A vision for care fit for the twenty-first century: Commission on Residential Care

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Summary

The Commission on Residential Care describes how ‘residential care’ can shift from being a service that most people dread, to one that helps people live the lives they want. It makes recommendations for national and local government, the NHS and other partners. Core to this is a proposal to separate the elements of ‘care’ and ‘housing’ in assessment, commissioning, provision and regulation.

The report presents many interesting ideas which can form the basis for further discussion, but overall it would benefit from presenting a clearer and more coherent vision.

This briefing will be of interest to councillors and officers in councils with adult social care responsibilities, and to all those who seek to improve social care services in their areas.

Briefing in full

Background

The Commission on Residential Care was chaired by former Care Minister Paul Burstow MP, working with a group of academics, experts and practitioners supported by the think tank DEMOS. The year-long inquiry carried out focus groups, a survey, a research review and visits to facilities home and abroad. Its aim was to establish a vision for residential care that is fit for purpose for the modern age and to set out how the vision can be achieved.

The main challenges facing residential care

Public perceptions
The Commission points to research which shows the negative public perception of care homes. Only around a quarter of people would consider moving to a care home, while 43 percent would definitely rule it out. Over half said that they feared neglect or abuse in care homes. In focus groups words associated with care homes included ‘stultifying’, ‘smelly’ and ‘uncaring’. Media scandals and the lack of positive publicity have reinforced the view of care homes as places of last resort, and this impacts on the status and self image of workers and managers.

**Funding crisis**

The future of social care is described as ‘balancing on an axis’, with progressive measures in the Care Act (carers’ rights, preventative support, duty of wellbeing etc) compromised by ‘chronic underfunding’. The ongoing funding crisis has led to severe problems for care homes – problems with quality, with staff recruitment, retention and wages, and difficulty in securing investment for expansion or improvement.

**Limited range of provision**

The range of housing with care options are limited and there is confusion about terminology relating to the different types of care.

**Demographic pressures**

Demographic pressures are increasing, with more frail older people, more people with dementia and an increased prevalence of people with highly complex needs – both older people and adults of working age with disabilities who are now living longer and with a greater desire for independence.

**NHS input**

The NHS is putting greater expectations on what residential care can deliver at a time when support from primary care and other community health services is decreasing.

**Models of good practice**

The report gives examples of how peoples’ lives have been transformed by moving to housing with care when the struggle of coping, often alone, became overwhelming. For some people, this is the right and even liberating option, rather than the last resort. It summarises research about what people would like to see from housing with care – in a nutshell this is the ability to live much as they do now, but with dignity and kindness in any support they require.

It indicates that there is no one model of housing with care that will fit all needs. However, there are common themes in services that have proved effective, and models which it feels might be useful to explore. These include:
‘different models within models’, for instance intergenerational living or different levels of need allowing for step up and step down care
• teaching models where specialist placements, such as dementia care, can take place
• ‘green house’ style models with apartments and communal kitchen areas to promote social networks
• ‘smart’ models and ‘smart homes’ using technology to support basic care needs and to connect with others
• colocation with community facilities such as colleges and children’s centres
• for working age adults in particular, colocation with employers, training sites and opportunities to start a family
• ageing hub models – colocation with advice and health services
• housing offering rehabilitation, reablement, step down and short stay facilities.

Four priority steps for change

The Commission identifies four steps for reforming housing with care so that it delivers the outcomes people value:
1. build on what we have
2. create a flourishing market of supply
3. tackle how we think about housing with care
4. decide how to fund care.

Step 1 – Build on what we have

The Commission indicates that the housing with care sector is an unrealised resource, which could prove an asset if health and social care commissioners engage with it systematically. For example it has the potential to provide:
• step up/step down reablement for people who need support before returning home from hospital
• rehabilitation for people with serious physical or cognitive injury
• short stay or respite care for carers
• outreach services to provide ‘housing with care’ in people’s homes.

While purpose built design may be the ideal, this will not always be possible with a large current stock of provision. The Commission points out that care failures are generally attributable to poor culture rather than the physical environment, and workforce development is essential to good housing with care.

As part of changing culture, the Commission recommends that each person’s care and housing requirements should be considered and paid for separately. This would mean that people could make separate decisions on the basis of what they want to achieve.

Assessment should be focused on care needs without any presupposition about where the care would be delivered. Local commissioners would not attempt to purchase a bed or a room, but a package of support based on outcomes. After this has been developed, where it takes place should be a matter of individual
Commissioners should shape the market to ensure the maximum choice of provision rather than driving the market through bulk purchasing decisions. This model also gives the potential for people to live in tenancies with the security of tenants’ rights, and to use the benefits system for housing payments.

The split between care and housing would also apply to regulation. The CQC would be responsible only for regulating the quality of care, with the physical environment falling within building standards for other communal settings like for hotels. This would address anomalies in how the CQC inspects different settings e.g. care homes and settings where people are owners or tenants.

**Step 2 – Create a flourishing market of supply**

The Commission points out that a range of care options are needed, but innovative models of housing with care can often be limited by the structures around them.

Regulatory definitions of a care home as a location involving ‘the provision of residential accommodation, together with nursing or personal care’ can prevent the development of more flexible options. Local structural plans often do not consider the need for housing with care, nor are they required to ensure that adequate land is available to serve the local community. Planning-use classes reinforce the distinction between care homes and extra care housing and limit useful variations.

In order to produce a range of flexible housing with care options, including mixed tenure models, the Commission suggests that structural and spatial planning should be geared up to stimulating the housing with care market.

**Step 3 – Tackle how we think about housing with care**

Part of bringing about change will involve changing negative public perceptions and cutting through confusion. Adopting the term ‘housing with care’ and separating care from housing will contribute to this. For example, extra care housing does not have the negative connotations of care homes because it is seen more as a type of housing than a type of care. Making decisions about moving house are generally less emotive than the idea of moving to a care home. The individual is able to make a housing choice, rather than having a care package with an ‘obligatory location attached’. The Commission believes that it will be more ‘transparent and meaningful’ to talk about what housing options can be chosen e.g. private bedroom homes, apartment homes, shared apartments, care villages, location and setting.

Other ways of tackling misconceptions include bringing the public into the provision and inspection of housing with care, encouraging people to plan for their later years and making the move to housing with care more aspirational.

**Step 4 – Decide how to fund care**

The Commission points out that the Dilnot review was not asked to address the crucial question of how much funding is needed for the future of social care. It
believes that reforms in the Care Act cannot be achieved if eligibility criteria are set at substantial and above. Lack of investment in housing with care is causing instability in the market and NHS and housing budgets should be directed towards improving provision.

Key Recommendations

Leading from the front

The Government should establish a shared vision of what role housing with care plays and what it should achieve. The terms ‘residential care’ and ‘care home’ should be replaced by ‘housing with care’ in policy and guidance. It should develop proposals for tenancy in care homes so people pay rent rather than ‘hotel costs’.

Working in housing with care

The care sector should become a living wage sector with a fair funding formula developed by national and local government and providers. Skills for Care should become the national professional organisation representing staff and promoting excellence. Minimum levels of training and development should be introduced and linked to a licence to practice. Management should be recognised as a career path, with specialist training, qualifications and pay.

Commissioning and assessment

Care should be outcome-based and separated from housing in individual assessment and local commissioning. Local commissioners should use market shaping duties to encourage good practice, and to develop the widest possible range of housing options. Social care assessments should always include consideration of technology enabled care services. Health and social care commissioners must do more to improve access to health services in housing with care settings.

Providing housing with care

The Government should sponsor grants to stimulate innovation. Care home providers should work with national and local government to consider a tenancy framework suitable for care home settings, and to look into mutual ownership models.

Building housing with care

Local spatial plans should be coproduced with JSNAs and include an assessment of the population’s housing with care needs and the need for general accessible housing. Local planning authorities should support housing with care facilities. The community infrastructure levy (CIL) should be reviewed to establish whether housing with care providers are disproportionately disadvantaged. Planning incentives should be explored. There should be a change in planning-use classes to create a dedicated class covering all housing with care. The measures to allow local
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authorities to convert offices to housing should be extended to other public sector estates such as the NHS and universities.

Regulation, registration, inspection

A single category called housing with care covering all settings should be used in CQC registration. The CQC should carry out outcome-based inspections of care in all housing with care settings, but should no longer inspect the housing element, including in care homes. Its role should be expanded to inspect local authority commissioning.

Funding

The Treasury should commission the Office for Budget Responsibility to conduct regular long-term projections of the demand for care services. ‘Open book accounting’ and a ‘fair funding formula’ should be applied to care and housing. Providers should separate rental, service charges and care fees and make these transparent.

Comment

An in-depth look at residential care, how it operates, and how it can be improved to fit the needs of the upcoming ‘boomer’ generations is both welcome and timely. There are many useful ideas in this report, but also much which needs further exploration and refinement before a coherent vision can be articulated or a programme for action designed.

A positive idea emerging from the report is aligning the JSNA more closely with building development and spatial planning, and amending planning regulations so that building housing with care can be achieved more easily and coherently.

Proposals to split care and housing elements are interesting, but need further investigation to identify the impact in practice.

Proposing to use the term ‘housing with care’ instead of ‘residential care’ to refer to the spectrum of housing for people with care needs is a helpful suggestion. However, the report itself veers between using these terms in the broad sense, and in the narrow sense of care homes, and is thus sometimes confusing. For instance, it states, “The brand of residential care is fatally damaged”, but it is almost exclusively care homes that face negative perceptions, not models like extra care housing. Similarly, the suggestion of not using the term ‘care home’ in policy and guidance could well be impractical.

With its focus on what people would want from housing with care in the future, it is possible that the report overemphasises the aspirations of people who envisage
themselves much as they are now but with some disability, and underplays the
needs of the extremely frail people who now require significant care. Anyone with
very old relatives will recognise how priorities downsize to increasingly focus on
conserving energy and immediate needs such as good food, kindness and safety.

A succession of reports over thirty years have advised what good care in care homes
looks and feels like. The report is right to suggest that it is the culture of care, rather
than the physical environment, that plays the major role in a good or bad
experience. It is right that culture comes from the people who own, manage and
work in care homes. While recruitment, training and supervision all contribute to the
quality of care, all these factors are compromised by lack of finance. Step four of the
report – to what level we fund care – is something on which society as a whole
needs to take a view.

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