect.gov.uk/index/information-and-services/health-and-well-being/health-services/residential-care-and-nursing-homes/introduction-to-residential-care-and-nursing-homes.htm Accessed on 1st November 2011.

If an older person requires a level of support greater than that which can be provided in their own residence, they may then require residential or nursing care. According to NI Direct, a person has the right to choose a suitable residential or nursing care home. The HSC Trust in which a person resides, can provide support on choosing a suitable care home, as can the RQIA who have a list of all registered homes in Northern Ireland and publish their inspection reports (which take place at least twice a year) for each home online.

Quality of care within residential and nursing care homes is maintained firstly by the five HSC Trusts and the independent sector-based care homes which provide the care, and secondly by the RQIA with whom all care homes for older people must be registered and provide care in line with statutory regulations. Residential and nursing care homes must also comply with the Minimum Standards established by the DHSSPS[45]. These standards were introduced in 2005 and have since been supplemented by the introduction of additional care standards.

Number of providers

The following information has been taken from the Adult Community Statistics publications[46]. It should be noted that there may be variations in the data following the mergers of HSC Trusts as a result of the Review of Public Administration (RPA) in 2007. The new HSC Trusts were formed from the financial year 2007/08.

Table 3.4 presents data for residential care homes; however, there is a change in the definition of the data, and so interpretation is difficult. This reinforces the need for accurate data to be consistently recorded to enable worthwhile analysis. Note[1] below the Table provides further explanation on this anomaly. It is also worth noting that this data is not restricted to older people and therefore includes people with learning disabilities, physical disabilities and mental health issues.

Table 3.4: Residential care home accommodation in Northern Ireland by sector

Year/ Trust	Number of residential care homes			Number of residential care home places available		
	Statutory	Independent	Total	Statutory	Independent	Total
2009/10 Total	58	178	236[1]	1555	3267	4822
2008/09 Total	62	239	301[1]	1665	3270	4935
2007/08 Total	62	255	317	1732	3246	4978
2006/07 Total*	62*	267*	329*	1760*	3363*	5123*
2005/06 Total*	114*	288*	402*	2120*	3556*	5676*

*Totals have been arranged into the new HSC Trusts from legacy Trust data.
Source: DHSSPS (2011)[47].

Note[1]: The number of residential care homes has decreased from 301 in June 2009 to 236 in June 2010. This is mainly due to deregistration of 57 'adult placements' which were formally recorded as small residential homes but are now registered under the Adult Placement Agency Regulations.

[45] The Nursing Homes Regulations, Northern Ireland (2005) and Residential Care Homes Regulations, Northern Ireland (2005).
[46] Community Information Branch, Department of Health Social Services and Public Safety (2011) *Statistics & Research: Adult Community Statistics*. Available at: http://www.dhsspsni.gov.uk/index/stats_research/stats-cib/statistics_and_research-cib-pub/adult_statistics/statistics_and_research-cib-community_statistics.htm Accessed 16 September 2011.
[47] Department of Health, Social Services and Public Safety (2011) *Adult Community Statistics*. DHSSPS: Belfast. [Online] Available at: http://www.dhsspsni.gov.uk/index/stats_research/stats-cib/statistics_and_research-cib-pub/adult_statistics/statistics_and_research-cib-community_statistics.htm Accessed 31 October 2011.

Table 3.5 presents data for the number of nursing homes registered under the Registered Homes (NI) Order 1992 as at 30 June 2010. According to the Regulation and Quality Improvement Authority, in 2010 there were a total of 253 nursing care homes registered in Northern Ireland providing a total of 9,387 nursing home places.

Table 3.5: Nursing care homes registered in Northern Ireland as at 30 June 2010

Trust	Number of premises providing nursing care (older people)	Number of available nursing care beds
	Total	Total
Belfast HSC Trust	50	1,953
Northern HSC Trust	61	2,309
South Eastern HSC Trust	55	2,048
Southern HSC Trust	49	1,586
Western HSC Trust	38	1,491
Northern Ireland	**253**	**9,387**

Source: The Regulation and Quality Improvement Authority.

Provision of residential and nursing care across Trusts

In 2009/10, a total of 236 residential care homes were available across Northern Ireland providing a total of 4,822 residential care home places. Table 3.6 provides a breakdown of this provision by sector and HSC Trust in 2009/10 and 2008/09 [see Appendix 3 for some earlier years].

Further data was provided within the Adult Community Statistics on the number of residential places available within nursing homes, with 1,189 being the Northern Ireland total for 2009/10. The Southern HSC Trust had the highest number of residential places available within nursing homes with a total of 529. This was followed by the Northern HSC Trust with 387; the Western HSC Trust with 125; South Eastern HSC Trust with 117 and Belfast HSC Trust with 31. This data was also collected for previous years but due to an error in coding for all previous years, it was not comparable.

Table 3.6: Residential care home accommodation in Northern Ireland, by type of home and HSC Trust in 2010

Year/ Trust	Number of residential care homes			Number of residential care home places available		
	Statutory	Independent	Total	Statutory	Independent	Total
2009/10 Total	**58**	**178**	**236**[1]	**1555**	**3267**	**4822**
Belfast HSC Trust	15	30	**45**	398	891	**1289**
Northern HSC Trust	14	45	**59**	418	615	**1033**
South Eastern HSC Trust	12	49	**61**	313	970	**1283**
Southern HSC Trust	6	20	**26**	162	312	**474**
Western HSC Trust	11	34	**45**	264	479	**743**
2008/09 Total	**62**	**239**	**301** [1]	**1665**	**3270**	**4935**
Belfast HSC Trust	15	32	**47**	398	879	**1277**
Northern HSC Trust	14	82	**96**	413	679	**1092**
South Eastern HSC Trust	15	50	**65**	397	917	**1314**
Southern HSC Trust	6	41	**47**	168	319	**487**
Western HSC Trust	12	34	**46**	289	476	**765**

Source: DHSSPS (2011)[48].

According to the DHSSPS, as at 30 June 2010 there were a total of 6,694 nursing and care home packages in effect for people aged 65 and over. Table 3.7 provides a breakdown of this provision by HSC Trust.

Table 3.7: Nursing home care packages in effect for persons aged 65 and over by HSC Trust as at 30 June 2010

Trust	Number of nursing home care packages (older people)
Belfast HSC Trust	1,508
Northern HSC Trust	1,625
South Eastern HSC Trust	1,367
Southern HSC Trust	1,273
Western HSC Trust	921
Northern Ireland	**6,694**

Source: DHSSPS[49].

[48] Department of Health, Social Services and Public Safety (2011) *Adult Community Statistics*. DHSSPS: Belfast. [Online] Available at: http://www.dhsspsni.gov.uk/index/stats_research/stats-cib/statistics_and_research-cib-pub/adult_statistics/statistics_and_research-cib-community_statistics.htm Accessed 31 October 2011

[49] Department of Health, Social Services and Public Safety (2011) *Adult Community Statistics*. DHSSPS: Belfast. [Online] Available at: http://www.dhsspsni.gov.uk/index/stats_research/stats-cib/statistics_and_research-cib-pub/adult_statistics/statistics_and_research-cib-community_statistics.htm Accessed 16 November 2011

Current delivery model

Clients in residential and nursing homes are required, subject to a means test, to contribute to the cost of their residential or nursing home costs. If the client has more than £23,250 in capital, including the value of their home unless there are specific exceptions, they will be assessed as being able to meet the full cost of care[50]. Capital will be assessed according to the information in Table 3.8 below.

Table 3.8: Capital assessment for contribution to care home fees

Client's capital	How capital is used to calculate contribution to fees
Over £23,250	Client will be assessed as being able to meet the full cost of care.
Between £14,250 and £23,250	Capital between these amounts will be calculated as providing the client with an income of £1 per week for every £250 of savings.
£14,250 or under	Capital will be ignored in calculating how much the client has to contribute to the cost of care.

Some provision by the independent sector is more expensive than a Trust would be prepared to pay for in terms of the weekly cost thresholds. A resident is not permitted to use their own resources to pay the difference. In 1993, the health and personal social services regulations (Northern Ireland) set the guidance in relation to residential care top-up fees. The Department produced the guide "Charging for Residential Accommodation" to explain the application of the regulations. The main guidance stated that where a resident, with the agreement of a Trust, enters more expensive accommodation, the difference may only be met by a third party such as a relative or friend of the resident. A third party top-up is only permitted where additional payments are the result of an informed choice and that the rationale for the additional payment is fully transparent, such as being based on an optional, additional service[51].

However, whilst this guidance should be applied in theory, Age NI and the Office of Fair Trading (OFT) found evidence to suggest that older people are sometimes being misinformed about the nature of top-ups. Age NI has provided the following case study examples highlighting breach of the guidance[52].

Case Study 3.1: An individual was paying a contribution of £60 per week towards her father's residential care fees. However, it transpired that her father was offered no choice of homes at the time of admission and the top-up fee was presented to her as mandatory. This family **did not intentionally choose a more expensive care home** and they were not clearly informed about the nature of top-up fees or that a top-up fee would be required based on their choice of home. No explanation was given as to why this home warranted an extra charge. As a result, the additional payments were not the result of an informed choice and therefore no top-up fee should have been charged.

Source: Age NI.

[50] Northern Ireland Executive (2009) *Minister still committed to introducing free personal care.* [Press release] Available at: http://www.northernireland.gov.uk/news/news-dhssps-18052009-minister-still-committed Accessed 16 September 2011.
[51] Age NI (2010) *Policy in Practice Briefing: Third Party Contributions Residential Care and Nursing Home Settings* [Online] Available at: http://www.ageuk.org.uk/Global/age-ni/documents/policy/Age_NI_Briefing_Third_Party_Contributions_to_Care_Home_Costs.pdf Accessed 24 October 2011.
[52] Age NI (2010) *Policy in Practice Briefing: Third Party Contributions Residential Care and Nursing Home Settings* [Online] Available at: http://www.ageuk.org.uk/Global/age-ni/documents/policy/Age_NI_Briefing_Third_Party_Contributions_to_Care_Home_Costs.pdf Accessed 27 October 2011.

Case Study 3.2: An individual entered a residential care home and was awaiting a financial assessment. The cost of the care home was £90 more than the Trust would normally pay for someone with this person's care needs however the Trust agreed to pay £65 of the additional fee, with the balance being paid by the family. However, in this instance, **no other care home was available to meet the individuals assessed care needs** and as a result, the Trust should not have charged a top-up.

Source: Age NI.

Both of these cases suggest that the DHSSPS should conduct a full review of guidance on care home placements and the regulations surrounding top-up fees, as the cases suggest that the current charging policy is not being actively implemented in all cases. The fact that top ups are becoming more common is indicative of the fees paid by DHSSPS not keeping pace with costs (see section 5 of this report).

Costs of care

A study by PwC in 2005[53] estimated indicative costs from the point of view of the independent providers of care home provision in NI, and implied that such costs were in excess of the level of fees being paid by DHSSPS. In 2004/05, PwC estimated that the cost per week for an independent residential care home was £377, whilst the weekly cost for nursing home care was £466. Fees paid in 2004/5 were, respectively, £273 and £420. Given cost inflation during 2005-2011 (e.g. wages, heating, modernisation to meet Health and Safety regulations), the gap between costs and fees continued to exist notwithstanding some efforts of the Department in the mid to late 2000's to close the gap [see Section 5].

Current workforce

A report by PwC in 2005[54] noted that staff skill mix requirements were an increasingly challenging area amongst the majority of independent care home providers. Home providers indicated the need for working in the care sector to be seen as a positive career option, as competition with the statutory sector, in particular for nursing staff, along with the perception of the independent care home industry was considered by many providers to contribute towards staffing recruitment and retention problems. The PwC (2005) report suggested that the recruitment of staff in the independent sector is an increasing issue because it is difficult to compete with the statutory sector in terms of remuneration, terms and conditions and career progression opportunities. The providers surveyed in the PwC report indicated that often nurses viewed nursing home care as a career of 'last resort' or a temporary post until they could secure their desired community or acute post.

Sustainability of care homes

The urgency of the debate about residential 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[55]. HSC Trusts compile waiting lists and lists indicating unmet need which, due to the growing pressures on social care services, lead to the rationing of services by only offering support to those with the most urgent or very high levels of care needs.

[53] PwC (2005) *Research to identify the true economic cost in Northern Ireland of Independent Residential and Nursing Elderly Care Home Sector Provision and Domiciliary Care.* PricewaterhouseCoopers LLP: London.
[54] Ibid
[55] Access Research Knowledge (2010) *Policy Brief: Social Care in Northern Ireland.* [Online] Available at: http://www.ark.ac.uk/pdfs/policybriefs/policybrief2.pdf Accessed on 1st November 2011.

Others must wait until a place in a care home or service provider slot becomes available[56].

Whilst there are currently no figures for unmet demand recorded regionally by the DHSSPS, it is estimated that by 2015 there will be an additional 8,000 nursing home weeks required[57] indicating the possibility that within the current system, unmet demand will increase. This growing unmet demand is worsened by the fact that Health and Social Care services are funded at a slightly lower per capita level in NI than in England, despite the health and social care need in NI being estimated at around 17% higher than England[58].

According to the HSC Board's Draft Commissioning Plan for 2011/12[59], the Board made the following priorities in relation to older people:

- Extend the proportion of people cared for at home and reduce reliance on nursing home care by reviewing current assessment and discharge processes from hospital to home, patterns of demand and costs.

- From April 2011, work with Trusts to ensure that older people with continuing care needs wait no longer than eight weeks for assessment to be completed and should have the main components of their care needs met within a further 12 weeks.

[56] Age NI (2011) *Media Briefing: Commission on Funding of Care and Support (the Dilnot Commission)* Age NI: Belfast [Online] Available at: http://www.ageuk.org.uk/Global/age-ni/documents/policy/Age-NI-Dilnot-Commission-Media-Brief-July-2011.pdf Accessed 24 October 2011.
[57] NICON (2011) *Building on progress: Rising to the challenge, Election Briefing, Areas for Action for Health and Social Care in Northern Ireland 2011-2015.* [Online] Available at: http://www.nhsconfed.org/Documents/NICON_Election_Briefing_Summary_Building_on_Progress_Feb2011.pdf Accessed 31 October 2011.
[58] NICON (2011) *Building on progress: Rising to the challenge, Election Briefing, Areas for Action for Health and Social Care in Northern Ireland 2011-2015.*[Online] Available at: http://www.nhsconfed.org/Documents/NICON_Election_Briefing_Summary_Building_on_Progress_Feb2011.pdf Accessed 31 October 2011.
[59] Health and Social Care Board and Public Health Agency (2011) *Draft Commissioning Plan 2011/12.* HSCB and PHA: Belfast [Online] Available at:
http://www.hscboard.hscni.net/publications/Commissioning Plans/450 HSCB Commissioning Plan 2011-2012 Draft.pdf
Accessed 1st November 2011.

Key findings

- The amount of public funding devoted to the social care system for older people in NI is substantial at at least £442m in 2009/10, which represented 10% of the total DHSSPS spend of £4.4bn.
- The available evidence suggests the use of independent providers represents a lower cost option for the HSC Trusts as compared to in-house (statutory) provision.
- Domiciliary care packages are provided free at the point of use. There are indications of increased rationing and hence unmet demand.
- Residential and nursing home provision consists of a mixture of statutory and independent providers.
- During 2005/06 - 2009/10 there has been a downward trend in the total number of residential homes and bed spaces (especially on the statutory side).
- The state provides limited, means tested assistance to pay for stays in homes. Even where this assistance is provided, third party (or top-up) fees often occur.
- Despite some improvements in the mid-late 2000's, the fees paid by DHSSPS to independent providers, especially of care homes, are indicated to be lower than costs.

4. Good practice

Introduction

This section outlines some examples of where countries have introduced different types of social care models and how they have been implemented. For each type of social care model identified, the advantages and disadvantages are discussed.

What happens elsewhere, and what works well?

Table 4.1 illustrates some of the main types of social care system currently being used in different countries and the main arguments for and against each system.

Every case is unique. External models cannot be readily transferred, but much can be learned by NI from elsewhere. Other European countries (e.g. Denmark or Germany) have opted for high quality, universal provision funded either from public spending or social insurance. It is unclear, however, whether there is an appetite in NI (or elsewhere in the UK) for a higher level of taxation or insurance contributions to fund such systems. The Dilnot proposals (especially if adopted in England) may provide a more manageable balancing of responsibilities between the taxpayer and the individual.

Table 4.1: Broad social care systems compared

Social care system type	Example of this system in practice	Advantages	Disadvantages
Mainly private financed plus (basic) means tested safety net	• England and Northern Ireland	• Almost the default position, probably where NI's current system will remain in the absence of policy change • Relatively affordable to the taxpayer (especially if means testing is more stringent or the standard of care more basic)	• Budget constraints mean that the state funded "basic" care will become less and less adequate over time[60] • Loss of universal standards • Increased financial burden on individuals (top-ups) • Individuals must face unpredictable (and possibly large) lifetime care costs • UK private insurance products so far very limited • Individuals may be confused as to who pays—assuming the system is "free" until it is too late • Unmet need leads to increased demand in the longer term and higher spending elsewhere in the DHSSPS
Universal, "free" tax funded – care is funded by the state out of general tax revenues	• Denmark	• Can produce high quality of care • Compatible with values of universalism/social solidarity • Theoretically, can have mixed provision i.e. both in-house and independent provider	• "Works" only if taxpayers willing to pay (in the absence of this, the system will tend towards mainly private provision plus means testing) • UK and NI experience suggests that hospital services tend to be given priority relative to social care within health departmental budget
Health care villages	• US (in the form of Continuing Care Communities or Assisted Living) – individuals buy a "share" in an elderly care community and this capital is repaid when they leave or die. There is little or no State level or Federal support and provision tends to be through private or not for profit organisations • England (Joseph Rowntree Foundation Trust)[61]	• Attempt to tap individuals' assets without creating the situation (as currently) where some are forced to sell their house to pay for care • Balance providing safety/assistance to older people with a measure of continued independent living[62] • Economies of scale in service provision if sufficiently large • Ideally, chosen "place to live" and not a care setting	• How many people would choose to live in a community entirely made up of other old people? • Scalability - is the NI population big enough to provide critical mass for health care villages?[63]

[60] Domiciliary care in NI is currently not means tested or charged for and therefore rationing of services is increasingly common.
[61] Joseph Rowntree Foundation (2009) *Options for Care Funding: What could be done now?* Joseph Rowntree Foundation: York.
[62] Rodgers, R. (2011) *Planning and Delivering Continuing Care Retirement Communities*. Tetlow King Planning [Online] Available at http://www.housinglin.org.uk/library/Resources/Housing/Support_materials/Other reports_and_guidance/Planning and Delivering_CCRCs_publication.pdf Accessed 22 September 2011.
[63] Croucher, K., Hicks, L and Jackson, K. (2006) *Housing with Care for Late Life*. Joseph Rowntree Foundation: York. [Online] Available at: http://www.dhcarenetworks.org.uk/library/Resources/Housing/Housing_advice/Housing_with_care_for_later_life.pdf Accessed 21 September 2011. and Croucher, K (2006) *Making the Case for Retirement Villages*. Joseph Rowntree Foundation: York. [Online] Available at: http://www.jrf.org.uk/9781859354650.pdf Accessed 21 September 2011.

Social care system type	Example of this system in practice	Advantages	Disadvantages
Social insurance – compulsory social insurance to fund health and social care	• Germany	• Can provide high quality of care • Universalism/social solidarity • Mixed economy of providers • Securitisation / Hypothecation of revenues collected into social care funding	• The insurance needs to be compulsory or the system will tend towards mainly private provision plus means testing) • If insurance contributions do not keep pace, an increasing level of individual top ups or recourse to general welfare benefits will be required[64] • It is not clear if the universal aspects of the German system will continue
Suggestions as set out by the Dilnot Commission, 2011 – maintain an element of private funding but supplement (above a "cap" and means tested threshold) by public funding	• The Dilnot Commission proposed a mixed system for England costing an estimated additional £1.7bn per annum. to UK taxpayers, with a read across, if applied to NI, of up to £80m	• An attempt to strike a balance between taxpayer and individual contributions • Try to create more transparency and certainty so individuals (and financial markets) can make better decisions • Attempt to avoid "moral hazard" problems - people who have built up assets during working life are not heavily penalised • Facilitates middle class bequests (if such inheritance transfers are seen as a good thing)	• Distributional effect taxpayer resources supporting individuals with above average income • Will the Coalition government pay up? • The Dilnot proposals retain private responsibility to pay for "general living costs" (up to £10,000 per annum) • Facilitates middle class bequests (if such inheritance transfers are seen as a bad thing)
Social Impact Bond model – 'innovative finance' that could help social sector organisations tackle long term (unmet) social needs at a time of constrained public finances[65]	• Offer the potential for private investors to provide working capital and other finance to providers to deliver new services through outcomes based contracts	• Private sector providers would put up the money to provide a service for DHSSPS • On realisation of certain identified success/performance targets they would be paid back their investment plus a dividend from the DHSSPS • If commissioned, private provision achieves cashable savings to the DHSSPS who then pays back the providers a dividend out of that saving	• Private sector providers may not be able to provide the DHSSPS with such an investment up front for services • How far do banks, philanthropic funders and Non Governmental Organisations (NGOs) in NI have the necessary capacity?
"Total place" approach – getting the maximum combined impact from all agency spend on older people	• Bournemouth, Dorset and Poole (BDP) "Total Place" Pilot[66] – tests how a whole area approach to public services, focusing on older people, can provide better services at less cost, avoiding duplication and more tailored to local needs	• Better practical and budgetary integration of primary/social care relative to acute care • Trusts would be able to achieve the maximum combined impact from all agency spend on older people	• Despite NI having whatever advantages that follow from having an integrated health and social care department (relative to England), it is probable that local authorities in England have been more advanced in seeking to take a "total place" approach to getting the maximum combined impact from spend across various bodies/agencies

[64] C. Glendinning, B. Davies, L. Pickard and A. Corras-Herrera 2004, *Funding Long-Term Care for Older People Lessons from Other Countries*, University of York, Social Policy Research Unit, York.
[65] PwC (2011) *"Out in the Open Delivering Public Sector Reform"* PricewaterhouseCoopers LLP, London in 'Open Public Services: White Paper', HM Government, July 2011, paragraph 6.9.
[66] Centre for Policy on Ageing (2011) *"How can local authorities with less money support better outcomes for older people?"* Joseph Rowntree Foundation: York.

Social care in Northern Ireland and the Republic of Ireland (RoI)

Whilst home care in NI is categorised as a nursing matter, falling under the remit of the Elderly and Community Care Unit within DHSSPS, in the RoI, home care is considered a public health issue within the Health and Safety Executive (HSE). At present, there is no system for home care regulation in the RoI, although the HSE is currently rolling out National Quality Guidelines for Home Care Support Services throughout the home care system[67].

The RoI government supports the concept of maintaining older people's independence and providing care for older people in their own homes for as long as possible. Despite this, the "fair deal" scheme, which provides financial assistance for nursing home care, does not extend to home care and therefore domiciliary care remains the more expensive option for service users in the RoI. Table 4.2 highlights that the RoI is relatively more weighted towards residential care even compared to NI and to date has less focus on preventative care. However, in considering this table we need to bear in mind that the Republic of Ireland's population is greater than that of NI.

Table 4.2: Comparison of the social care models in NI and the Republic of Ireland (RoI)

	NI	RoI[68]
Residential care	4% of NI 65+ population	7% of RoI 65+ population
Domiciliary care	23,000 state funded places	57,500 state funded places

Source: CARDI 2011.

Key findings

- Every case is unique. External models cannot be readily transferred, but much can be learned by NI from elsewhere.
- Other European countries (e.g. Denmark or Germany) have opted for high quality, universal provision funded either from public spending or social insurance. It is unclear whether there is an appetite in NI (or elsewhere in the UK) for a higher level of taxation or insurance contributions to fund such systems.
- The Dilnot proposals (especially if adopted in England) may provide a more manageable balancing of responsibilities between the taxpayer and the individual.
- Social Impact Bonds could perhaps be applied in NI, especially to the provision of domiciliary care.
- Based on the existing evidence, it is unclear how far healthcare villages could be developed in NI.

[67] *CARDI (2011)* Focus on… Models of Care [Online] Available at: http://www.cardi.ie/userfiles/Focus%20on%20Models%20of%20Care%20Aug%202011.pdf Accessed 31 October 2011.
[68] CARDI (2011) *Focus on… Models of Care* [Online] Available at: http://www.cardi.ie/userfiles/Focus%20on%20Models%20of%20Care%20Aug%202011.pdf Accessed 31 October 2011.

5. Achieving greater value for money and a financially sustainable sector in NI

Introduction

This section considers the balance which should be struck between achieving greater value for money (for public funding) and ensuring that private provision of care remains financially sustainable.

Procurement and commissioning systems

According to the Northern Ireland Audit Office (NIAO)[69], in 2005/06, Trusts spent £38m on the purchase of domiciliary care services from independent providers using a range of contractual arrangements for the delivery of different types of service or packages of care. The types of contracts offered to independent providers include block contracts, cost and volume, cost per case and spot contracts [see also Section 3]. Table 5.1 below outlines some of the advantages and disadvantages of each of these options.

Table 5.1: Advantages and disadvantages by contract type for Trusts and home care providers

	Block Contracting	Spot Contracting
Advantages for Trusts	• Control of access • Security of supply • Discounted weekly fee rates	• More user choice • More individualised service
Disadvantages for Trusts	• Funding risk dependency on need prediction • More standardised service • Less user choice	• Insecurity of supply • Higher pricing • Transaction costs maybe higher
Advantages for home providers	• Security of funding • Commissioner commitment	• Control of access • Individual pricing • Spread of purchasers/commissioners • More flexibility
Disadvantages for home providers	• Less control over access • Discounted weekly fee rates • Less flexibility • More commissioner dependent	• Insecurity of funding • Transaction costs maybe higher

Source: PwC (2005).

Trusts must also consider which option will lead to the procurement of a sustainable provision which not only meets people's needs but also provides value for money. According to the NIAO, this requires regular review of how services are commissioned and the types of contract being employed.

Value for money – cost of care in private compared to statutory homes

A study conducted in 2007 by KPMG[70] found that the average costs for statutory residential care homes in 2008 (£478 per bed per week) exceeded the costs of independent care homes in Northern Ireland by £118 per bed per week and indeed that of homes in England, outside of London (£405 per bed per week). This indicates that residential care provision in the independent sector may offer better value for money compared with that in the public sector.

[69] Northern Ireland Audit Office (2007) *Older People and Domiciliary Care*. NIAO: Belfast.
[70] KPMG (2007) Audit *of Statutory Residential Homes for Older People*. KPMG: Belfast.

The KPMG study also found that the occupancy rate in the statutory homes in NI was higher than independent sector ones (92% compared to 88.7%). Similar occupancy rates have been indicated for England[71]. However, the study highlighted that whilst statutory homes are viewed as essential parts of the system, in terms of the staff costs and sickness absence statistics, significant scope may exist to improve value for money in the statutory homes.

According to the DHSSPS[72], *"while direct comparison between homes is not straightforward, the information available would indicate that the cost of providing care in the private sector home would be less than the cost of care in a statutory* sector *home. However, value for money is about more than simply unit cost comparisons. It includes a host of other considerations like the quality of interaction that clients get from staff and whether their specific care needs are being met."*

Fair market fees for care homes

A study by PwC in 2005[73] estimated indicative costs for care home provision in NI and implied that such costs were in excess of the level of fees being paid by DHSSPS. In 2004/05, PwC estimated that the cost per week for an independent residential care home was £377, whilst the weekly cost for nursing home care was £466. Fees paid in 2004/5 were, respectively, £273 and £420. Given cost inflation during 2005-2011 (e.g. wages, heating, modernisation to meet Health and Safety regulations) the gap between costs and fees continued to exist notwithstanding some efforts by the Department in the late 2000's to close the gap.

[71] 89% in 2009 and 91% in 2008 (Department of Health October 2011, *op.cit.*)
[72] Department of Health, Social Services and Public Safety (2011) Minister in response to NI Assembly Question from Mr McCartney MLA, AQW 3242 / 11-15.
[73] PwC (2005) *Research to identify the true economic cost in Northern Ireland of Independent Residential and Nursing Elderly Care Home Sector Provision and Domiciliary Care.* PricewaterhouseCoopers LLP: London.

Table 5.2: Analysis of NI independent care home fees and costs

Year	Residential Tariff (Fees £)	PwC Residential (Costs £) *Note 1	Nursing Tariff (Fees £)	PwC Nursing (Costs £) *Note 1	DHSSPS Residential (Costs £) *Note 2	DHSSPS Nursing (Costs £) *Note 2	JRF Residential (Floor Costs £) *Note 3	JRF Nursing (Floor Costs £) *Note 3
2004/05	273.00	377.35	420.00	465.77	n.a. *Note 5	n.a.	n.a.	n.a.
2005/06	300.00	386.78	430.00	477.41	n.a.	n.a.	n.a.	n.a.
2006/07	360.00	396.45	460.00	489.35	n.a.	n.a.	n.a.	n.a.
2007/08	390.00	406.36	490.00	501.58	418.51	521.29	n.a.	n.a.
2008/09	405.00	416.52	510.00	521.12 *Note 4	428.97	534.32	463.00	589.00
2009/10	418.00	425.69	526.00	532.58	438.41	546.08	473.19	601.96
2010/11	426.00	439.73	537.00	550.16	452.88	564.10	488.80	621.82
2011/12	426.00	460.84	537.00	576.57	474.62	591.17	512.26	651.67
2012/13	426.00	470.52	537.00	588.68	484.58	603.59	523.02	665.36

Sources: JRF data - William Laing (2008)[74]*; DHSSPS data* - Clifford Coulter and Peter McLaughlin on behalf of the Community Care Finance Forum *and PwC data - PwC (2005)*[75].

**Note 1:* Using the PwC calculations for 2004/5 increased by actual Consumer Price Index (CPI) inflation rates p.a. (2.2% 2009; 3.3% 2010; and a forecast rate of 4.8% in 2011 and 2.1% 2012[76], these CPI inflation rates were also used to upgrade all the other cost estimates).

**Note 2:* Following the PwC (2005) report, DHSSPS produced this assessment of costs (in 2007/08 the same CPI inflation rates as above were also used to upgrade the DHSSPS cost estimates).

**Note 3:* William Laing (Joseph Rowntree Foundation) estimated costs for England, outside of London and in 2008/09 provided a 'floor' cost i.e. for a reasonable but not high quality building (the same CPI inflation rates as above were also used to upgrade the JRF cost estimates).

**Note 4:* Adjusted upwards because of the decision by DHSSPS, following work down by Clifford Coulter and Peter McLaughlin on behalf of the Community Care Finance Forum, to upgrade the tariff for nursing homes in 2008/09 to reflect the cost of continence products (assessed as £7 weekly). For consistency, we have similarly increased the (upgraded) PwC assessment of nursing costs by the same amount in that year.

**Note 5:* n.a. indicates that no data were available for each of these years.

[74] Laing, W. (2008) *Calculating a Fair Market Price for Care*. Joseph Rowntree Foundation: York.
[75] PwC (2005) *Research to identify the true economic cost in Northern Ireland of Independent Residential and Nursing Elderly Care Home Sector Provision and Domiciliary Care*. PricewaterhouseCoopers LLP: London.
[76] PwC (November 2011) NI *Economic Outlook*. PricewaterhouseCoopers LLP: Belfast.

Table 5.3: % shortfall of tariff compared to indicative costs

Year	PwC Residential	PwC Nursing	DHSSPS Residential Update	DHSSPS Nursing Update	JRF Residential Update	JRF Nursing Update
2004/05	-38%	-16%	n.a. *Note 1	n.a.	n.a.	n.a.
2005/06	-29%	-11%	n.a.	n.a.	n.a.	n.a.
2006/07	-10%	-6%	n.a.	n.a.	n.a.	n.a.
2007/08	-4%	-2%	-7%	-6%	n.a.	n.a.
2008/09	-3%	-2%	-6%	-5%	-14%	-15%
2009/10	-2%	-1%	-5%	-4%	-13%	-14%
2010/11	-3%	-2%	-6%	-5%	-15%	-16%
2011/12	-8%	-7%	-11%	-10%	-20%	-21%
2012/13	-10%	-10%	-14%	-12%	-23%	-24%

Sources: JRF data - William Laing (2008)[77]; DHSSPS data - Clifford Coulter and Peter McLaughlin on behalf of the Community Care Finance Forum; PwC data - PwC (2005)[78].

Note 1: n.a. indicates that no data were available for each of these years.

The results for 2004/5 show that there was a substantial shortfall in the level of fees paid (the tariff) compared to the estimated true cost (see column 1 compared to 2 in Table 5.2 and column 3 compared to column 4). If we then take the tariffs paid in each of the years after 2004/5 (see Table 5.2) and compare these to an estimate of the upgraded costs (using the PwC calculations for 2004/5 increased by an actual Consumer Price Index (CPI) inflation[79] rates p.a.) we see that the shortfall in tariffs relative to implied costs was reduced over a number of years (see also Figure 5.1 below). Indeed, comparing 2004/5 with 2009/10 it fell from -38% to -2% for residential care and from -16% to -1% for nursing care. An attempt by the Department to ensure tariffs were closer to costs thus had some effect. However, it is also implied that costs will grow more rapidly than the tariffs in the immediate future years. Moreover, given certain increases in labour related costs in recent years, the CPI inflation rate is likely to have underestimated the extent of the increase in costs.

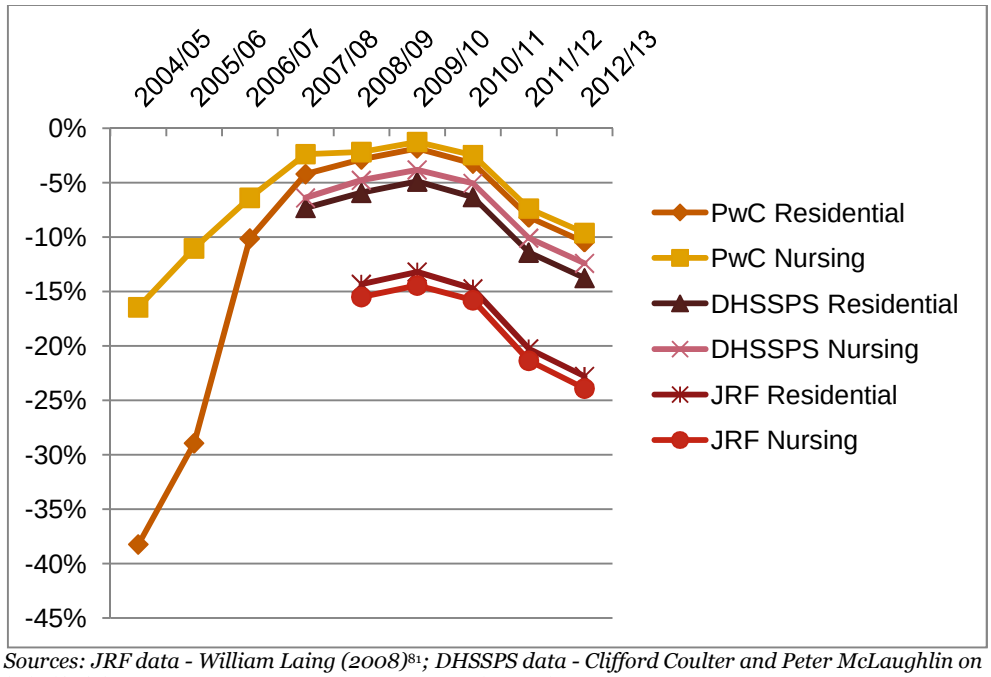
For comparison, Table 5.2 also shows for the years after 2007/08 the DHSSPS's own estimates of the costs of provision, and the costs in England (outside of London) based on the study by Laing (2008); if these can be used as a proxy for care in NI. In each case, the costs are implied to be higher than the tariffs actually paid to independent providers in NI and we find the same pattern as that established by the PwC estimate of costs relative to tariffs. At first, during the years up to 2009/10, the gap narrows (although does not close completely) but thereafter it widens again.

It is worth noting that three care homes in England have recently been successful in obtaining a judicial review of the amount of fees payable to them by their local authority. This resulted in the Council being required to re-evaluate their decision to pay care homes £390 per week per resident, due to the decision making process being judged unlawful. In this instance, the Council failed to correctly calculate the capital costs in relation to the assessment of the provider's costs[80]. It is thought

[77] Laing, W. (2008) *Calculating a Fair Market Price for Care*. Joseph Rowntree Foundation: York.
[78] PwC (2005) *Research to identify the true economic cost in Northern Ireland of Independent Residential and Nursing Elderly Care Home Sector Provision and Domiciliary Care*. PricewaterhouseCoopers LLP: London.
[79] Office for National Statistics.
[80] Austen, N., and Brown, G. (2011) *Care home fees judicial review*. Vertex Law. [Online] Available at http://www.vertexlaw.co.uk/knowhow/articles/articles_detail.php?id=000142 Accessed on 16th November 2011.

that recent successful judicial reviews will lead to other care home providers querying the decisions made by local authorities in relation to fees paid to them for residents; this could have implications for NI.

Figure 5.1: % shortfall of tariff compared to indicative costs



Sources: JRF data - William Laing (2008)[81]; DHSSPS data - Clifford Coulter and Peter McLaughlin on behalf of the Community Care Finance Forum and PwC data - PwC (2005)[82].

Key findings

- There may be opportunities to improve value for money through developing more efficient procurement/commissioning arrangements.
- The available evidence suggests that care home spaces can be provided at a lower cost in the independent sector compared to the statutory sector.
- The available evidence also suggests that in the mid 2000s there was a substantial shortfall in the tariff paid by the DHSSPS compared to the cost of provision per bed space by an independent provider. That shortfall narrowed after 2004/5 but was probably not closed completely, notwithstanding an increase in DHSSPS fees. Indeed, the available indicators suggest that the shortfall is now widening again.

[81] Laing, W. (2008) *Calculating a Fair Market Price for Care*. Joseph Rowntree Foundation: York.
[82] PwC (2005) *Research to identify the true economic cost in Northern Ireland of Independent Residential and Nursing Elderly Care Home Sector Provision and Domiciliary Care*. PricewaterhouseCoopers LLP: London.

6. *Points for further consideration regarding the future of social care in NI*

Introduction

This final section in the report provides some areas for further consideration based on our earlier findings.

The review commissioned by the DHSSPS Minister to report back by 30 November 2011 is to be a "strategic, independent assessment" of the entire sweep of DHSSPS activities. The Minister said, *"It will be necessary to stop doing what does not work, become more assertive in challenging out of date practices, and acknowledge that some of today's services and their current design are no longer fit for purpose"*[83].

Areas for consideration

With respect to the future of social care, the following are some key points that the DHSSPS Review needs to consider:

The current system is not sustainable

According to the Dilnot Commission, *"The current system is confusing, unfair and unsustainable. People can't protect themselves against the risk of very high care costs and risk losing all their assets, including their house. This problem will only get worse if left as it is, with the most vulnerable in our society being the ones to suffer."*

Age NI believes that our social care system is broken and that a new revised system is long overdue. They believe that the current system is no longer sustainable or capable of meeting the needs of older people today or in the future[84].

This would be true even with a large scale injection of public funding, which may not be likely to any great extent. In fact, in real terms the social care budget is likely to shrink by 7% between 2010-11 and 2014-15 (see Table 3.1), and all this as demand pressures, e.g. demographics are increasing[85]. Current pressures are likely to continue and intensify. In other words, the sustainability of domiciliary care is in question, as it is increasingly rationed in terms of quality and quantity. Similarly, will private provision of residential care be sustainable if payments made by DHSSPS continue to be less than the costs of the providers? The available indicators suggest that the shortfall between tariffs and costs is starting to widen again.

The need to act now

Accept there is an imperative to act now (an imperative emphasised by McKinsey regarding DHSSPS as a whole)—delay in reform does not remove any pain in the reform process, rather it intensifies it.

Value for money

In domiciliary care there could be potential for enhanced value for money through shifting to use of independent providers. In terms of care homes, there may be scope for some value for money in terms of a shift towards the independent sectors and also in terms of rehabilitation i.e. less use of hospital beds and more of nursing

[83] Agenda NI (2011) *Reviewing health*, pp. 14-15. Agenda NI: Belfast.
[84] Age NI (2011) *Future Direction and Funding of Adult Social Care: The current system and how this could be improved: A Briefing Paper for the HSSPS Committee*. Age NI: Belfast.
[85] UK-wide, a doubling in demand for social care spending (on current trends) was forecast for the next 20 years; HSMC (2010) *The billion dollar question, embedding prevention in older people's services-High impact changes*. Health Services Management Centre: University of Birmingham.

homes instead. Financial sustainability in the longer term may need to be considered, making sufficient allowances for maintenance issues.

Spending to save is a priority

For example, a greater focus on preventative measures and promotion of healthy ageing should, eventually, save spending on hospital level care etc. It would certainly be desirable to prevent a situation where a large percentage of hospital admissions show evidence of malnourishment[86]. As NAO argued at the UK-wide level, it is critical to break out of a downward spiral whereby inadequate focus on preventative spending and care in the community leads to relatively early onset of hospitalisation and heavier spend on acute care (alongside fewer resources for preventative spending and so on)[87]. In England, Partnership for Older People Projects' pilots, across 29 local authority areas (spending a total of £60m) have been successful. These ranged from lunch clubs to a better management of hospital discharges of older people. On average, for each £1 spent, benefits (in terms of reduced hospital spend) of £1.20 were realised[88].

Importance of technology and ICT

Recognise that in terms of spending to save, technology and especially ICT may be significant. For example, Microsoft now provides healthcare applications. Based on large data sets, these provide informed forecasts as to whether a patient may require hospital admission during the next 30, 40 or 50 days and also the processes necessary to make such an admission unnecessary. If this technology works then it is clearly beneficial to the patient (they can remain at home) and it also helps to reduce system wide health care costs[89].

Social Impact Bond model

Apply the Social Impact Bond model to private providers of either care homes or domiciliary care. The private sector providers would, in effect, put up the money to provide a service for DHSSPS and on realisation of certain identified success/performance targets they would be paid back their investment plus a dividend from the DHSSPS. The theory being that, if commissioned, private provision achieves cashable savings to the Department and the Department then pays back the providers a dividend out of that saving[90].

Integration of health and social care

There is potential to improve practical and budgetary integration of primary/social care relative to acute care etc. Whilst it might appear that NI should have whatever advantages that follow from having an integrated health and social care department (relative to England), it is probable that local authorities in England have been more advanced in seeking to take a "total place" approach to getting the maximum combined impact from all agency spend on older people[91]. In some cases, there could certainly be more integration across budget lines within the DHSSPS. For example, could more spending be allowed on community meals

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[86] The British Dietetic Association (2006) *Malnutrition in hospital.* BDA website.
[87] National Audit Office (1997) *The Coming of Age: Improving Care Services for Older People*. NAO: London. NAO (2000) *The Way to Go Home: Rehabilitation and Remedial Services for Older People.* NAO: London.
[88] Personal Social Science Research Unit (2009) *The National Evaluation of Partnerships for Older People: Executive Summary*. PSSRU: London.
[89] Interview with Neil Jordan (General Manager Worldwide Health, Microsoft) Agenda NI (2011) *Real impact on healthcare*, pp. 38-41.
[90] PwC (2011) *Out in the Open Delivering Public Service Reform*, PricewaterhouseCoopers LLP: London.
[91] Joseph Rowntree Foundation (2011) *How can local authorities with less money support better outcomes for older people?* JRF: York.

within the social budget which would probably imply that the spend on nutritional supplements would come down?

Other key points

- Ensure that the common standards are actually achieved across the HSC Trusts.
- Mitigate the threat of systemic breakdown (which itself reflects the "too big to fail" aspect of current structures)[92]. Ongoing policy for community care is to promote the development of a flourishing independent sector alongside good quality public services. Recent events surrounding Southern Cross Healthcare would serve to underline the value of such a mixed economy of care[93].
- Increase recognition, rewards and standards of staff, i.e. a proper workforce strategy which would transform being a social care worker into a career of choice.
- Recognise that outcomes are improved when older people themselves are involved in programme design and implementation, e.g. various partnership pilots in English local authority area[94].
- Incentivise rehabilitation, e.g. through systems of payment to domiciliary and residential care providers according to results, with some of those results being around a return to independent living.

In short, as identified by a number of other commentators[95], there is a need for a fundamental review of social care in NI as well as a public debate on fairness and sustainability in social care. A new system must prioritise preventative services, both to improve the quality of life of those who use a service and also to intervene before care needs become high and expensive. Central to social care reform are the opinions of older people and their experiences.

Key findings

- A fundamental review is necessary.
- The evidence we have reviewed suggests the current system is not sustainable, given the combination of rising demands (ageing and expectations) alongside ongoing funding pressures.
- These pressures are likely to intensify.
- Failure to reform now implies a missed opportunity, not only to enhance the quality of life of older people but also to spend to save through better preventative care.

[92] An issue noted by Department of Health (2010) A Vision for Adult Social Care: Capable Communications and Active Citizens. Department of Health: London.
[93] Department of Health, Social Services and Public Safety (2011) Minister reply to NI Assembly, question from Mr McCartney MLA (AQW 3242/11-15).
[94] JRF (2011) *How can local authorities with less money support better outcomes for older people?",* Joseph Rowntree Foundation: York.
[95] Age NI (2011) *Future Direction and Funding of Adult Social Care: The current system and how this could be improved: A Briefing Paper for the HSSPS Committee*. Age NI: Belfast.

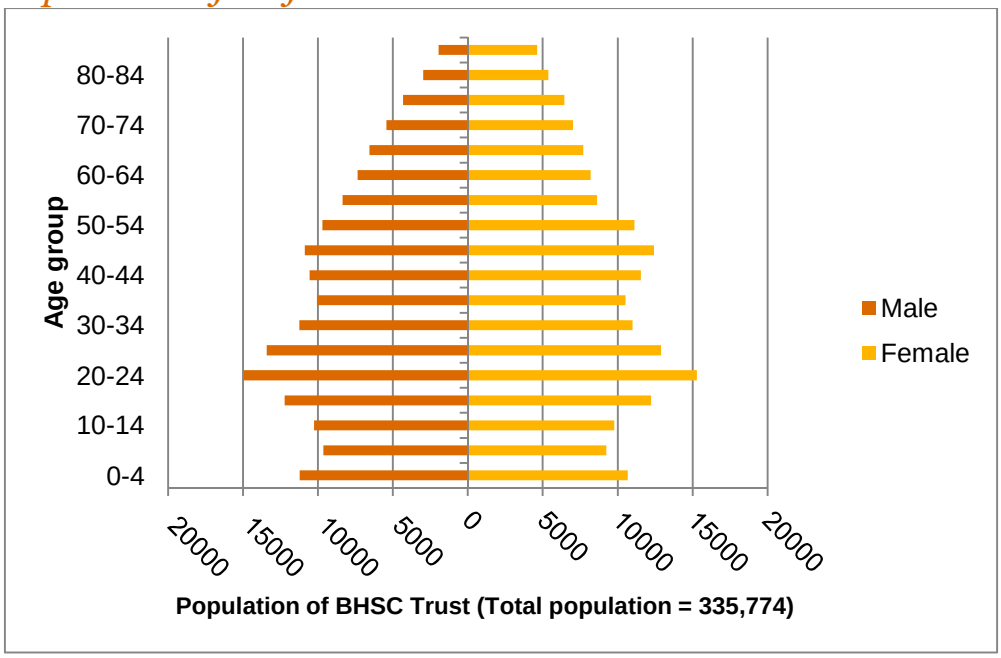
Appendices

Appendix 1: Demographic change in Northern Ireland by Trust

This appendix provides population pyramids for each of the five HSC Trusts for 2010 and 2023.

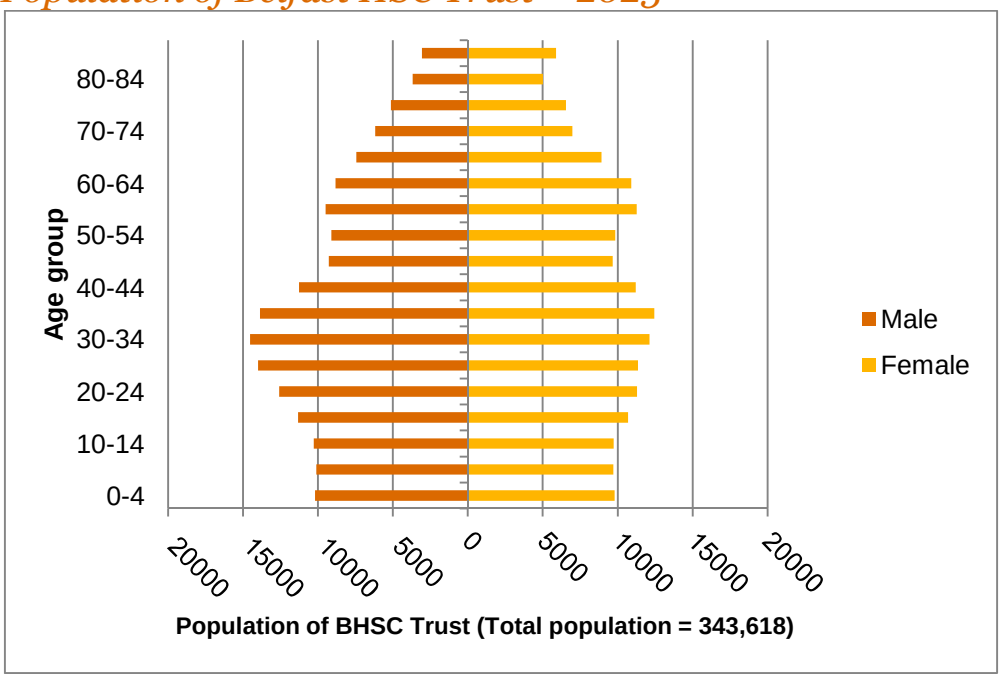
In examining the population pyramids below, it can be inferred that family structures are changing, with a fewer number of "working age" individuals and young people to support older relatives.

Population of Belfast HSC Trust - 2010



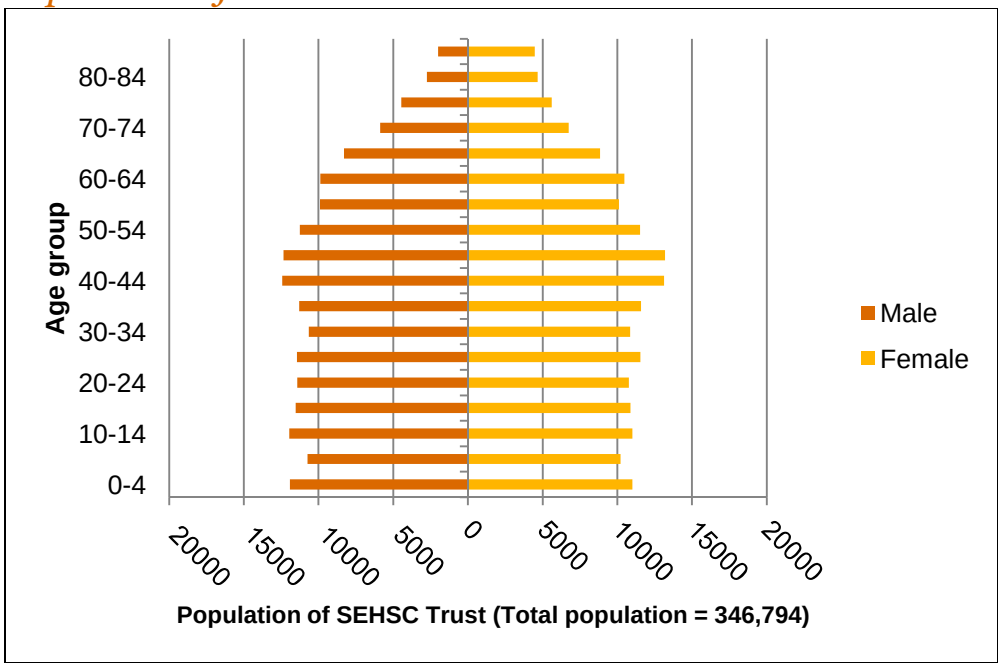
Source: Northern Ireland Statistics and Research Agency.

Population of Belfast HSC Trust – 2023



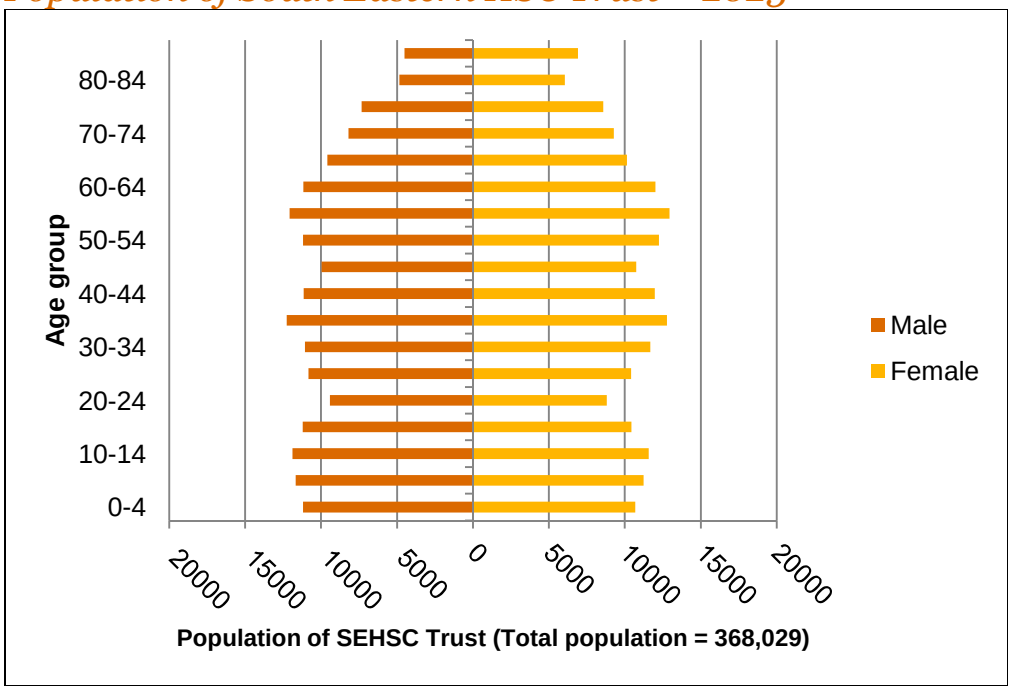
Source: Northern Ireland Statistics and Research Agency.

Population of South Eastern HSC Trust – 2010



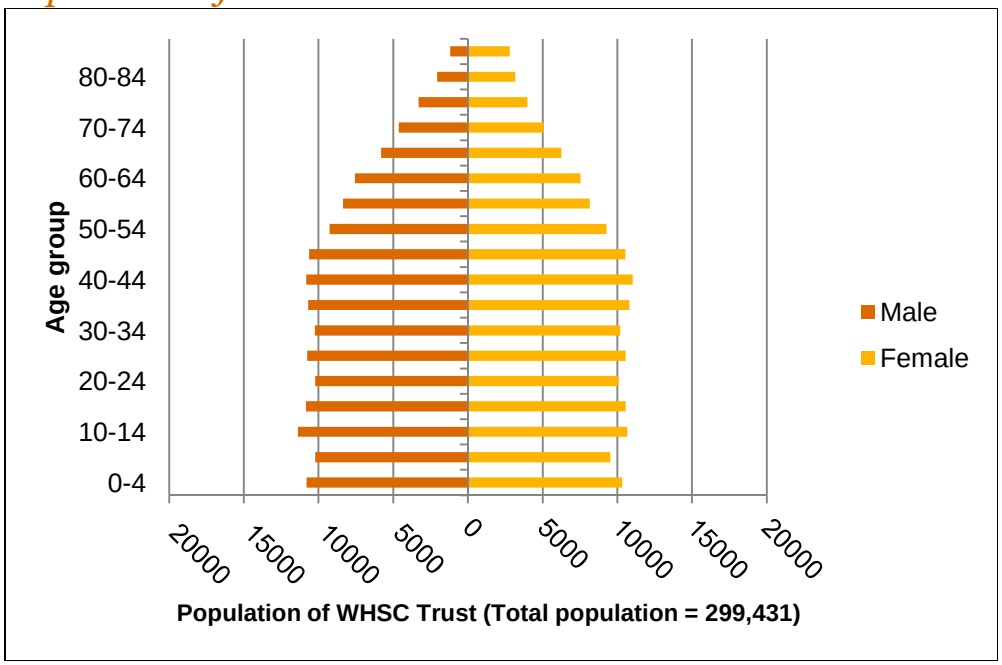
Source: Northern Ireland Statistics and Research Agency.

Population of South Eastern HSC Trust – 2023



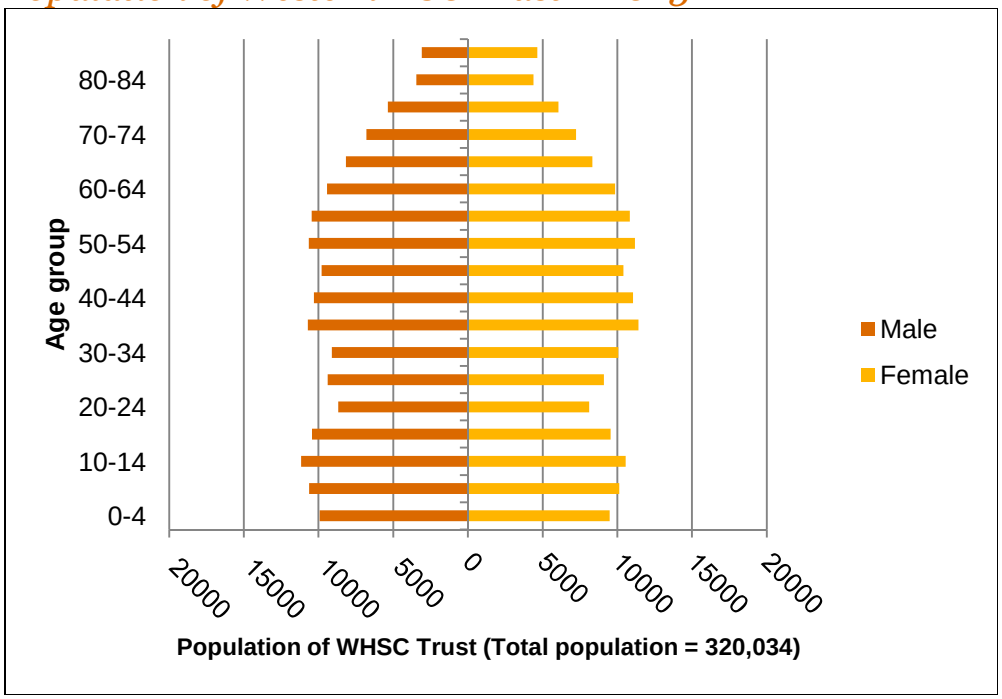
Source: Northern Ireland Statistics and Research Agency.

Population of Western HSC Trust – 2010



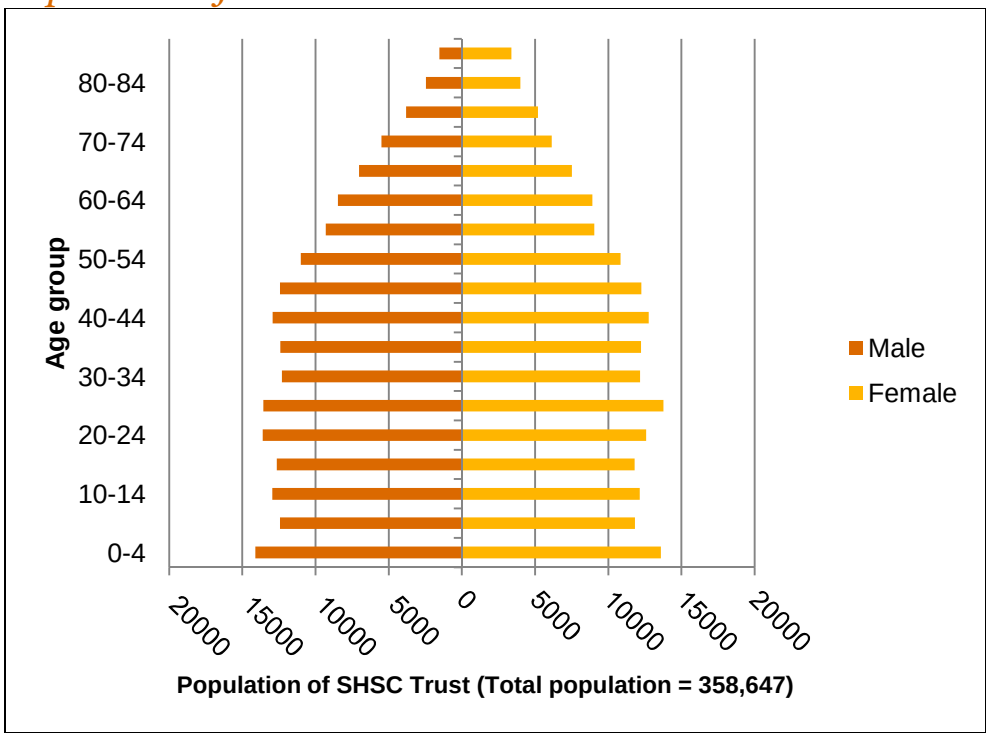
Source: Northern Ireland Statistics and Research Agency.

Population of Western HSC Trust – 2023



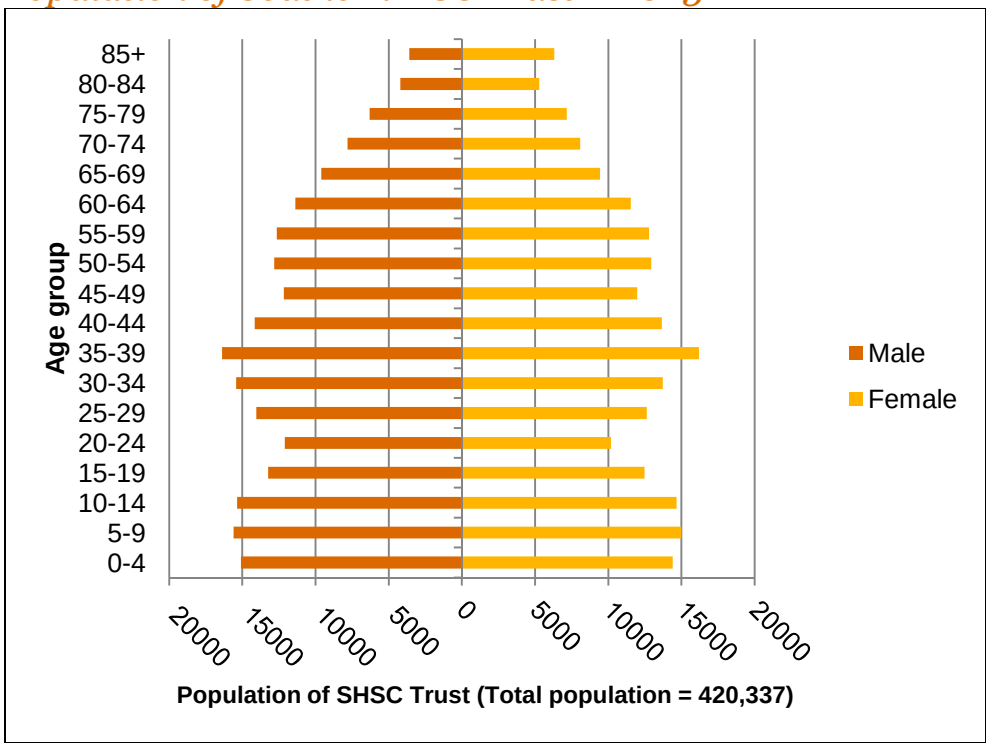
Source: Northern Ireland Statistics and Research Agency.

Population of Southern HSC Trust – 2010



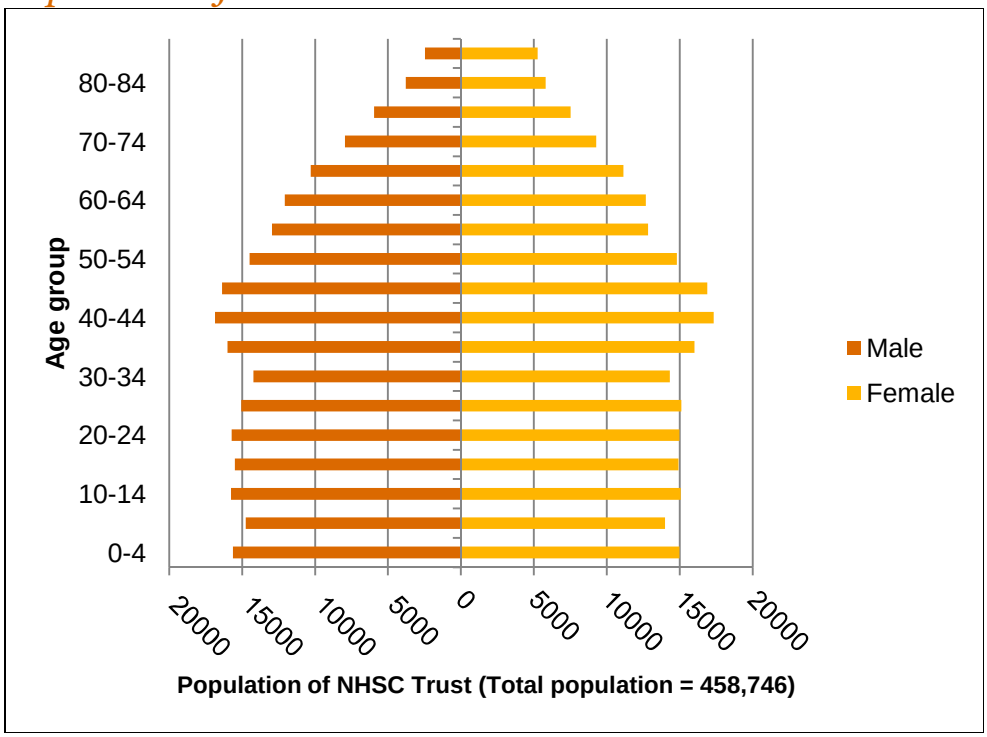
Source: Northern Ireland Statistics and Research Agency.

Population of Southern HSC Trust – 2023



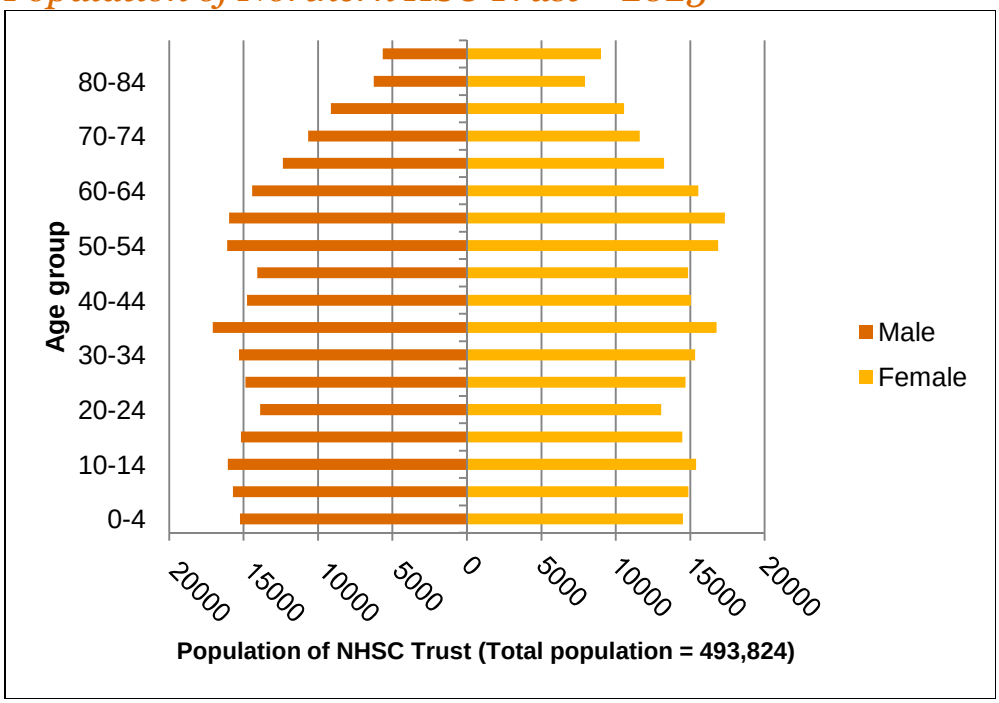
Source: Northern Ireland Statistics and Research Agency.

Population of Northern HSC Trust – 2010



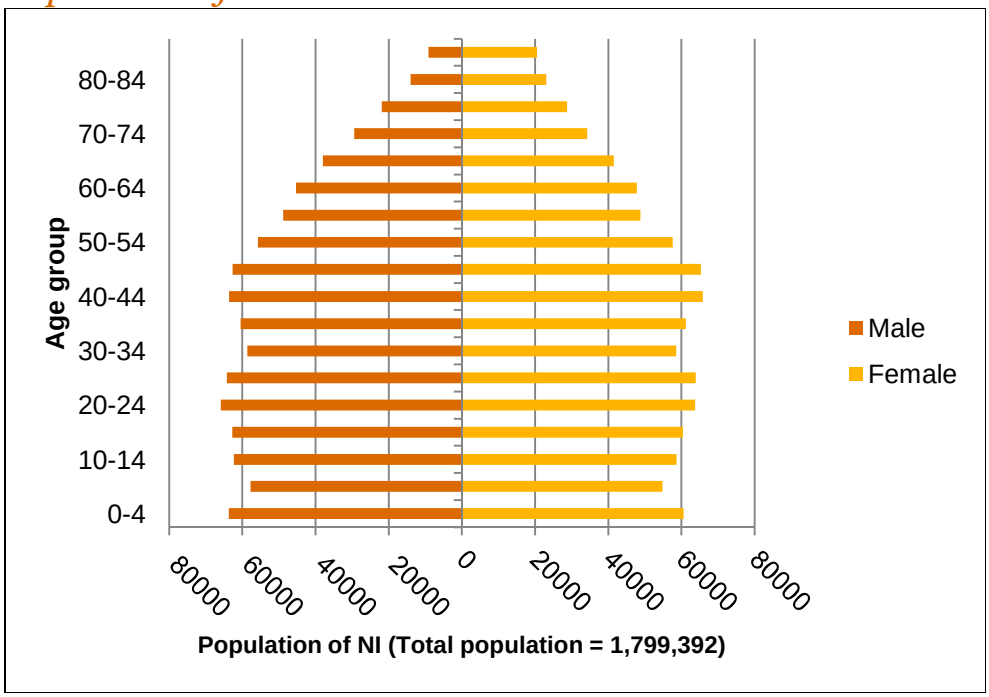
Source: Northern Ireland Statistics and Research Agency.

Population of Northern HSC Trust – 2023



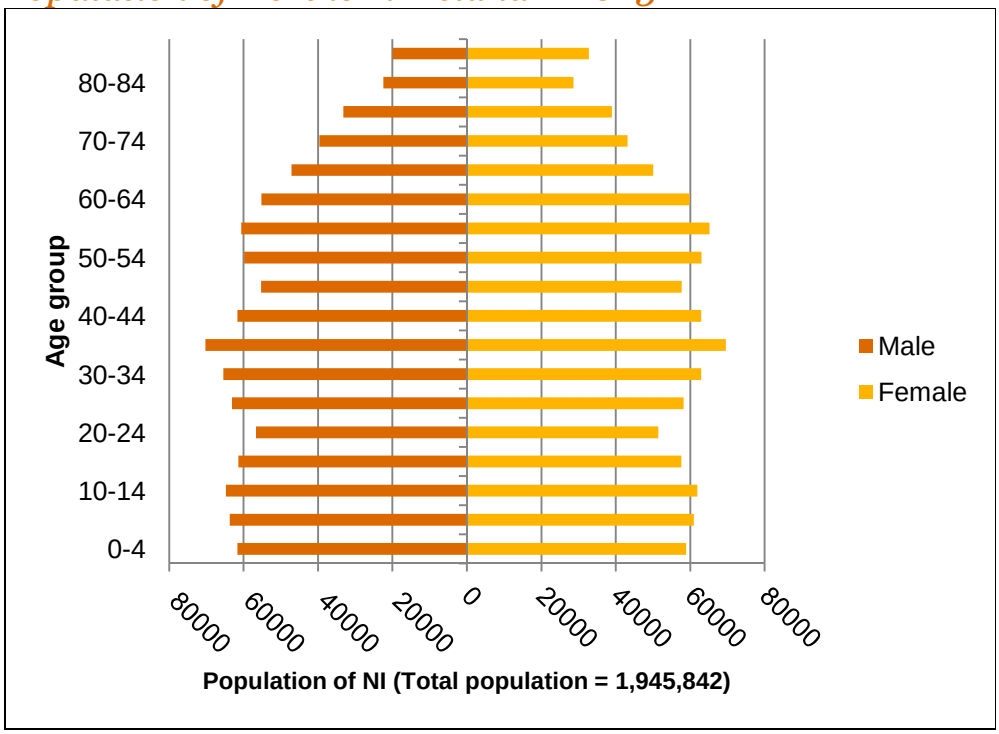
Source: Northern Ireland Statistics and Research Agency.

Population of Northern Ireland – 2010



Source: Northern Ireland Statistics and Research Agency.

Population of Northern Ireland – 2023



Source: Northern Ireland Statistics and Research Agency.

Appendix 2: Population over 65 by Council area, 2011 compared to 2021

This appendix provides a full comparison of the percentage population over 65 and 85 for all 26 Councils in Northern Ireland.

The table below illustrates that some of the local government areas are likely to have significantly above average percentages of the population aged above 65 and 85 in 2011 and 2021.

Table I: % of Population over 65 and 85 by Council area – 2011 compared to 2021

Council	% Population over 65		% Population over 85	
	2011 %	2021 %	2011 %	2021 %
Antrim	12.7	14.8	1.3	1.9
Ards	17.1	21.9	2.0	2.7
Armagh	14.3	16.9	1.6	2.3
Ballymena	16.9	20.2	2.2	3.3
Ballymoney	15.3	18.1	1.8	2.4
Banbridge	13.8	16.8	1.6	2.3
Belfast	15.4	16.8	2.1	2.7
Carrickfergus	16.2	21.1	2.0	3.2
Castlereagh	18.3	22.0	2.4	3.6
Coleraine	18.0	23.8	2.3	3.6
Cookstown	13.1	15.1	1.7	2.3
Craigavon	13.5	14.8	1.5	2.0
Derry	12.0	15.7	1.1	1.7
Down	14.3	17.4	1.9	2.5
Dungannon	12.2	12.6	1.4	1.6
Fermanagh	14.9	18.3	2.0	2.6
Larne	17.2	21.4	1.8	2.6
Limavady	12.7	18.1	1.5	2.2
Lisburn	14.1	17.5	1.6	2.4
Magherafelt	12.2	14.3	1.4	2.0
Moyle	16.7	20.3	2.0	2.7
Newry & Mourne	12.2	13.8	1.4	1.9
Newtownabbey	16.8	20.6	2.0	3.0
North Down	19.1	24.1	2.8	3.8
Omagh	12.9	16.2	1.5	2.1
Strabane	14.2	17.7	1.5	2.4
Northern Ireland	**14.7**	**17.6**	**1.7**	**2.5**

Source: Northern Ireland Statistics and Research Agency.

Appendix 3: Provision of residential care (2005/06 – 2009/10)

This appendix provides a breakdown of the number of residential care homes and number of residential places available to adults across Northern Ireland. The Table below provides detail by HSC Trust and by sector and allows comparison from 2005 – 2010.

Table II: Residential accommodation in Northern Ireland, by type of home and HSC Trust

Year/ Trust	Number of homes			Number of residential places available		
	Statutory	Independent	Total	Statutory	Independent	Total
2009/10 Total	**58**	**178**	**236**[1]	**1555**	**3267**	**4822**
Belfast HSC Trust	15	30	**45**	398	891	**1289**
Northern HSC Trust	14	45	**59**	418	615	**1033**
South Eastern HSC Trust	12	49	**61**	313	970	**1283**
Southern HSC Trust	6	20	**26**	162	312	**474**
Western HSC Trust	11	34	**45**	264	479	**743**
2008/09 Total	**62**	**239**	**301** [1]	**1665**	**3270**	**4935**
Belfast HSC Trust	15	32	**47**	398	879	**1277**
Northern HSC Trust	14	82	**96**	413	679	**1092**
South Eastern HSC Trust	15	50	**65**	397	917	**1314**
Southern HSC Trust	6	41	**47**	168	319	**487**
Western HSC Trust	12	34	**46**	289	476	**765**
2007/08 Total	**62**	**255**	**317**	**1732**	**3246**	**4978**
Belfast HSC Trust	15	39	**54**	398	910	**1308**
Northern HSC Trust	14	82	**96**	420	640	**1060**
South Eastern HSC Trust	16	59	**75**	450	897	**1347**
Southern HSC Trust	6	40	**46**	186	313	**499**
Western HSC Trust	11	35	**46**	278	486	**764**
2006/07 Total*	**62***	**267***	**329***	**1760***	**3363***	**5123***
Belfast HSC Trust*	15*	41*	**56***	398*	937*	**1335***
Northern HSC Trust*	14*	88*	**102***	420*	697*	**1117***
South Eastern HSC Trust*	16*	61*	**77***	470*	918*	**1388***
Southern HSC Trust*	6*	41*	**47***	186*	322*	**508***
Western HSC Trust*	11*	36*	**47***	286*	489*	**775***
2005/06 Total*	**114***	**288***	**402***	**2120***	**3556***	**5676***
Belfast HSC Trust*	29*	42*	**71***	511*	939*	**1450***
Northern HSC Trust*	21*	96*	**117***	481*	734*	**1215***
South Eastern HSC Trust*	27*	68*	**95***	537*	1061*	**1598***
Southern HSC Trust*	14*	46*	**60***	232*	331*	**563***
Western HSC Trust*	23*	36*	**59***	359*	491*	**850***

Source: DHSSPS (2011)[96].

[96] Department of Health, Social Services and Public Safety (2011) *Adult Community Statistics*. DHSSPS: Belfast. [Online] Available at: http://www.dhsspsni.gov.uk/index/stats_research/stats-cib/statistics_and_research-cib-pub/adult_statistics/statistics_and_research-cib-community_statistics.htm Accessed 31 October 2011.