Audit Commission

PERFORMANCE REVIEW IN LOCAL GOVERNMENT

a handbook for auditors and local authorities

Social Services
Performance Review in Local Government

Social Services
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Contents

Preface 3
An Overview: Management, Administration and Social Work 6
   Current management issues 8
   Bibliography 10
   Performance review guide 11
Children 16
   Current management issues 17
   Bibliography 20
   Performance review guide 21
Elderly People 26
   Current management issues 28
   Bibliography 29
   Performance review guide 31
Mentally Handicapped People 35
   Current management issues 37
   Bibliography 39
   Performance review guide 40
Mentally Ill People 44
   Current management issues 46
   Bibliography 47
   Performance review guide 48
Physically Handicapped People 51
   Current management issues 53
   Bibliography 54
   Performance review guide 55
Preface

This booklet is part of 'Performance review in local government: a handbook for auditors and local authorities'.

The handbook has been prepared by the Audit Commission as a working document to help auditors and local authorities appraise the effectiveness, efficiency and economy of services. It should help to focus attention on aspects of services that appear wasteful or capable of improvement, and to identify aspects of services that merit further investigation. It should also help to promote debate on how quality in services is to be assessed, alongside the quantifiable measures of efficient performance.

Summary of contents

The handbook consists of ten sections:

- Introduction
- Education
- Environmental Services
- Housing
- Law and Order
- Leisure and Libraries
- Planning and Transportation
- Social Services
- Central Services (to be published in 1987)
- Statistical Supplement (to be published annually from 1987)

This preface is reprinted for reference at the start of each booklet.

The introductory booklet gives the background context to the need for performance review, considers arrangements for it within an authority, and explores some of the difficulties which authorities may face in measuring performance and implementing change.

The service-specific booklets, like this one, provide for each service:

1. A brief description of the main elements of the service, and a discussion of the key issues in examining the performance of the service in terms of value for money. This section includes a bibliography of useful government and other publications.

2. A more detailed series of review questions which will help to guide the assessment and improvement of current arrangements for managing the service. Useful references and performance indicators are shown alongside the relevant questions. These include indicators of effectiveness (for example inspectors' reports, trends in usage, public attitudes) as well as quantifiable measures of efficiency (for example pupil/teacher ratios, m² per client).

Some of the questions in the performance review guides relate to policy matters to be decided by members, or are the professional responsibility of officers as their advisers. These questions are shown in italic. The auditor's interest is in ensuring that these issues have been addressed and that appropriate policies and management arrangements have been determined. Auditors should also be sensitive to such wider considerations when making judgements on resources usage.
The indicators listed in this booklet are not accompanied by a value. They simply designate what is to be examined, for example clients per employee, costs per m². However, there are some norms, standards or benchmarks which are widely accepted, or which have been positively identified during detailed reviews by the Audit Commission or some other recognised body. Where these exist, the appropriate value or range of values, for example X clients per employee, £Y per m², will be listed in the statistical supplement, which will be published annually.

Careful comparisons with other local authorities can provide a useful starting point for reviewing current practices. However, differences in the value of indicators between one authority and another, or between an authority and the given norm, should never form the sole basis for conclusions. Rather they should lead to more searching enquiries into the circumstances which give rise to such differences, and the opportunities which exist for improvements to be made.

The approach of the handbook
This handbook does not suggest that there should be uniform approaches to service provision, or standard levels of output. It recognises that the very essence of local government is variety, but emphasises that variety should stem from the efficient and effective meeting of local needs, rather than from poor management or inadequate policy making.

Three themes therefore run through the handbook:

1 The need to emphasise the outputs of services, and relate these to inputs.
Success in the public sector lies in the quality of the services provided. In general, the balance needs to be tipped from the current emphasis on inputs by providers, to an emphasis on the outputs received by the public. In some services, measures of output are clear. In others, where detailed research has not been carried out, the approach needs to be more cautious, particularly for services where the outputs may well be contentious, for example social work or the police service.

2 The need to make best use of available resources.
Performance appraisal is often portrayed as mere cost cutting. But in essence it is about querying whether money is being spent on those things that will improve the quality of services now and in the future. For example, money tied up in low-occupancy schools is money that cannot be used to pay for more teachers, or be diverted to provide care for the growing number of elderly people in our society.

3 The need for performance review to be an integral part of the management process.
At officer level, departmental managers should be keeping services under continual review. Many problems can be dealt with by the officers working within agreed policies. The members' responsibility is to satisfy themselves that the service is being managed properly and to examine in more depth those issues which have policy implications.
Using the handbook

The handbook has been prepared with auditors, officers and members in mind.

Auditors may find the handbook a useful adjunct to The Local Government Auditor (The Black Book), giving a service by service guide to value for money issues. The handbook documents and builds on a lot of the good work that has already been done around the country.

Officers may find it a useful statement on service delivery and performance. It has been developed in discussion with many professionals in the field. Chief officers may find it useful for questioning middle managers, and middle managers may find it helpful for raising issues of quality and effectiveness, when auditors are questioning efficiency and economy.

Members may find it a useful guide to the audit approach, and a helpful basis for reviewing, and where necessary challenging the approach of officers with regard to the performance of particular services.

The scope of the handbook

The handbook documents, for each service, the key elements which contribute to its success or failure, the key criteria on which to justify its continued existence.

It does not attempt to give an exhaustive description of every facet of every service, nor every issue of policy, quality, professional judgement or effectiveness. It simply represents the state of the art, drawing together the available information and work done so far. Constructive criticisms and contributions would be welcomed, particularly on issues which are omitted, or only briefly covered, in this edition.

An update service is planned, beginning in 1987 with a new section on central services, minor amendments to the service-specific sections and a statistical supplement. Thereafter the handbook will be revised in whole, or in part, according to changes in policy and practices around the country.

Comments should be sent to
The Director of Management Practice,
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An Overview: Management, Administration and Social Work

Introduction to the service

The chapters that follow relate to various client groups of people affected by social services provision. However, it is not possible to consider service delivery in isolation from the social context in which it takes place, nor the overall policy and management issues that affect it. Important too are the inter-relationships of certain services, particularly those for the elderly, who may suffer multiple disabilities.

Social service departments (SSDs) perhaps face more management challenges than most other local authority departments, since they address personal services across a whole spectrum of age, need and social circumstances. The numbers and needs of these clients are also changing at a time when financial resources are limited. There is thus a need to manage a switch of resources from, for example, children to the elderly. At the same time it is universally regarded as desirable to encourage care in the community at the expense of residential care. This encompasses not just the transfer of finances but the possible closure of some establishments and the opening of others, the retraining of staff, alteration of establishments and possibly a re-thinking of professional attitudes.

Currently the trend in social services is to move towards keeping direct involvement in people's lives to a minimum consistent with identifying those 'at risk' - a difficult balancing act. This calls for the strengthening and sustenance of community networks which allow people to care for themselves rather than becoming dependent on public services.

Increasingly, clients have the possibility of alternative options of care from the private sector, particularly for the elderly. The National Health Service (NHS) is seeking to concentrate its resources on medical care at the expense of some services which are thought more appropriate for local government. This transfer is sometimes assisted by initial funding by the NHS, which tapers off in later years.

Certain authorities face very different social circumstances to others - the inner cities being a marked contrast to other less deprived areas. Private sector provision, voluntary assistance, inter-authority cooperation, NHS liaison and funding, and councils' attitudes to the role and extent of social services, vary significantly between authorities, as does management ability.

Although these are the differences, there are also some issues that are similar. These are common to most of the chapters that follow, but will be of greater or lesser significance depending on the client groups. They are introduced briefly under 'Current management issues' below.

Trends

Expenditure has steadily increased in real terms during the last decade (see graph) but that on field work at a significantly faster rate than management and central services.

Expenditure

About a quarter of social services expenditure is incurred in social (field) work, management and central services, most of which are concerned with but not directly allocated to the care of the elderly, children and other client groups. In total, the estimated gross expenditure on these activities amounted to £720 million in 1985/6 or £15 per head of population.
Table 1 shows how the populations from which social services clients tend to be drawn have changed over the years. Currently there is a fall in the number of children but the over-75 population, which makes increasingly heavy demands on social services, is increasing and will continue to do so. In addition there has been a perceived increase in the proportions of difficult children in care and in cases arising from child abuse. Social services staff levels are rising.

### Table 1

<table>
<thead>
<tr>
<th>Year</th>
<th>&lt;15 years</th>
<th>65-74</th>
<th>&gt;74</th>
<th>Total (millions)</th>
<th>Social services staff (000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1901</td>
<td>12.4</td>
<td>1.3</td>
<td>0.4</td>
<td>14.2</td>
<td></td>
</tr>
<tr>
<td>1931</td>
<td>11.1</td>
<td>2.5</td>
<td>1.0</td>
<td>14.6</td>
<td></td>
</tr>
<tr>
<td>1961</td>
<td>12.4</td>
<td>4.0</td>
<td>2.2</td>
<td>18.6</td>
<td></td>
</tr>
<tr>
<td>1971</td>
<td>13.4</td>
<td>4.8</td>
<td>2.7</td>
<td>20.9</td>
<td></td>
</tr>
<tr>
<td>1981</td>
<td>11.6</td>
<td>5.2</td>
<td>3.3</td>
<td>20.1</td>
<td>251</td>
</tr>
<tr>
<td>1982</td>
<td>11.3</td>
<td>5.1</td>
<td>3.3</td>
<td>19.7</td>
<td>255</td>
</tr>
<tr>
<td>1983</td>
<td>11.2</td>
<td>5.0</td>
<td>3.4</td>
<td>19.6</td>
<td>263</td>
</tr>
<tr>
<td>1984</td>
<td>11.0</td>
<td>4.8</td>
<td>3.6</td>
<td>19.4</td>
<td></td>
</tr>
<tr>
<td>Projections</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1991</td>
<td>10.9</td>
<td>5.0</td>
<td>3.9</td>
<td>19.8</td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>11.8</td>
<td>4.7</td>
<td>4.0</td>
<td>20.5</td>
<td></td>
</tr>
</tbody>
</table>

(Sources: *Annual Abstract of Statistics* (1985) and *Social Trends* (1986))
Current management issues

The major common issues across all client groups are:

1. Policy definition and coordination — the need to have some sense of purpose and direction, which is reflected in clearly communicated policy statements and resource allocations.
2. The need to plan longer term and jointly with both other bodies and the recipients of care regarding service provision, and to monitor achievement of such plans.
3. The need to review the organisation of social work, in particular case management.
4. The need to manage resources efficiently, in terms of the occupation and utilisation of premises, staffing, commodity prices, energy and building maintenance.

Policy and planning

Council policy on services for each client group should be clearly stated and shared with and understood by SSD staff.

Changing policies should be reflected in the allocation/reallocation of resources; and the Council should have methods for measuring its success in achieving its objectives. The House of Commons Report on Community Care says:

'Appropriate care should be provided for individuals in such a way to enable them to lead as normal an existence as possible given their particular disabilities and to minimise disruption of life within their community.'

This means providing the appropriate services and support needed by clients and their families so that where possible they may live independently or with their families. Where this is not possible, suitable hospital or residential care should be provided by the NHS, local authority, voluntary or private sector.

The government response to the Report on Community Care was generally supportive. It recognised that 'a good quality community orientated service may well be more expensive than a poor quality institutional one' and said that the aim should be not to save money, but to use it responsibly.

Although the Report was concerned mainly with mental handicap and mental illness, the underlying philosophy extends not only to other forms of disability, but also to the care of the elderly. Care within the community, by means of family support, fostering or adoption, is also seen as increasingly important for children.

However, the common purpose of enabling clients to lead independent and active lives within their own homes or those of their families as far as practicable and for as long as they wish is subject to differing requirements of statute. For example, in the case of children's services the central consideration is the child's best interest, which may not necessarily coincide with either his/her own or the family's wishes. For the elderly, mentally handicapped or mentally ill people, other interests have also to be considered.

Community care necessitates a very different pattern of services to residential care, involving day care, respite care, emergency care, support for carers, together with a whole range of domiciliary services for the elderly. It is important to note that clients often fall into more than one service group.
Children and elderly people may also be mentally and/or physically handicapped, or mentally ill. A particular problem is the elderly person suffering from senile dementia wishing to live on his/her own or with the family but being unaware of incapacity and the problems created by it for relatives and neighbours.

The 1986 Disabled Persons Act has given more positive responsibilities to local authorities for the care and welfare of handicapped and mentally ill people.

There is thus a growing need for liaison and joint planning and sometimes provision of services with other bodies in the area, in particular the NHS, education and housing departments, and private and voluntary organisations. In some cases there is joint financing of projects by the District Health Authority and the local authority. Coordinated policies on provision need to include measures to ensure that adequate after-care facilities exist to deal with people discharged from hospital or residential care. Provision must also include adequate methods of assessing and reviewing need for services.

The management of social workers and other resources

Social workers have a key role in personal social services both indirectly in the promotion of community networks referred to above and in the direct supervision and care of the SSD’s clients. Their activities are set out below.

Into and through care
- Resettlement and rehabilitation into the community following periods of residential or some other form of institutional care.
- Maintaining, supporting, reviewing people in care and/or residential settings.
- Organising placement in care and/or residential settings.

Direct involvement
- Providing practical help and advice with personal and social problems, and monitoring the situation on an ongoing basis.
- Providing psychological/emotional help and support to individuals, groups and families with personal and social problems, and monitoring the situation.
- Developing and maintaining caring networks for named individuals.

Indirect involvement
- Developing and maintaining resources/networks for neighbourhoods and communities.
- Informing the population at large about resources.
- Education of target populations and general public on social service issues.

Social workers also play a major role in the essential joint planning and coordination with other services involved, for example the NHS, education and housing departments, police, MSC, private and voluntary organisations.

The resources of the SSD have to be deployed in a way that enables the requirements of each of the services to be met. Social workers, managers and many administrative staff are involved in all of them.
There is a variety of organisational systems for social workers. Some SSDs for instance are centralised, others decentralised. Some have separate teams for long term and short term involvement with particular client individuals or families. There are varying degrees of specialisation with client groups. There is no consensus as to 'best practice'.

The nature of the work and the risks involved (for staff as well as clients) make management control and review vitally important. It is difficult to maintain the balance between tight control and professional flexibility. Good case records are essential in the interests of clients, staff and good management.

Evaluating the effectiveness of services is difficult because of the varied nature and extent of clients' needs, abilities and skills, as well as their self-reliance and family support. The involvement of the NHS and other bodies also adds complexity; and clients' needs will vary over time. Generally, indicators of effectiveness must be related to the aims and objectives of the individual services involved and these are discussed in the appropriate chapters.

Similarly, unit costs are available for each service. They could also be available for social workers' case loads given an adequate recording system; but, failing that, indicators of efficiency for social workers, management and administration are limited to crude 'first cut' examples such as cost per 1000 population or client population.

**Bibliography**


*Social Workers Their Role and Tasks* (1982) National Institute for Social Work

The 'Barclay Report' describes social work in detail.


Both these reports contain recommendations of general application.


This report describes the findings of a pilot study on the management of social work undertaken by the Special Studies Directorate of the Audit Commission.
Performance review guide
This section sets out a detailed series of questions which will help to guide the review and improvement of current management arrangements.

Some of the questions relate to policy matters to be decided by members, or are the professional responsibility of officers as their advisers. These questions are shown in italic. The auditor's interest is in ensuring that these issues have been addressed and that appropriate policies and management arrangements have been determined. Auditors should also be sensitive to such wider considerations when making judgements on resource usage.

Useful performance indicators and reference documents are shown alongside the relevant questions. Careful comparisons with other local authorities can provide a useful starting point for reviewing current practices. However, differences in the value of indicators between one authority and another, or between an authority and accepted norms, should never form the sole basis for conclusions. Rather they should lead to more searching enquiries into the circumstances which give rise to such differences, and the opportunities which exist for improvements to be made.

<table>
<thead>
<tr>
<th>Review questions</th>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Policy definition and coordination</strong></td>
<td></td>
</tr>
<tr>
<td><strong>What is the underlying philosophy for social services in the Authority?</strong></td>
<td><strong>Policy statement exists and is in the possession of, and understood by, SSD staff</strong></td>
</tr>
<tr>
<td>• It is nowadays generally accepted that direct intervention by social services into people's lives should be at a minimum, unless clients are 'at risk'.</td>
<td>[See: Managing Social Work More Effectively]</td>
</tr>
<tr>
<td>• In the light of this, support for clients, or potential clients, is best achieved if social workers direct their efforts to strengthening and maintaining community networks which allow people to care for themselves.</td>
<td></td>
</tr>
<tr>
<td>• Failing this, helping clients to live independently or as a family is generally preferable to taking them formally into care.</td>
<td></td>
</tr>
<tr>
<td>• Once in care, placement in families is generally considered better than institutional care.</td>
<td><strong>Trends in proportions of clients in non-residential care</strong></td>
</tr>
<tr>
<td>• The accent, therefore, is on a preventive rather than reactive approach, but the extent to which this can be pursued depends on consideration of the costs and benefits involved in a fully preventive approach.</td>
<td></td>
</tr>
<tr>
<td>• In all cases there should be close cooperation between social workers and staff from the other services involved, eg NHS, police, probation, private and voluntary bodies.</td>
<td></td>
</tr>
</tbody>
</table>

Does the SSD's policy statement identify people eligible for the various social services and the priorities to be observed?
Have standard assessment and review procedures been developed for different client groups?

Refer to the appropriate chapters for questions relating to specific services.

2 Planning of service provision

Is there close consultation and planning with the NHS, MSC, LEAs, Housing Authorities, neighbouring SSDs, private and voluntary bodies in identifying clients in need of care, and providing services appropriate to their needs?

Over what time period, at what level of detail, are plans made?

Do plans adequately reflect changing local demographic, social and economic factors?

What steps are taken to avoid duplication between services provided by SSDs and discretionary services provided by district councils?

To what extent are clients involved in planning the services provided for them?

Refer to the appropriate chapters for questions relating to specific services.

3 The organisation of social work

How is social work organised?

- There are many possible structures, eg by area (patch, sub-area) or by function (long term, short term, specialist teams, client group teams etc).
- There is no consensus as to best practice. What matters is whether a structure works effectively in the local situation and that there are arrangements for assessing this.

Does the SSD have guidelines for evaluating referrals?

Is there supervision of decisions on referrals to minimise risk of incorrect rejection or unnecessary acceptance of referred cases?

How long do different client groups have to wait before receiving a visit from a social worker?

How does this compare with other areas/other local authorities?
## Review questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are urgent cases 'seen' within 24 hours?</td>
<td></td>
</tr>
<tr>
<td>Are 'low rung' options in 'ladders of care' fully used?</td>
<td>Proportion clients receiving residential or intensive domiciliary care (%)</td>
</tr>
<tr>
<td>• 'Low rung' options are those which enable clients to do most for themselves.</td>
<td></td>
</tr>
<tr>
<td>• 'High rungs' would include residential and other intensive care.</td>
<td></td>
</tr>
<tr>
<td>What arrangements are there for review of cases:</td>
<td>Training plans/activity programmes/objectives for individual clients</td>
</tr>
<tr>
<td>a) by team leaders?</td>
<td>[See: Caseload Management, and Managing Social Services More Effectively]</td>
</tr>
<tr>
<td>b) by higher management?</td>
<td>Changes taking place</td>
</tr>
<tr>
<td>• Review should be searching enough to ascertain that goal planning and services provided are appropriate, and frequent enough to ensure that both are varied as necessary with client needs.</td>
<td></td>
</tr>
<tr>
<td>• In particular steps should be taken to secure discharge from care or the down grading of service intensity as soon as those courses of action become appropriate.</td>
<td></td>
</tr>
<tr>
<td>• Case work records should be adequate for the purposes of review and accountability.</td>
<td></td>
</tr>
<tr>
<td>What are the arrangements for supervising social workers?</td>
<td></td>
</tr>
<tr>
<td>Are offices easily located by and accessible to the public?</td>
<td></td>
</tr>
</tbody>
</table>

## 4 Management of resources

### 4a Social workers

How does expenditure on field work, management and administration compare with other SSDs, taking account of differing client case loads?

Are there clear guidelines on the responsibilities and case levels of staff in different grades?

How does management allocate case work between staff of different grade, experience and ability?

Is there sufficient information to enable work loads to be assessed?

Is there evidence that the work load is monitored to ensure equitable case loading and satisfactory case progress?

Are staffing levels adjusted in line with changes in number and type of referrals?
Performance Review in Local Government — Social Services

Review questions

How does grading structure compare with other authorities?

How many social workers are there per member of management and support staff?

What proportion of staff time is spent on in-house and external training?

4b Other staff

Are staffing levels based on reasoned criteria? How do they compare with other authorities?

Are staff working arrangements flexible enough to meet peaks and troughs in activity levels?

Do they provide for movement between establishments?

• Note that this may be constrained by the need for continuity of care.

Are the tasks of domestic and other staff clearly defined?

Is there adequate provision for training staff to cope with problems arising from changes in care patterns?

• For example, there tends to be a growing proportion of more difficult adolescents in residential care.

4c Premises and facilities

Are existing facilities fully utilised?

• The effect of progress in programmes of facility utilisation should be kept under review.

• Where appropriate, steps should be taken to improve occupancy, eg offering places to other local authorities, private and voluntary bodies.

• Space may need to be kept for emergencies and for respite cases.

Is there close liaison with neighbouring authorities and other providers to ensure that spare capacity is not overlooked?

Are all premises used by social services included in an Authority-wide energy management scheme?

How do premises maintenance costs compare with other authorities?

Key Indicators/References

% in each grade
Salary cost per employee (£)

[See: Managing Social Work More Effectively]

Clients per employee
Resident weeks per employee
Attendance days per employee

Job descriptions

Training days per staff member

Occupancy (%)
Attendance days % place days available
Hours provided % hours available

Normalised performance indicator
[See: Saving Energy in Local Government Buildings]

Cost per m² (£)
Cost per client week/day (£)
## Review questions

### 4d Supplies and transport

Are arrangements for buying provisions and other supplies satisfactory?

- Note that procedures and constraints on purchasing arrangements for and by clients should avoid 'care labels', eg local authority order books, standard clothing.
- MSC (through Sheltered Employment Procurement and Consulting Services and the Local Authorities Associations) has drawn up a catalogue of priority supplies for handicapped people, eg school books and equipment, supplies for sheltered workshops.

How do commodity prices compare with other authorities/other service departments?

Are the most economic modes of transport provided?

### 4e Costs and income

Overall how do the unit costs of various residential and day services provided compare with those in other similar authorities and with other services in the same authority?

- Note that high unit costs in residential care may denote that there are a large number of high dependency clients.

Are targets set by the Council for individual resource costs?

Is there full recovery of costs from other local authorities for non-residents?

Are charges for services assessed in good time and promptly collected?

What steps are taken to maximise income, eg from grants for sheltered workshops, sales from workshops and adult training centres?

## Key Indicators/References

<table>
<thead>
<tr>
<th>Review questions</th>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are arrangements for buying provisions and other supplies satisfactory?</td>
<td>Commodity prices&lt;br&gt;Cost per client week (£)&lt;br&gt;[See: Reducing the Cost of Local Government Purchases]</td>
</tr>
<tr>
<td>How do commodity prices compare with other authorities/other service departments?</td>
<td>Comparisons with other LAs/services of cost per passenger mile</td>
</tr>
<tr>
<td>Are the most economic modes of transport provided?</td>
<td></td>
</tr>
<tr>
<td>Overall how do the unit costs of various residential and day services provided compare with those in other similar authorities and with other services in the same authority?</td>
<td>Cost per client pa (£)&lt;br&gt;Cost per resident week (£)&lt;br&gt;Cost per attendance day (£)&lt;br&gt;Net cost per employee in sheltered accommodation (£)&lt;br&gt;Cost per child day in day care centres/nurseries/playgroups (£)&lt;br&gt;Cost per child week/year in observation and assessment centres/LA's own centres (£)&lt;br&gt;Cost per child fostered pa (£)&lt;br&gt;Cost per child week/year in community homes/LA homes/community homes with education/LA homes with education (£)</td>
</tr>
<tr>
<td>Are targets set by the Council for individual resource costs?</td>
<td></td>
</tr>
<tr>
<td>Is there full recovery of costs from other local authorities for non-residents?</td>
<td></td>
</tr>
<tr>
<td>Are charges for services assessed in good time and promptly collected?</td>
<td></td>
</tr>
<tr>
<td>What steps are taken to maximise income, eg from grants for sheltered workshops, sales from workshops and adult training centres?</td>
<td>Income % gross expenditure</td>
</tr>
</tbody>
</table>
Children

Introduction to the service
This chapter should be read in conjunction with the overview chapter on Management, Administration and Social Work.

Social Services Authorities (shire counties, London boroughs and metropolitan districts) are required to admit to care any child under 17 who is in need of care, where the Authority considers it necessary to do so in the child's interest. The reasons for doing so include:

- the lack of parents or guardian
- the parents or guardian are incapable of providing for the child adequately
- the child is abandoned or lost.

It is then the Authority's duty to keep the child in care up to the age of 18, where his/her welfare requires it. The Authority's major objective, however, should be the child's rehabilitation, and the vast majority of children in care eventually return to their own homes.

The Courts may also commit a child into the care of the Authority, which then has full parental rights. A care order may be removed only by the Court. Alternatively, the Court may make a supervision order placing the child under the supervision of the Authority. The reasons for making care or supervision orders include:

- the child's development or health is considered to be impaired or neglected
- the child is being abused or exposed to moral danger
- the child is beyond parental control
- the child is not being properly educated.

Social Services Authorities (SSAs) have a duty to provide preventive services which will help to avoid the need for a child to be admitted into care or to appear before a juvenile court.

They also have responsibilities in respect of adoption, the welfare of 'protected' children pending adoption, childminding, private fostering, registration and inspection of private children's homes, panels of guardians ad litem, and reporting officers, provision of welfare reports in other proceedings and provision of advice and information.

The legal requirements are complex yet allow considerable discretion to Social Services Authorities as to the form of care and other services provided.

Trends
The total number of children in care has fallen in recent years, both because the child population has fallen and because there has been a greater emphasis on preventive rather than care services. However, there has been an upsurge in the proportion of more difficult children in care. For those in care, the trend has been towards fostering and away from residential care. The fall in residential care has meant the closure of some community homes.

Intermediate treatment (IT) has grown in importance and is frequently specified by the Courts in making supervision orders.

Expenditure
In 1985/6 expenditure by SSAs in England and Wales on services for children was estimated at £535 million net (£11 per head of population). This did not, however, include the (considerable) cost of the time of social workers, managers and central support staff.
Other significant trends include the increases in numbers of children with childminders and playgroups.

Expenditure trends reflect these changes.

**Table 1**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>Fostered</th>
<th>In voluntary and community homes</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>100.6</td>
<td>33.1</td>
<td>40.1</td>
<td>27.6</td>
</tr>
<tr>
<td>1981</td>
<td>96.9</td>
<td>37.4</td>
<td>31.1</td>
<td>28.3</td>
</tr>
<tr>
<td>1982</td>
<td>93.2</td>
<td>38.7</td>
<td>27.7</td>
<td>26.8</td>
</tr>
<tr>
<td>1983</td>
<td>86.6</td>
<td>38.6</td>
<td>23.3</td>
<td>24.9</td>
</tr>
<tr>
<td>1984</td>
<td>78.9</td>
<td>37.9</td>
<td>19.1</td>
<td>21.9</td>
</tr>
</tbody>
</table>

(Source: *Reports to Parliament under Child Care Acts*)

**Table 2**

<table>
<thead>
<tr>
<th>Year</th>
<th>Nurseries</th>
<th>SSA</th>
<th>Private</th>
<th>Childminders</th>
<th>Playgroups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1976</td>
<td>27.0</td>
<td>24.5</td>
<td>64.3</td>
<td>368.8</td>
<td></td>
</tr>
<tr>
<td>1981</td>
<td>28.4</td>
<td>20.8</td>
<td>104.5</td>
<td>382.3</td>
<td></td>
</tr>
<tr>
<td>1982</td>
<td>28.6</td>
<td>21.9</td>
<td>101.3</td>
<td>385.2</td>
<td></td>
</tr>
<tr>
<td>1983</td>
<td>28.8</td>
<td>22.7</td>
<td>109.7</td>
<td>398.2</td>
<td></td>
</tr>
<tr>
<td>1984</td>
<td>29.1</td>
<td>24.1</td>
<td>121.1</td>
<td>403.2</td>
<td></td>
</tr>
</tbody>
</table>

(Source: *Ibid*)

**Current management issues**

The major issues for members and officers to consider are:

1. The numbers of children for whom preventive services, care services and rehabilitation have to be provided.
2. The nature of the services to be provided.
3. The efficient and effective management of the children's service.

**The nature and level of provision**

Establishing the numbers of children needing services requires a review of the demographic statistics for the local authority area, the past experience of the SSA and the means and criteria by which children at risk are identified.

The generally accepted view is that it is better not to disrupt a child's family relationship by taking him/her into care unless the family clearly cannot provide an acceptable level of parenting and there is no better alternative to local authority care. Hence the importance of preventive services (though...
voluntary reception into care can be a constructive part of 'prevention' by helping to avoid the necessity for compulsory committal to care following a court order, and improving the longer term prospects of rehabilitation or preventing a permanent breakdown in the family).

Close liaison with the Courts is required to ensure that Court disposals do not result in care orders being made unnecessarily. In criminal proceedings it is accepted that for most young people a non-custodial penalty is preferable and that detention centre and youth custody disposals should be reserved for those unable or unwilling to respond to the alternatives.

Care orders in criminal proceedings should not be made except where appropriate to the seriousness of the offence and where the child is in need of care or control he/she would not otherwise receive.

Preventive services include preschool playgroups, self-help (or family) centres, childminding, day nurseries, out of school supervision and activities, holiday schemes, preventive intermediate treatment and respite care and intensive work with families by field workers. Strong links with education, leisure, youth and community services, the police and probation services are important in preventive work.

The Child Care Act 1980 states 'In reaching any decision relating to a child in their care, a local authority shall give first consideration to the need to safeguard and promote the welfare of the child throughout his childhood; and shall so far as practicable ascertain the wishes and feelings of the child regarding the decision to give due consideration to them, having regard to his age and understanding.' This extract is central to an Authority's policies for children in care.

The first element in the provision of care is an assessment of need. There will usually be an initial assessment to meet immediate and short term requirements. There should be a comprehensive assessment as a basis for a long term plan and this involves consideration of all relevant information on the child and his family and close liaison with the other agencies concerned, for example LEA, DHA, GPs, Police, NSPCC, NAYPIC, family rights and parents' groups. Assessment may be conducted while the child is at an Observation and Assessment Centre.

Care may then take one of several forms:
- rehabilitation in the family home under social work supervision and other help, including the preventive services mentioned above
- fostering
- adoption
- custodianship
- residential care
  - community homes
  - community homes with education (formerly approved schools)
- provision other than this may include
  - formal intermediate treatment for young offenders, as an alternative to custody or informal IT for those at risk of offending
  - help for children leaving care to become independent.

The range of services available should enable social workers to reach decisions about meeting a child's needs on the basis of his/her best interests. There is a duty to attempt to re-unite a child with his/her family.

It is now generally accepted that, where the child's and parents' wishes
accord, fostering is preferable to residential care; but this also depends on the child's suitability for that course of action. In certain cases there may be positive benefit in some residential care.

Each case must be reviewed at least once every six months and the form of care provided may well alter as assessed needs change.

Effective assessment and review requires a high standard of information collation and maintenance which according to the Social Services Inspectorate (SSI) is not always attained.

Child care is a particularly difficult subject for reliable performance indicators and extreme care is needed in using indicators, especially in making comparisons between local authorities.

Though the numbers of children needing care may be expected to rise and fall with changes in the whole child population, the proportion of children actually in care varies for a number of reasons. Some of them, for example poor housing, are reflected in the GREA. Others include local family attitudes, socio-economic factors including unemployment, and the success with which the SSA pursues preventive policies.

Effectiveness is reflected in many ways including:
- the identification of children at risk
- the success or failure of preventing children needing to be received into care
- children successfully re-united with their families
- the provision of the necessary range of facilities and services appropriate to the needs of the area
- the reduction in child abuse cases
- the reduction of delinquent activities
- the general promotion of children's welfare in the area, so far as this can be judged
- time taken to determine and provide appropriate services.

Unfortunately, performance tends to be negatively observed, so that, for example, a small number of disastrous (and sometimes fatal) events are brought to light whilst the degree of success for the vast majority is not reported. Possibly DHSS and Social Services Inspectorate reports may provide a guide to effectiveness in the future.

The extent to which children are fostered in preference to being cared for in residential accommodation may provide indicators both of effectiveness (as being in the best interests of the children) and of efficiency (as being less costly to the community). However, it is most important that apparently unfavourable indicators of this kind are used simply to raise questions and not as a basis for comment in their own right.

Authorities with clearly defined child care policies will probably show a declining proportion of children in care or under supervision out of care per 1000 under age 18.

Management of resources
Within each form of provision unit costs provide useful bases of comparison, provided like is being compared with like. For example, community homes are grouped according to the age and 'difficulty' of the occupants and comparisons should relate to those groupings. Council policies on the
standard of provision must also be taken into account in making comparisons. Comparative exercises are best undertaken with the collaboration of the professional managers concerned.

Occupancy levels are a major factor in unit costs. However, the need to keep accommodation available for urgent cases needs to be recognised before suggesting that there may be under occupancy.

**Bibliography**

*Observation and Assessment* (1981) DHSS

*Foster Care*, 3rd Impression (1983) DHSS/Scottish Education Department/Welsh Office
Guidance to social workers and others involved.

*Intermediate Treatment Facilities approved by the Secretary of State* LA Circular 83(6) Annex (1983)
A guide to intermediate treatment.

*Social Services Committee Report on Children in Care – Second Report* (1983/4 Session)

*Social Work Decisions in Child Care* (1985) DHSS
Includes recent research findings and a 'True for Us?' series of exercises for social services managers.

Deficiencies found by SSI and recommendations for improvement (also Circular 86(6)).

One section deals with a client's view of performance in provision for the under fives including day nurseries, playgroups, mother and toddler groups etc.

*Inspection and Supervision of Social Workers in the Assessment and Monitoring of Cases of Child Abuse when Children Subject to a Court Order have been Returned Home* (1986) Social Services Inspectorate
Review of assessments standards, records and supervision.

*Social Services Planning and Control – Audit Guide, Audit Commission* (1985)
These documents describe the services and the problems and considerations for their management. They should be read before undertaking an audit review of child care.
Performance review guide

This section sets out a detailed series of questions which will help to guide the review and improvement of current management arrangements.

Some of the questions relate to policy matters to be decided by members, or are the professional responsibility of officers as their advisers. These questions are shown in italic. The auditor's interest is in ensuring that these issues have been addressed and that appropriate policies and management arrangements have been determined. Auditors should also be sensitive to such wider considerations when making judgements on resource usage.

Useful performance indicators and reference documents are shown alongside the relevant questions. Careful comparisons with other local authorities can provide a useful starting point for reviewing current practices. However, differences in the value of indicators between one authority and another, or between an authority and accepted norms, should never form the sole basis for conclusions. Rather they should lead to more searching enquiries into the circumstances which give rise to such differences, and the opportunities which exist for improvements to be made.

Review questions

<table>
<thead>
<tr>
<th>Numbers needing services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the Council and/or its Committees properly informed about trends in child population, the scale of deprivation, and progress in identifying children at risk?</td>
</tr>
<tr>
<td>Does the Council's capital programme and planning for disposition of properties reflect the trends revealed?</td>
</tr>
<tr>
<td>Does the Council have a declared philosophy and policy on child care reflected in an integrated child care strategy?</td>
</tr>
<tr>
<td>Are the arrangements for identifying children in need of preventive, care and rehabilitative services (including day care services) adequate?</td>
</tr>
<tr>
<td>What are the main routes for admission into care?</td>
</tr>
</tbody>
</table>

Key Indicators/References

- Child population % total population
- % child population received into care
- % received into care
- % committed into care
- % place of safety orders
- % parental rights resolutions
- Policy statement
- [See: Child Abuse]
### Review questions

<table>
<thead>
<tr>
<th>2 Nature of provision</th>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2a Overall</strong></td>
<td></td>
</tr>
<tr>
<td>Do the Council's policies include the criteria for admission to and selection of type of care?</td>
<td>Policy statement exists and is in the possession of, and understood by, SSD staff</td>
</tr>
<tr>
<td>Are policy objectives adequately communicated to members, social services staff, the public and particularly to the natural parents?</td>
<td>Proportion of children receiving different forms of care, eg residential homes, CHE, IT (%)</td>
</tr>
<tr>
<td>Are standards of service clearly set out for each form of provision? How do these compare with other local authorities?</td>
<td>Time between child reported at risk and determination of need</td>
</tr>
<tr>
<td>Are strategies and standards for different forms of child care (eg day care, fostering, residential care) internally consistent?</td>
<td></td>
</tr>
<tr>
<td>What sort of image does Council provision have in the Community?</td>
<td>Attitude surveys</td>
</tr>
<tr>
<td>• For example, in one London borough council priorities on allocating places in day nurseries led to a stigma being attached to council provision.</td>
<td>Press reports</td>
</tr>
<tr>
<td><strong>Does liaison with the police and the Courts result in the following order of disposal preferences being observed?</strong></td>
<td>Disposals compared with SSD advice</td>
</tr>
<tr>
<td>a) Police cautioning</td>
<td></td>
</tr>
<tr>
<td>b) Fines and conditional discharges</td>
<td></td>
</tr>
<tr>
<td>c) Preventive services, eg informal intermediate treatment</td>
<td></td>
</tr>
<tr>
<td>d) Supervision Order with requirements, eg formal Intermediate Treatment</td>
<td></td>
</tr>
<tr>
<td>e) Care order</td>
<td></td>
</tr>
<tr>
<td>f) Detention centre</td>
<td></td>
</tr>
<tr>
<td>g) Youth custody</td>
<td></td>
</tr>
</tbody>
</table>
Review questions

2b Preventive services

Are preventive services the first consideration so far as possible, to avoid the need for the child being admitted into care?

- SSAs have a duty to provide preventive services.
- These include:
  - preschool playgroups
  - support for parents
  - self-help centres
  - mother and toddler groups
  - encouragement of childminding
  - day nurseries
  - out of school supervision and activities
  - holiday schemes
  - preventive intermediate treatment
  - respite care to give parents a break.

Are preventive services successful in reducing the numbers of children in care? How is that success assessed?

Key Indicators/References

<table>
<thead>
<tr>
<th>Children Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion cases in receipt of preventive services</td>
</tr>
<tr>
<td>Numbers of places and % taken up</td>
</tr>
<tr>
<td>Numbers of childminders/children needing minding</td>
</tr>
<tr>
<td>Numbers of places and % taken up</td>
</tr>
<tr>
<td>[See: Social Work Decisions in Child Care (p51) for a more complete list]</td>
</tr>
<tr>
<td>Trends in % clients in 'care'</td>
</tr>
</tbody>
</table>

2c Assessment, observation and review of children in care

Is there a comprehensive multi-disciplinary assessment for each child as the basis for a long term plan as well as immediate and short term action?

Is it speedily as well as thoroughly undertaken?

How frequently are assessments reviewed?

- The views of parents and children (where they are old enough) should be heard and considered in making assessments and reviewing them.
- Adequate assessment and review is not possible without fully documented information.

What evidence is there of past success in achieving short term and long term objectives?

Is there provision for identifying children requiring permanent family placement, whether long term fostering, custodianship or adoption or other permanent placement such as small group residential homes?

Are parents kept closely informed about decisions and the reasons for making them?

 Fully documented assessments available
 % children for whom no objectives have been set
 Time under assessment (excluding remand cases)
 Time spent on comprehensive assessment
 At least once in six months

[See: Reports on Child Abuse]

Complaints

[See: Social Work Decisions in Child Care]
**Review questions** | **Key Indicators/References**
--- | ---
Does the Authority monitor children in care to ensure that their needs are being met and that they are discharged from care as soon as it is in their interests to be so?
- Children who are the subject of care orders can only be removed from care with the authority of the Court. | Average length of time in care

### 2d Fostering

Is there a policy of positive encouragement of fostering (including the setting of targets) wherever residential care is not the most appropriate treatment? If so, has the proportion of children being fostered increased?

Does the Authority have staff with full time responsibility for approving foster parents?

Are there regular reports to Council/Committee which show progress in fostering children, including the costs of so doing?

**Is there any evidence of undue numbers of fostering breakdowns?**

**Key Indicators/References**
- Proportion of children in care fostered (%)
- New foster parents per homefinder pa
- Expenditure per fostered child (£)
- Failures % total fostered cases

### 2e Adoption

Is there a Council policy to encourage adoption in all suitable cases? If so, have specialist adoption officers been appointed?

- There is a statutory requirement to provide services for adoption, either directly or by agreement with an approved society. These could include post adoption support and counselling of adult adopted persons.

Has the appointment of specialist officers resulted in increased rates of adoption?

Does the Authority have an Adoption Allowance Scheme?

Is the adoption service well publicised and is progress regularly reported to Council/Committee?

**Key Indicators/References**
- Adoptions % children in care pa
- Children in care per FTE adoption officer
**Review questions**

<table>
<thead>
<tr>
<th>2f Residential accommodation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does Council policy require admission to residential care to be restricted to children for whom this is the best option in the light of their individual needs and requirements?</td>
</tr>
<tr>
<td>Does Council provision and the capital programme take account of changes in the balance of care forms, eg increases in fostering?</td>
</tr>
<tr>
<td><em>Is stay in residential accommodation maintained at the minimum necessary in the interests of the child and given the current availability of other forms of care?</em></td>
</tr>
<tr>
<td>What is Council strategy for after-care, eg preparation of youngsters for leaving care?</td>
</tr>
<tr>
<td>Are there adequate arrangements for liaison with other services to achieve it?</td>
</tr>
<tr>
<td>Is the implementation of the strategy monitored?</td>
</tr>
<tr>
<td>What evidence is there of the eventual outcome of care?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children per 1000 child population in residential accommodation</td>
</tr>
<tr>
<td>Children in care in residential accommodation (%)</td>
</tr>
<tr>
<td>Disposal of surplus premises</td>
</tr>
<tr>
<td>Average length of stay</td>
</tr>
<tr>
<td>[See: Child Abuse, and SSI Report]</td>
</tr>
<tr>
<td>[See: Circular CI (86)6]</td>
</tr>
<tr>
<td>Committee reports</td>
</tr>
</tbody>
</table>

**3 Management of resources**

See general checklist of questions on pages 13–15
Elderly People

Introduction to the service
This chapter should be read in conjunction with the overview chapter on Management, Administration and Social Work.

Councils in shire counties, metropolitan districts and London boroughs have powers to provide a wide range of services for the elderly. Generally they have great discretion in the level of services provided, but an element of obligation is introduced by statutory requirements to provide adequate home help services and services for mentally or physically handicapped or mentally ill people who may also be elderly.

The services provided for elderly people include day care, meals on wheels, residential care, sheltered housing, aids and adaptations, TV licences and a range of domiciliary services, including home helps.

Care of the elderly is generally the responsibility of social services departments (SSDs). However, sheltered accommodation and other dwellings suitable for the elderly are provided by housing departments, including those in shire districts. In these cases there may be financial and other contributions from the SSD. Sheltered and other housing may also be provided by housing associations, private and voluntary bodies.

In addition, district councils may provide meals on wheels, holidays, TV licences and recreational facilities.

Though only 15% of elderly people actually receive local authority care of some kind, the proportion increases as age reaches 75 and over and this is the group which is expected to increase the most in coming years.

Trends
The elderly population, defined as men 65 years and over and women 60 years and over, has grown both in numbers (4.3 million in 1931 to 9.7 million in 1981) and as a proportion of the population (6% to 18%). Projections from 1981 to 2031 show increases of 34% in the elderly population as a whole and 59% for those aged 75 and over, compared with 3% for those under 65. Clearly population changes of this magnitude have quite profound implications for the national and local economy and for health and social services. For example, Table 1 shows how the proportions of elderly people in residential care increase with age.

<table>
<thead>
<tr>
<th>Age</th>
<th>65</th>
<th>70</th>
<th>75</th>
<th>80</th>
<th>85</th>
<th>90</th>
<th>95</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>0.5</td>
<td>1.8</td>
<td>3.0</td>
<td>5.1</td>
<td>9.2</td>
<td>17.8</td>
<td>40.9</td>
</tr>
<tr>
<td>Females</td>
<td>0.4</td>
<td>1.8</td>
<td>4.1</td>
<td>7.4</td>
<td>15.1</td>
<td>24.7</td>
<td>43.1</td>
</tr>
<tr>
<td>Total</td>
<td>0.4</td>
<td>1.8</td>
<td>3.6</td>
<td>6.5</td>
<td>13.1</td>
<td>22.8</td>
<td>42.6</td>
</tr>
</tbody>
</table>

(Source: Social Trends (1986))
In real terms, local authority expenditure on services for the elderly has diminished. The proportion of elderly persons in residential care has also fallen, although the actual numbers have remained constant.

Many places are now provided in private homes (see Table 2) where growing numbers of elderly people are supported by supplementary benefits/board and lodging payments. In many areas there are now more resident places in the private sector than are provided by the local authorities, which are closing down some of their facilities. There is also a trend to withdrawing support from agency placements outside the area, leaving support to the DHSS.

Table 2
Residential accommodation for elderly people aged 65 or over
(United Kingdom 000s)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Homes provided by local authorities</td>
<td>105.6</td>
<td>121.7</td>
<td>122.3</td>
<td>120.9</td>
</tr>
<tr>
<td>Registered voluntary and private homes</td>
<td>46.3</td>
<td>65.3</td>
<td>76.7</td>
<td>87.9</td>
</tr>
<tr>
<td>Total residents in homes</td>
<td>151.9</td>
<td>187.0</td>
<td>199.0</td>
<td>208.8</td>
</tr>
</tbody>
</table>

* England and Wales only

(Source: Social Trends (1986))

Against this there has been an increase in the provision of home helps, though not to the extent recommended in the DHSS guidelines issued in 1972 to be achieved by 1983.

Overall, the trend is to provide day care which enables elderly people to live their lives in their own homes for as long as possible, for both social and economic reasons.
Performance Review in Local Government — Social Services

Current management issues

The main issues for management are:

1. Estimating the current and future numbers of elderly people needing care, and agreeing a joint strategy with NHS and voluntary organisations on the scale and nature of provision.
2. Managing services efficiently and effectively.

Estimating the number of elderly people in need of care is difficult. Census data will show the number of elderly people and those in certain vulnerable groups, for example those living alone. However, membership of a vulnerable category does not necessarily equate either with actual need for or a wish to receive a service; nor is non-membership a guarantee of lack of need. Moreover, many elderly persons are in reasonable physical condition and anxious to remain on their own or in the care of their relatives but are (unknown to them) mentally incapable of doing so.

The call for a service will also depend on local conditions, for example family traditions, the history of social service provision, the perceived quality of services provided and the political views of the Council. The Seebohm Committee (1968) was certain that without an early detection system 'suited to local circumstances', an adequate overall service could not be provided.

Many people apply for care, and others are referred by the National Health Service, relatives, voluntary organisations or other social services sections. A review of the home help service by Cheshire County Council, for example, showed the following sources of referral.

<table>
<thead>
<tr>
<th>Table 3</th>
<th>Source of referral of client (Cheshire County Council 1980)</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Primary and secondary health care</td>
<td>61</td>
</tr>
<tr>
<td>Self-referral or relatives</td>
<td>22</td>
</tr>
<tr>
<td>Social services</td>
<td>10</td>
</tr>
<tr>
<td>DHSS</td>
<td>3</td>
</tr>
<tr>
<td>Voluntary organisations, etc</td>
<td>1</td>
</tr>
<tr>
<td>Don't know/not answered</td>
<td>4</td>
</tr>
<tr>
<td><strong>Base for %</strong></td>
<td><strong>926</strong></td>
</tr>
</tbody>
</table>

All public aid to the elderly is expensive but hospital (NHS) and residential care (social services) generally make a much greater call on resources than other care within the community. Since most people value independence and there is an internationally held view that the elderly should 'live in their own homes as long as possible', limiting residential care to highly dependent persons who cannot be otherwise satisfactorily cared for is clearly effective as well as economic and efficient. (However, note that some packages of intensive domiciliary care may not invariably be cheaper.)

Taking social service department residential accommodation as 100, the relative cost of some other types of care is as follows:
The proliferation of possible forms of support requires a sophisticated approach to the determination of care given.

It is most important that policy planning relating to the provision of services should be undertaken in close cooperation with the NHS, Housing Authorities and private and voluntary organisations. In particular the means by which private sector provision is financed, for example by supplementary benefit or local authority support, should be taken into account.

The quality of private provision may not always reach local authority standards and this needs to be considered in comparing the two. Local authorities are responsible for registering and inspecting private residential accommodation. The application of the same criteria of assessment might be regarded as a measurement of one aspect of effectiveness.

Generally, performance measurement in this area is difficult, and effectiveness is best assessed by reference to the SSD's aims and objectives. If, for example, the policy is to place an emphasis on domiciliary care, there should be a decreasing proportion of persons in residential care. However, an assessment in this case would need to take account of any changes in the age structure.

Any general assessment of performance needs to take account of all services available to the elderly, whether provided by the SSD or not.

Unit costs provide a basis for assessing management efficiency and economy for each form of provision, for example comparisons between different homes for the elderly. In making this sort of comparison, account needs to be taken of the levels of dependency of the residents as well as of the conscious provision of higher standards of care. In looking at unit costs it is important to take account of factors such as social security payments, housing benefits, home helps etc.

Local authorities must make a charge for residential accommodation but charges above prescribed criteria are at their discretion. The basis for charging should be the cost at full occupancy (subject to ability to pay – though many residents will be in receipt of supplementary benefit). Charges for home help services are discretionary and in many authorities the cost of assessment and collection is regarded as too high to merit charges being made.

Bibliography

A review of the use of home helps.

Report of the Committee on Local Authority and Allied Personal Social Services (1968) White Paper Cmnd. 3703
The Seebohm Report on Social Services.
Home Help: key issues in service provision, Rodney Hedley and Alison Norman (1982) Centre for Policy on Ageing
A review of the home help services including guidelines on provision and examples of priority setting.

Sets out facilities available for the elderly which ensure their independence as far as possible.

Report of a working party sponsored by the DHSS on standards for private homes.

Housing and Elderly People (1985) City of Wakefield MDC
A report on housing needs in Wakefield which gives useful descriptions of the different forms of provision available.

Home Truths, Tim Booth (1985) Sheffield University
Results of study of elderly people in residential care by Joint Unit for Social Services Research at Sheffield University.

Deals with the totality of provision for elderly people including their needs for transport, leisure services etc.

Social Services: Provision of Care to the Elderly (1983) HMSO
Managing Social Services for the Elderly More Effectively (1985) HMSO
These three documents provide guidance to auditors on reviewing services for the elderly.
Performance review guide

This section sets out a detailed series of questions which will help to guide the review and improvement of current management arrangements.

Some of the questions relate to policy matters to be decided by members, or are the professional responsibility of officers as their advisers. These questions are shown in italic. The auditor's interest is in ensuring that these issues have been addressed and that appropriate policies and management arrangements have been determined. Auditors should also be sensitive to such wider considerations when making judgements on resource usage.

Useful performance indicators and reference documents are shown alongside the relevant questions. Careful comparisons with other local authorities can provide a useful starting point for reviewing current practices. However, differences in the value of indicators between one authority and another, or between an authority and accepted norms, should never form the sole basis for conclusions. Rather they should lead to more searching enquiries into the circumstances which give rise to such differences, and the opportunities which exist for improvements to be made.

### Review questions

<table>
<thead>
<tr>
<th>1 Scale and nature of provision for elderly people needing care</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a Estimates of need</td>
</tr>
</tbody>
</table>

*Has the Council produced a clear statement of policy on the scale and nature of services to be provided for elderly people?*

*If so, is it based on an analysis of relevant information on demographic trends and the likely numbers needing Authority services?*

*Is the policy aimed at providing services which enable elderly people to live independently in their own homes or with their families wherever that is appropriate?*

*What are the arrangements for identifying elderly persons in need of care? Are they proactive or responsive?*

*Are the needs of mentally ill and handicapped elderly people adequately provided for?*
  *The incidence of senile dementia increases with age, giving rise to a need for appropriate residential care or support for home carers.*

### Key Indicators/References

- **Statement of policy exists and is in the possession of, and understood by, SSD staff**
- **Elderly population <75**
- **75–85**
- **>85**
- **% elderly needing services**
- **% elderly needing residential care**
- **% elderly under 75 in residential accommodation**
- **% elderly 75 and over in residential accommodation**
- **% elderly under 75 in receipt of day care and domiciliary services**
- **% elderly 75 and over in receipt of day care and domiciliary services**
- **Reports and records of elderly people in the area**
- **Number visited**
### Review questions

<table>
<thead>
<tr>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do the proportions of persons receiving services compare with other local authorities?</td>
</tr>
</tbody>
</table>

#### 1b Liaison

Has the Council agreed with the District Health Authority, the Family Practitioner Committee, Housing Authorities, neighbouring Social Services Authorities and private and voluntary organisations on the nature of services to be provided, who is to provide them and how they are to be financed?

Is there a positive liaison with others providing domiciliary services, e.g., Community Nurses (Family Practitioner links), Community Psychiatric Nurses (Consultant links), Age Concern etc?

What are the arrangements for ensuring that the housing needs of the elderly are met?

- Arrangements would include agreement with housing authorities and housing associations to provide suitable dwellings and sheltered accommodation, including where appropriate alarms, aids, adaptations, warden service etc.
- Many authorities do not keep waiting lists as such. Others who do may include people who have no prospect of receiving accommodation or other services.

#### 1c Service delivery

**Are there agreed criteria for the provision of different forms of care, and are quality standards laid down by the Council for the various forms of provision?**

**Are assessments and subsequent reviews of dependency and need undertaken by a multi-disciplinary team, especially for admission to old people's homes?**

How long are the waiting lists for the various services for elderly people? Does the Council keep them under review?

What steps are taken to reduce waiting lists to acceptable levels?

- Places may be sought in facilities run by other local authorities, and private or voluntary bodies and/or additional provision may be planned.

What are the arrangements for seeking the views of clients on the services provided?

---

Reports and correspondence
Minutes of meetings

[See: Staying at Home and Housing and Elderly People]

Placings in sheltered and other dwellings
Dwellings covered by warden service
Alarms etc installed
Waiting lists

Statements of standards
Complaints

Dates of initial and review assessments

Average waiting time for priority groups

Effects upon waiting times

Attitude surveys
### Review questions

<table>
<thead>
<tr>
<th>Community services</th>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td>How does Council policy provide positive support for the elderly in enabling them to live independent lives within their own homes wherever possible?</td>
<td>[See: Managing Social Services for the Elderly More Effectively]</td>
</tr>
<tr>
<td>How does Council policy provide positive support for the elderly in enabling them to live independent lives within their own homes wherever possible?</td>
<td>Trends in admissions to residential care</td>
</tr>
<tr>
<td>- Domiciliary services are normally provided as packages rather than as individual services and include the following:</td>
<td>Net expenditure per 1000 elderly</td>
</tr>
<tr>
<td>- aids and adaptations, eg stair lifts, showers, ramps, heating improvements, alterations to steps and doors, handrails, household repairs</td>
<td>Net expenditure on domiciliary services % total net expenditure on elderly</td>
</tr>
<tr>
<td>- financial support for TV licences, telephones etc</td>
<td>[See: Staying at Home]</td>
</tr>
<tr>
<td>- alarm systems, eg radio alarms with mobile wardens or central point, flashing lights, telephones (usually provided by the housing department as part of a balance of provision of sheltered accommodation and central alarms)</td>
<td></td>
</tr>
<tr>
<td>- visiting wardens</td>
<td></td>
</tr>
<tr>
<td>- 'good neighbours'</td>
<td></td>
</tr>
<tr>
<td>- home carers providing a wide range of domestic care</td>
<td></td>
</tr>
<tr>
<td>- home helps providing help with household tasks</td>
<td></td>
</tr>
<tr>
<td>- meals on wheels</td>
<td></td>
</tr>
<tr>
<td>- occupational therapy.</td>
<td></td>
</tr>
<tr>
<td>• Support services outside the home include:</td>
<td>[See: Home Help: key issues in service provision, and Coventry Home Help Project]</td>
</tr>
<tr>
<td>- day care centres</td>
<td>Attendances at day care centres</td>
</tr>
<tr>
<td>- luncheon clubs</td>
<td>Meals taken</td>
</tr>
<tr>
<td>- holidays and outings.</td>
<td>Numbers taking holidays and outings</td>
</tr>
</tbody>
</table>

Are home carers informed of available social security benefits, eg attendance allowances? | | |

Are home carers informed about respite care facilities, eg for persons caring for EMI relatives? | Respite care days provided |

### Residential accommodation

*Is residential accommodation graded according to the dependency of residents?*

Is some residential accommodation kept available for emergencies and for respite care?
2 Management of services

Are criteria laid down for the delivery and periodic review of domiciliary and other community services, eg frequency of attendance, home help hours, meals to be provided etc?

How do these compare with other authorities?
- Note that a higher than average expenditure on these services may enable much less expenditure of other local authority and/or NHS resources.

How do levels of expenditure on community services compare with other authorities?

See also general list of questions on pages 13–15 which have particular relevance to residential care.

Key Indicators/References

See: Managing Social Services for the Elderly More Effectively

Net expenditure per 1000 elderly (£)
Gross cost per hour, eg home helps (£)
Hours per case
Gross cost per attendance day, eg at day centres (£)
Gross cost per meal (£)
Cases per home help organiser
Mentally Handicapped People

Introduction to the service
This chapter should be read in conjunction with the overview chapter on Management, Administration and Social Work.

About 0.3% of the population are severely mentally handicapped. Many other people have a degree of handicap calling for a widely varying range of support from the social services department (SSD) and/or from other public, private or voluntary organisations. Some mentally handicapped people are also physically handicapped or suffer from mental illness or personality disorder. In 1980, it was estimated that the numbers of people with mental handicap varied from area to area within a range of 2.9 to 3.4 per 1000 population.

Most mentally handicapped people live independently or with their families. 90% of mentally handicapped children live at home. However, the proportion in residential care increases with age and 60% of severely mentally handicapped adults receive institutional care.

The main services required by mentally handicapped people are:

a) prevention or early detection of mental handicap so far as practicable
b) comprehensive assessment of abilities and needs (by a multi-disciplinary team) and periodic reassessment
c) coordinated advice, support and practical help for their families
d) education, social and work training, day care and occupation or employment according to individual capacity
e) residential accommodation appropriate to need.

Local authorities provide a wide range of facilities to meet these requirements for clients living at home or in residential accommodation. These include sheltered employment, and day care services such as social work support, special care and activity units, social centres or social education centres including facilities for those needing special care.

Trends
Table 1 illustrates changes which have taken place in recent years. The trend away from NHS to SSD residential care which followed the 1971 White Paper 'Better Services for the Mentally Handicapped' is evident. If projected targets are realised, the balance of care between hospitals and SSD residential accommodation will have moved from 91:9 in 1969 to 49:51 in 1991.

The figures for adult training centres (ATCs) also include some people in residential care. Falling NHS provision brings greater pressures for providing more ATC places.

Expenditure
SSDs in England and Wales spent an estimated £232 million net on services for people with mental handicap in 1985/6 (under £5 per head of population). Services are also provided by the NHS, Manpower Services Commission, Housing Authorities, Local Education Authorities (special education) and many voluntary and private organisations.
Table 1
Care for mentally handicapped people in England (000s)

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital places</th>
<th>Residential places</th>
<th>SSD</th>
<th>Private/voluntary</th>
<th>ATCs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1959</td>
<td>56</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1974</td>
<td>51</td>
<td></td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1979</td>
<td>46</td>
<td></td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1980</td>
<td>44</td>
<td></td>
<td>11</td>
<td></td>
<td>42</td>
</tr>
<tr>
<td>1981</td>
<td>43</td>
<td></td>
<td>11</td>
<td>4</td>
<td>44</td>
</tr>
<tr>
<td>1982</td>
<td>42</td>
<td></td>
<td>11</td>
<td>4</td>
<td>45</td>
</tr>
<tr>
<td>1983</td>
<td>40</td>
<td></td>
<td>12</td>
<td>5</td>
<td>47</td>
</tr>
<tr>
<td>1984</td>
<td>38</td>
<td></td>
<td>12</td>
<td>5</td>
<td>47</td>
</tr>
</tbody>
</table>

(Source: Health and Personal Social Services Statistics for England (1985))

It is also of note that, for some groups at least, the life expectancy of mentally handicapped persons is now similar to that of the general population.

The graph shows the growth in local authority expenditure in real terms since 1979.

MENTALLY HANDICAPPED PEOPLE

Gross expenditure at constant value (£ millions)

130 150 170 190 210 230 250 270 290 310 330 350
78/79 79/80 80/81 81/82 82/83 83/84 84/85 85/86 86/87 87/88
Current management issues

The main issues are:

1. Identifying mentally handicapped people in need of services, in cooperation with the NHS, other local authority services and private and voluntary organisations.
2. Assessing and periodically reviewing the nature of the services needed and by whom they are to be provided.
3. Where appropriate, helping to find suitable employment - open or sheltered - and training in cooperation with the MSC and other bodies.
4. Managing the Authority's own facilities efficiently and effectively.

The number of people with mental handicap is becoming more reliably known because since the early 1970s most will have passed through the special education system. There is a need for authorities to have registers or some other record identifying mentally handicapped people.

It is essential that local authorities do not act in isolation in caring for mentally handicapped persons. Joint planning with the NHS and the private and voluntary organisations as well as with education and housing departments should be the norm. In some cases there is joint financing of projects by the District Health Authority (DHA) and the Authority.

Certain local authorities, (for example Somerset, East Sussex (Brighton), Hillingdon) are taking over almost all the services for mentally handicapped people. Such moves are helped by the permanent transfer of funds from the NHS to the local authority (dowries). There is, however, some divergence of view as to the effectiveness of such schemes.

In many areas Community Mental Handicap Teams have been established. Their functions vary from area to area but normally focus on planning, service development or service delivery. The National Development Team for Mentally Handicapped People (NDT) recommend that regular members of CMHT’s would be nurses trained and experienced in mental handicap, social
workers, consultants in mental handicap, clinical psychologists, occupational therapists, physiotherapists and speech therapists.

Coordinated policies on provision need to include measures to ensure adequate after-care facilities exist to deal with persons discharged from hospital or residential care. In some areas Community Mental Handicap Teams oversee the care of clients living independently or with their families. It is also common practice to nominate key workers for all clients to ensure continuity and completeness of the services provided. This is especially important in view of the planned closure by the NHS of some long stay institutions.

Introducing services for groups of mentally handicapped people can initially bring conflict with the public in localities where facilities are being set up. The Council can help to overcome this and make a major contribution generally by efforts to educate the public in the nature of mental handicap, enlist their support and encourage voluntary help.

Evaluating effectiveness of services is difficult because of the varied nature and extent of clients' needs, abilities and skills, as well as their self-reliance and family support. The involvement of the NHS and other bodies also adds complexity. Moreover a client's needs will vary over time. Careful assessment of need is the key to effective performance and would normally include some statement of expected progress for each client. The extent to which that progress is achieved would reflect on the effectiveness of either the assessment or the service provided or both.

Services need to be dynamic enough to respond to changing needs, and the emphasis should be on rehabilitation.

Other indicators could be derived from more general policy aims, for example the extent to which emphasis on support to clients and/or their families in their own homes results in both client satisfaction and a shift away from residential care.

Waiting times for service provision are also useful indicators of effectiveness.

The National Development Group for the Mentally Handicapped has drawn up a checklist of standards for improving services in the form of a series of principles which cover the range of services available, from antenatal care through childhood and adult life to eventual arrangements for the client's funeral.

Pointers to management efficiency may be drawn from unit costs and occupancy or attendance levels but great care is needed in doing so.

It needs to be recognised that the extent of involvement by the Authority in this service largely depends on historical and demographic factors, viz:

- the established balance between provision by the SSD and by other bodies
- socio-economic factors, sub-cultural attitudes and attitudes of local employers.

These factors make inter-authority comparisons difficult. In particular, in some areas the extent of family care may have reduced the numbers of mentally handicapped adults recorded. The needs of others may come to light only when employment is lost, for example local sentiment may secure employment with a parent's employer which is maintained until the firm's closure or parental death leaves the handicapped person in need of care.
Bibliography

Better Services for the Mentally Handicapped (1971) White Paper Cmnd. 4683
Still the basis of government policy for the care of mentally handicapped people.

Mental Handicap: Progress, Problems and Priorities, DHSS (1980) HMSO
Reviews progress since the 1971 White Paper.

Improving the Quality of Services for Mentally Handicapped People (1980)
National Development Group for the Mentally Handicapped
A checklist of standards for services provided for mentally handicapped people.

Housing for mentally ill and mentally handicapped people, Jean Ritchie and Jill Keegan (1983) HMSO
Report on a study undertaken for the DOE.

Helping Mentally Handicapped People with Special Problems (1984) DHSS
A review of good practice in services for mentally handicapped people particularly those with special needs. Includes lists of key points for practitioners and managers.

Community Care – Second Report from House of Commons Social Services Committee (1985) HMSO
Deals with main aims of care for handicapped people.


Reviews and comments on developments in service provision.

Social Services: Care of Mentally Handicapped People, Audit Inspectorate (1983) HMSO
This report deals with the subject in some detail.

A pilot study report on the management of social work.
**Performance review guide**

This section sets out a detailed series of questions which will help to guide the review and improvement of current management arrangements.

Some of the questions relate to policy matters to be decided by members, or are the professional responsibility of officers as their advisers. These questions are shown in italic. The auditor's interest is in ensuring that these issues have been addressed and that appropriate policies and management arrangements have been determined. Auditors should also be sensitive to such wider considerations when making judgements on resource usage.

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### Review questions

<table>
<thead>
<tr>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td>[See: Mental Handicap: Progress, Problems and Priorities]</td>
</tr>
</tbody>
</table>

#### 1 Identifying needs for services

Does the SSD know how many mentally handicapped people it has in the area?

- Some authorities maintain registers.
- Nationally numbers range from 2.9 to 3.4 per 1000 population.

Is there, in practice, joint planning with the NHS, MSC, LEAs, Housing Authorities, neighbouring local authorities, private and voluntary bodies to provide appropriate services for mentally handicapped persons in need of care?

- Some LAs are taking over all services for the mentally handicapped except for primary health care and necessary hospital treatment. This involves the permanent transfer of funds (dowries) from the NHS.

Is planning supported by a Joint Care Planning Team?

- The team would have representatives from the SSD, NHS, LEA, housing department, MSC (the Disablement Resettlement Officer), voluntary organisations and parents.
**Review questions**

<table>
<thead>
<tr>
<th>What steps are taken to prevent mental handicap or ensure early detection, assessment and subsequent support?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The potential for prevention is considerable but this is almost entirely health led, except for broad attention to health education and social conditions.</td>
</tr>
<tr>
<td>• Schools may contribute to the detection of unrecognised mental handicap. This depends on the alertness of teachers and good contacts with the School Psychology Service. Early intervention and support is dependent on good working links between schools, social services and health authorities.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td>[See: Improving the Quality of Services for Mentally Handicapped People]</td>
</tr>
<tr>
<td>Reports from child assessment centres</td>
</tr>
</tbody>
</table>

---

**2 Nature of services provided**

Is there a Council statement of policy on services for mentally handicapped people?  

Is the policy emphasis on supporting clients' independence in their own homes or with their families wherever that course of action is suitable?  

Is that policy reflected in the allocation or reallocation of resources?  

• DHSS guidelines suggest that total residential provision for the mentally handicapped should be 153 places per 100,000 population. Currently, the NHS provides 95–106 of these places on average but this is likely to fall.  

How successful is the Council in achieving its objectives?  

Is an early initial assessment of abilities and needs made by a multi-disciplinary team?  

Are there periodic reassessments throughout the client's life?  

Are clients' families kept closely aware of assessments and proposed action?  

Is a training plan drawn up for each client?  

Is progress monitored?  

Are clients involved in the planning of services provided to them?  

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[See: Improving the Quality of Service for Mentally Handicapped People]  

Proportion clients in non-residential care (%)  

---  

[See: Improving the Quality of Services for Mentally Handicapped People]  

Reports from child assessment centres
### Review questions

| Has the Authority established Community Mental Handicap Teams in the area? |
| • The NDT recommends one team per 60–80,000 general population. |

| Are carers and clients living independently in the community informed about all services available and social security benefits payable? |
| • Services include counselling, day services (preschool playgroups, day nurseries, day centres) nursery and special education, occupational therapy, baby sitting, home helps, laundry, aids and adaptations etc. |
| • Attendance allowances are payable where constant attention is needed. |

| For what proportion of clients living with their families or in community placements are there specific plans for their future accommodation? |

| Is there provision for residential respite care for clients who live on their own but need a break from the strains of so doing or for clients whose families need a break? |

| How many respite care families have been recruited and how frequently are they used? |

| What other support services are provided to ease the burden on carers? |
| Do services include the provision of suitable housing including sheltered accommodation etc? |
| • This involves cooperation with housing associations, private and voluntary organisations. |

| Are there effective means of ensuring that mentally handicapped persons discharged from hospital or residential care, or whose care arrangements have broken down, receive appropriate further support? |

| Are efforts made where suitable to find foster parents for children with mental handicap, including day fostering? |

| Does the Authority seek adoptive families in suitable cases? |

| Is there a full range of day care services for mentally handicapped children and adults? |

| Are there sufficient places at ATCs? |

| Is there adequate liaison between ATCs and the special education system? |

### Key Indicators/References

| Take up of services and benefits |
| Key worker nominated |
| Contacts with Community Mental Handicap Team (CMHT) |
| Numbers in receipt of services |

| Documented plans |

| Residential respite care days |
| Number of clients receiving residential respite care |
| Number of placements with respite care families |

| Allocations of dwellings |
| [See: Community Care – Government Response to the Second Report] |

| [See: Improving the Quality of Services for Mentally Handicapped People, and National Development Team for Mentally Handicapped People Fourth Report 1981–1984] |

| Number fostered |

| Number adopted |

| Attendances |

| Places available |
| Places taken up |
Review questions

**Is there adequate liaison between FE colleges, the schools system and the SSD?**

What other facilities does the Authority provide, eg cooperatives, community placements?

**What steps are taken to avoid public anxiety about proposals to provide or continue the provision of facilities for mentally handicapped people?**

Are members kept informed about the numbers of people in care and awaiting care, and the types of care selected?

What do clients/carers/parents think of the services provided?

### 3 Finding employment and training

Are there arrangements, including close liaison with Disablement Resettlement Officers (DROs), for finding employment for clients?

- These would involve consideration of open employment, sheltered workshops, Sheltered Placement Schemes (SPS) and Adult Training Centres, generally in that order.
- 'SPS' – individual placement schemes through MSC – are often preferred by both LAs and clients because segregation is avoided. They are also less expensive.
- Local authorities should be able to advise employers about the MSC's Job Introduction Scheme and Fares to Work Scheme.

### 4 Management of facilities

See general list of questions on pages 13–15.
Mentally Ill People

Introduction to the service
This chapter should be read in conjunction with the overview chapter on Management, Administration and Social Work.

The total extent of mental illness is unknown, although in the 1975 White Paper 'Better Services for the Mentally Ill' it was estimated that 5 million people in England alone consulted doctors about mental health problems and 600,000 were in receipt of special psychiatric services. However, very few studies have been undertaken to identify the need for local authority services and most provision is reactive. This may be a factor in the relatively small proportion of cases receiving local authority care in one form or another.

Mental illness takes many forms and degrees of severity, some of which require long term hospital care. However, for most of the time the majority live within the community, at home or in social services accommodation. Only a relatively small proportion results in the provision of local authority care of one kind or another. Nevertheless, people may experience recurrence or resurgence of their illness and it is important for the social services department (SSD) to keep in touch with clients and to maintain their assessed needs under review.

The Mental Health Act 1983 places significant duties on SSDs for the appointment of approved social workers, the provision of alternatives to psychiatric hospital care and planned post-hospital care.

Trends
Table 1 shows the trend away from hospital inpatient to outpatient care and from NHS to local authority care. These were advocated in the 1975 White Paper 'Better Services for the Mentally Ill', which is still the basis of national policy. Care in unstaffed accommodation has grown particularly rapidly. This reflects a trend away from full residential care to providing support or rehabilitation to achieve independence in mutual support groups living in hostels or other dwellings supplied by the Council.

The graph shows a steady increase in gross expenditure in real terms by local authorities on mentally ill people – a confirmation of the trend in Table 1.

Expenditure
The total estimated expenditure on services for the mentally ill in 1985/6 was nearly £30 million net (less than £1 per head of population). Services for the mentally ill are, of course also provided by the NHS as well as the MSC, LEAs (special education) and a number of private and voluntary organisations and self-help groups.
### Table 1
Services for mentally ill people (England)

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitals</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Daily occupied beds</td>
<td>113</td>
<td>94</td>
<td>75</td>
<td>73</td>
<td>71</td>
<td>69</td>
<td>n/a</td>
</tr>
<tr>
<td>(000s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient attendances (000s)</td>
<td>1467</td>
<td>1603</td>
<td>1691</td>
<td>1727</td>
<td>1740</td>
<td>1761</td>
<td>n/a</td>
</tr>
<tr>
<td>Percentage in hospital less than one month</td>
<td>42</td>
<td>51</td>
<td>57</td>
<td>58</td>
<td>58</td>
<td>59</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Homes and Hostels</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local Authorities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Places in staffed premises</td>
<td>n/a</td>
<td>1716</td>
<td>2333</td>
<td>2467</td>
<td>2514</td>
<td>2557</td>
<td>2523</td>
</tr>
<tr>
<td>Places in un-staffed premises</td>
<td>n/a</td>
<td>482</td>
<td>1391</td>
<td>1514</td>
<td>1549</td>
<td>1616</td>
<td>1723</td>
</tr>
<tr>
<td>Voluntary and private places</td>
<td>n/a</td>
<td>1350</td>
<td>2142</td>
<td>n/a</td>
<td>n/a</td>
<td>2367</td>
<td>2558</td>
</tr>
<tr>
<td>Places in day centres</td>
<td>n/a</td>
<td>n/a</td>
<td>4967</td>
<td>4907</td>
<td>5025</td>
<td>5159</td>
<td>5332</td>
</tr>
</tbody>
</table>

(Source: Health and Personal Social Services Statistics for England (1985))

#### MENTALLY ILL PEOPLE

Gross expenditure at constant value (£ millions)

![Expenditure Graph](image-url)
Current management issues

The main issues for management are:

1. Identifying mentally ill persons in need of care, in cooperation with the NHS, MSC, private and voluntary organisations and other local authority services, for example education and housing departments.
2. Determining the nature of care needed and by whom it is to be provided.
3. Helping to find employment - open or sheltered - and training, where appropriate, in cooperation with the MSC and other bodies.
4. Managing facilities efficiently and effectively.

The Authority should not act in isolation in caring for people with mental illness. Joint planning with the NHS is essential, and the Authority should also have close relationships with neighbouring local authorities, the Disablement Resettlement Officer (DRO), private and voluntary organisations as well as with education and housing departments. In some cases there is joint financing of projects by the Authority and the District Health Authority.

Planning should include a clear definition of responsibility in respect of each mentally ill person.

The tendency towards recurrence or resurgence of mental illness means that there is a need for coordinated policies to ensure that adequate facilities exist to deal with people discharged from hospital or residential care. Among those arrangements would be clearly understood relationships between the hospital, family practitioner service, community nurses and social workers.

The residential services available include hostels for short stay care and rehabilitation; staffed homes where skilled support is available; unstaffed homes where clients manage with minimum support in bed-sitters or as a mutual support group sharing costs and chores; and supervised lodgings where the client lives in a sub-let room or as part of a family. The accommodation for staffed and unstaffed homes may be rented from the housing department, which may also provide sheltered dwellings.

Other local services which may be used in addition to residential care include day care, social clubs, home helps, occupational and speech therapy, training centres, sheltered employment, sheltered placement schemes and housing. Day provision takes a variety of forms (for example day treatment units, resource centres, community centres) which may be managed jointly or independently by the SSD, the Health Authority or voluntary bodies.

Developing community based services for groups of people with mental illness can bring conflict with the public in the areas where facilities are located. The Council can help to overcome this and make a major contribution generally by efforts to educate the public in the nature of mental illness, enlist their support and encourage voluntary help.

Local authority support is often needed by clients living in their own homes and by the client's family where they are caring for him/her. In both cases the availability of home helps, social work, respite care and other forms of support is important.
SSDs also have a role to play in preventive care (where circumstances permit) by identifying clients with early signs of mental illness, or subjected to conditions likely to bring it about.

Clients often need help in securing employment, and cooperation with Disablement Resettlement Officers is very important. In some cases sheltered employment may be appropriate.

Evaluation of effectiveness is difficult because of the varied nature of clients' problems and self-reliance, but the extent to which they manage in the community and/or in open employment could be established by existing research methods. The trend in the balance between residential and day care is readily available but obviously needs qualification by ascertaining client satisfaction as well as the shift away from residential care.

Waiting times for the provision of various services are useful indicators of effectiveness. The ease with which respite care can be arranged and people prone to occasional outbreaks of mental disorder can get treatment, possibly involving temporary residential accommodation, are particularly important factors.

The efficiency with which management uses its resources may be indicated by comparisons of unit costs and occupancy levels for the various services but these need to be analysed with great care.

It needs to be recognised that the involvement of any local authority in this service in a particular area will depend on local historical and demographic factors, viz:

- the changing balance between provision by the social services department (SSD) and by other bodies, NHS, private and voluntary organisations
- socio-economic factors, including local family attitudes.

These considerations make inter-authority comparisons difficult. In particular the extent of family care will affect the incidence of recorded cases.

Bibliography

Better Services for the Mentally Ill (1975) White Paper Cmnd. 6233
Still the basis of national policy.

Housing for mentally ill and mentally handicapped people, Jean Ritchie and Jill Keagan (1983) HMSO
Report on a study undertaken for the DOE.

Community Care – Second Report from House of Commons Social Services Committee (1985) HMSO
Deals with main aims of care for the handicapped.

White Paper Cmnd. 9674
Generally supports the Second Report and also recognises that a good quality community oriented service may be more expensive than a poor quality institutional one.
**Performance review guide**

This section sets out a detailed series of questions which will help to guide the review and improvement of current management arrangements.

Some of the questions relate to policy matters to be decided by members, or are the professional responsibility of officers as their advisers. These questions are shown in *italic*. The auditor's interest is in ensuring that these issues have been addressed and that appropriate policies and management arrangements have been determined. Auditors should also be sensitive to such wider considerations when making judgements on resource usage.

Useful performance indicators and reference documents are shown alongside the relevant questions. Careful comparisons with other local authorities can provide a useful starting point for reviewing current practices. However, differences in the value of indicators between one authority and another, or between an authority and accepted norms, should never form the sole basis for conclusions. Rather they should lead to more searching enquiries into the circumstances which give rise to such differences, and the opportunities which exist for improvements to be made.

### Review questions

<table>
<thead>
<tr>
<th>Review questions</th>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Identifying persons in need of care</strong></td>
<td></td>
</tr>
<tr>
<td>Is there close consultation and planning with the NHS, MSC, LEAs, Housing Authorities, neighbouring SSDs, private and voluntary bodies, in identifying mentally ill persons in need of care, and in providing services appropriate to their needs?</td>
<td>Clients per 1000 population</td>
</tr>
<tr>
<td>Is there a Joint Planning Care Team (JPCT) with members drawn from the organisations involved?</td>
<td></td>
</tr>
<tr>
<td>• Some SSDs have taken over responsibility for services (except primary health care) for the mentally ill. This involves arrangements for the appropriate transfer of funds from the NHS (dowries).</td>
<td></td>
</tr>
</tbody>
</table>

| **2 Nature of care provided** | |
| Is there a Council statement of policy on services for mentally ill people in need of care? | Policy statement exists and is in the possession of, and understood by, social services staff involved |
| Is the policy emphasis on supporting clients' independence in their own homes or with their families, wherever that course of action is suitable? | Proportion clients in non-residential care (%) |
| Is that policy reflected in the allocation or reallocation of resources? | |
| How does the Council monitor the success of its policies? | Reports to Committee Committee response |
| Is a care plan drawn up for each client and is the plan regularly reviewed? | Achievement of planned targets, eg length of time for rehabilitation |
Is the client and his/her family involved in drawing up the care plan?

Is progress monitored?

Are clients and/or their families informed about the support services available to them?
- These include social workers, respite care, resource centres, community centres, social clubs, home helps, occupational and speech therapy, day treatment units, vocational assessment units, work experience, sheltered employment.
- Social security benefits may be payable, e.g., attendance allowance for those requiring constant attention such as elderly people with senile dementia.

Is there provision for residential respite care for clients who live on their own but need a break from the strains of so doing, or for clients whose families need a break?

How many respite care families have been recruited and how frequently are they used?

What other support services are provided to ease the burden on carers?

Are there effective means of ensuring that mentally ill persons discharged from hospital or residential care receive appropriate further support?
- This may include staffed or unstaffed hostel accommodation. The latter may consist of bed-sitters or mutual support groups helping each other to return to independence with minimum intervention from the SSD.
- This accommodation may be rented from the Housing Authority.

Are efforts made to foster mentally ill children in suitable cases?
- Note that mental illness in children is rare.

How many clients are in supervised lodgings?

Does care provided include the provision of sheltered accommodation, special housing or shared accommodation schemes?

Are persons prone to bouts of mental illness able to secure care (e.g., temporary residential accommodation) easily?

<table>
<thead>
<tr>
<th>Review questions</th>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the client and his/her family involved in drawing up the care plan?</td>
<td>Residential respite care days provided</td>
</tr>
<tr>
<td></td>
<td>Number of clients receiving residential</td>
</tr>
<tr>
<td></td>
<td>respite care</td>
</tr>
<tr>
<td>Is progress monitored?</td>
<td>Number of placements</td>
</tr>
<tr>
<td>Are clients and/or their families informed about the support services available</td>
<td>Places provided</td>
</tr>
<tr>
<td>to them?</td>
<td></td>
</tr>
<tr>
<td>• These include social workers, respite care, resource centres, community</td>
<td></td>
</tr>
<tr>
<td>centres, social clubs, home helps, occupational and speech therapy, day</td>
<td></td>
</tr>
<tr>
<td>treatment units, vocational assessment units, work experience, sheltered</td>
<td></td>
</tr>
<tr>
<td>employment.</td>
<td></td>
</tr>
<tr>
<td>• Social security benefits may be payable, e.g., attendance allowance for those</td>
<td></td>
</tr>
<tr>
<td>requiring constant attention such as elderly people with senile dementia.</td>
<td></td>
</tr>
<tr>
<td>Is there provision for residential respite care for clients who live on their</td>
<td></td>
</tr>
<tr>
<td>own but need a break from the strains of so doing, or for clients whose families</td>
<td></td>
</tr>
<tr>
<td>need a break?</td>
<td></td>
</tr>
<tr>
<td>How many respite care families have been recruited and how frequently are they</td>
<td></td>
</tr>
<tr>
<td>used?</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td>hospital or residential care receive appropriate further support?</td>
<td></td>
</tr>
<tr>
<td>• This may include staffed or unstaffed hostel accommodation. The latter may</td>
<td></td>
</tr>
<tr>
<td>consist of bed-sitters or mutual support groups helping each other to return to</td>
<td></td>
</tr>
<tr>
<td>independence with minimum intervention from the SSD.</td>
<td></td>
</tr>
<tr>
<td>• This accommodation may be rented from the Housing Authority.</td>
<td></td>
</tr>
<tr>
<td>Are efforts made to foster mentally ill children in suitable cases?</td>
<td></td>
</tr>
<tr>
<td>• Note that mental illness in children is rare.</td>
<td></td>
</tr>
<tr>
<td>How many clients are in supervised lodgings?</td>
<td></td>
</tr>
<tr>
<td>Does care provided include the provision of sheltered accommodation, special</td>
<td></td>
</tr>
<tr>
<td>housing or shared accommodation schemes?</td>
<td></td>
</tr>
<tr>
<td>Are persons prone to bouts of mental illness able to secure care (e.g., temporary</td>
<td></td>
</tr>
<tr>
<td>residential accommodation) easily?</td>
<td></td>
</tr>
</tbody>
</table>

[See: Community Care – Government Response to the Second Report]
## Review questions

| What steps are taken to avoid public anxiety about proposals to provide facilities for mentally ill people? | Complaints  
Public attitude surveys  
Responses to publicity |
| Are members kept informed about the numbers receiving services and awaiting services and the types of care selected? | Waiting times for services |
| What do the clients/carers think of the services provided? | Attitude surveys |

### 3 Finding employment

Are there arrangements, including close liaison with Disablement Resettlement Officers (DROs), for finding employment for clients?

- These would involve consideration of open employment, sheltered workshops, Sheltered Placement Schemes (SPS).
- Sheltered Placement Schemes – individual placement schemes through MSC – are often preferred both by LAs and clients because segregation is avoided. They are also less expensive.

### 4 Management of facilities

See general list of questions on pages 13–15.
Physically Handicapped People

Introduction to the service

This chapter should be read in conjunction with the overview chapter on Management, Administration and Social Work.

The House of Commons Report on Community Care (see page 8) was mainly concerned with mental illness and mental handicap. However, the same philosophy is relevant to all disabilities and the trend towards community based care is evident in this service as in others. For example, the physical, emotional and psychological needs of handicapped school-leavers are now being catered for increasingly within polytechnics and colleges.

Joint planning and cooperation between the local authority, the NHS, voluntary and private organisations, and other bodies such as LEAs, Housing Authorities, the MSC and DHSS, are essential if handicapped people are to receive an effective service.

Many physically handicapped children and elderly persons are in receipt of social services and/or special educational services for children, or services for elderly people. This means that the clientele for various services are not always separately distinguishable. Close coordination between sub-sections of the SSD is therefore crucial.

In many cases the provision of sheltered or very sheltered accommodation may meet the needs of individual clients better than residential care. This involves cooperation with Housing Authorities or housing associations as well as the rapidly growing private building sector.

Other local authority services include:
- sheltered employment
- day care services
- laundry and incontinence services
- disabled child care services and groups
- aids and adaptations
- home helps and other domiciliary services
- meals on wheels
- telephones and alarm systems
- occupational therapy
- concessionary fares
- counselling and information
- assistance to voluntary organisations.

Trends

Expenditure on local government services for physically handicapped people has increased in real terms, but not as rapidly as that for mentally handicapped people. However, the range of services provided and the diversity of handicaps involved makes overall comparisons difficult.
Table 1 shows that residential care has increased overall, but that between 1981 and 1984 an increase in voluntary and private homes was partially offset by a fall in the numbers of residents in local authority homes. The provision of local authority day care places also fell 1980–1984, which is perhaps unfortunate in view of the perceived results of unemployment in increasing the number of people becoming reliant on day centres.

Table 2 on the other hand shows very large increases in aids and adaptations, reflecting efforts to provide support for disabled persons living at home. Note that this table excludes occupational therapy and other support services received from SSDs and improvement grants from housing departments.

Table 1
Residential and day care for physically handicapped people (000s)

<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Residents (UK)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• LA homes</td>
<td>n/a</td>
<td>5.4</td>
<td>n/a</td>
<td>5.2</td>
<td>5.0</td>
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<tr>
<td>• Voluntary and private homes</td>
<td>n/a</td>
<td>8.4</td>
<td>n/a</td>
<td>9.0</td>
<td>9.2</td>
</tr>
<tr>
<td>Day centres (England only)</td>
<td>9.8</td>
<td>9.6</td>
<td>9.4</td>
<td>9.1</td>
<td>9.4</td>
</tr>
</tbody>
</table>

(Source: Health and Personal Social Services Statistics for England (1985))
### Table 2
Local authority services provided for disabled people in England and Wales (000s)

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aids to households</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>· Telephone installation</td>
<td>15.6</td>
<td>9.7</td>
<td>12.5</td>
<td>16.0</td>
</tr>
<tr>
<td>· Telephone attachments</td>
<td>1.6</td>
<td>1.4</td>
<td>2.4</td>
<td>3.2</td>
</tr>
<tr>
<td>· Telephone rental</td>
<td>73.8</td>
<td>94.5</td>
<td>96.6</td>
<td>100.2</td>
</tr>
<tr>
<td>· Television (supply)</td>
<td>1.7</td>
<td>0.5</td>
<td>0.4</td>
<td>0.5</td>
</tr>
<tr>
<td>· Television licence</td>
<td>40.5</td>
<td>20.1</td>
<td>19.9</td>
<td>19.4</td>
</tr>
<tr>
<td>· Radio (supply)</td>
<td>0.7</td>
<td>0.9</td>
<td>1.2</td>
<td>1.2</td>
</tr>
<tr>
<td>· Other personal aids</td>
<td>202.2</td>
<td>277.8</td>
<td>323.2</td>
<td>371.1</td>
</tr>
<tr>
<td>Adaptations to property</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(private dwellings only)</td>
<td>24.0</td>
<td>34.1</td>
<td>45.3</td>
<td>52.9</td>
</tr>
</tbody>
</table>

(Source: Department of Health and Social Security; Welsh Office)

### Current management issues

The main issues are:

1. Identifying handicapped persons in need of care, in cooperation with the NHS and other local authority services (for example education and housing), neighbouring local authorities, the MSC and private or voluntary organisations.
2. Determining the nature of services needed and by whom they are to be provided.
3. Finding suitable training and employment — open or sheltered — or maintaining handicapped persons in their present jobs, where appropriate in cooperation with the Manpower Services Commission and other bodies.
4. Managing facilities efficiently and effectively.

Identifying physically or sensorially handicapped people can be a problem. Many of them are not anxious to declare their disabilities. Though there is (usually) an accurate register for the blind and partially sighted, the registers for the deaf and those with other disabilities are not reliable. As mentioned earlier, other client groups such as the elderly may also be entitled to receive services for physically handicapped people.

It is most important that local authorities do not act in isolation in meeting their statutory responsibilities for handicapped people. The identification of clients and the provision of services need to be coordinated, and duplications/omissions avoided. Joint planning with the NHS is often practised and local authorities should also have close relationships with private and voluntary organisations as well as with education and housing departments and with adjoining local authorities. In some cases there is joint financing of projects by the District Health Authority and the Authority.

Coordinated policies on provision need to include measures to ensure that adequate facilities exist to deal with people discharged from hospital or residential care. Among those arrangements would be clearly understood relationships between district health and local authority staff and hospital staff.
and GPs. Arrangements should also include ensuring that clients receive the social security benefits to which they are entitled and that these are taken into account in deciding on local provision.

Measurement of effectiveness is difficult because of the varied nature of clients' problems and their self-reliance, and the wide range of services provided. The extent to which the disabled manage independently and in open employment could be an indicator. The balance between residential and day care is readily available but obviously needs careful analysis. The take up of services and waiting time for allocation to care also mark effectiveness.

The efficient management of resources involves matching supply to the needs determined. The requirement for specific resources may change as programmes progress. For instance, an effective rehabilitation programme may reduce occupancy and increase the unit costs of residential accommodation and other services, the provision of which will then need to be reviewed.

Bibliography

Community Care – Second Report from House of Commons Social Services Committee (1985) HMSO
Deals with main aims of care for handicapped people.

DHSS LA Circular 13/74
Sets out the powers and duties of local authorities relating to handicapped people.

DHSS LA Circular 78(16) Children in Hospital: Maintenance of Family Links
Advises local authorities of their responsibility.

A pilot study report on the management of social work.
Performance review guide

This section sets out a detailed series of questions which will help to guide the review and improvement of current management arrangements.

Some of the questions relate to policy matters to be decided by members, or are the professional responsibility of officers as their advisers. These questions are shown in *italic*. The auditor's interest is in ensuring that these issues have been addressed and that appropriate policies and management arrangements have been determined. Auditors should also be sensitive to such wider considerations when making judgements on resource usage.

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### Review questions

<table>
<thead>
<tr>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered physically and sensorially handicapped people per 1000 population</td>
</tr>
<tr>
<td>Numbers registered</td>
</tr>
<tr>
<td>Take up of services</td>
</tr>
</tbody>
</table>

#### 1 Identifying needs

Is there joint planning in practice with the NHS, MSC, LEAs, Housing Authorities, neighbouring authorities, private and voluntary bodies to identify physically and sensorially handicapped persons in need of care or support and to provide appropriate services for them?

- Registers are maintained for:
  a) blind and partially sighted
  b) deaf with/without speech
  c) partially deaf
  d) physically handicapped.

What other steps are taken to identify physically handicapped persons and inform them of the range of services available from the Authority and other service providers?

#### 2 Nature of services provided

Has the Council stated its policies on services for physically handicapped people?

Is the emphasis of policies on supporting clients' independence in their own homes or with their families wherever that course of action is suitable?

Are those policies reflected in the allocation or reallocation of resources?

Are the clients involved in the planning of services provided to them?

Policy statement exists and is in the possession of, and understood by, social services staff involved

Proportion clients receiving suitable non-residential services (%)

Programmes of support for informal carers
Performance Review in Local Government — Social Services

Review questions

**How does the Council assess its success in achieving its policies?**

**Are the types of service selected for each handicapped person kept under review and changed as circumstances alter?**

**Does consideration include the provision of sheltered or very sheltered accommodation?**
- This necessitates close liaison with housing authorities, Housing Associations, private and voluntary sectors, eg Spastics Society, Shaftesbury Society and the many other societies for disabled persons.

**Does the emphasis on support in the home include rapid installation of the aids and adaptations needed to make this possible?**

**Are there effective arrangements to ensure that clients are not discharged from hospital or residential care without arrangements being made for their after-care or support?**

**Is there provision for residential respite care and domestic support for clients who live on their own but need a break from the strains of so doing or for clients whose families need a break?**
- This may take the form of holidays for the clients concerned.
- Residential respite care includes 'host family' arrangements.

**What arrangements are there for the further or higher education of physically handicapped young people?**
- A particular problem is the lack of provision for deaf school-leavers.
- Consideration also needs to be given to the care needed on completion of education.

**How long do clients have to wait for assessment and receipt of various services?**

**Are members kept informed about the numbers of people in receipt of or awaiting care, the types of care selected, waiting times for services and the rate of service take up?**
- Disabled people may choose not to use unsatisfactory services and reasons should be sought for low take up rates.

### Key Indicators/References

<table>
<thead>
<tr>
<th>Review questions</th>
<th>Key Indicators/References</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How does the Council assess its success in achieving its policies?</strong></td>
<td>Case records</td>
</tr>
<tr>
<td><strong>Are the types of service selected for each handicapped person kept under review and changed as circumstances alter?</strong></td>
<td>Elapsed time for installation or supply</td>
</tr>
<tr>
<td><strong>Does consideration include the provision of sheltered or very sheltered accommodation?</strong></td>
<td>Participation rate among 16–19 year olds registered as disabled (%)</td>
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<td>Retention rates (%)</td>
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<td>Elapsed time from application</td>
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<td>Committee reports</td>
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<td>Results of client surveys</td>
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<td>Complaints</td>
</tr>
</tbody>
</table>

56
### Review questions

#### 3 Finding employment and training

Are there arrangements, including close liaison with Disablement Resettlement Officers (DROs), for finding employment for physically handicapped people, or maintaining them in their present employment?

- These would involve consideration of open employment, sheltered placement schemes and sheltered workshops.
- Sheltered placement schemes – individual placement schemes through MSC – are often preferred by both local authorities and clients because segregation is avoided. They are also less expensive.
- Local authorities should be able to advise local employers about the MSC's Job Introduction Scheme and Fares to Work Scheme.

What success has the SSD had in finding employment for physically and sensorially handicapped people capable of work, or maintaining them in their present employment?

- This often requires the education of employers and the application of modern technology.

<table>
<thead>
<tr>
<th>Key Indicators/References</th>
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<tbody>
<tr>
<td>Unemployment rate for each group of registered disabled persons (%)</td>
</tr>
<tr>
<td>Placings in each category</td>
</tr>
</tbody>
</table>

#### 4 Management of facilities

See general list of questions on pages 13–15.
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