RESIDENTIAL LIFE TODAY, GOVERNMENT RHETORIC AND INDIVIDUAL RIGHTS, A MATCH FOR REALITY?

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Abstract.

This paper explores the position of older people in influencing and negotiating their own living and care arrangements, with a particular focus on residential care. Firstly it outlines the factors that have lead to the current position with regard to key social policies impacting on the lives of older people, both in the broad sphere of service user and community participation and in the area of residential care itself.

The paper then examines recent research into the experiences of life in residential care and the extent to which older people’s rights through various items of legislation, government guidance and other influential ‘good practice’ publications have been realised. This will be at both strategic and individual levels.

A discussion of some of the tension manifest in this situation will suggest possible areas upon which future attention should be focussed.

Historical Context

Momentum towards greater user and carer involvement built up through the course of the 1980s culminating in a group of policy papers: the Griffiths Report (Griffiths, 1988); Caring for People-Community Care In the Next Decade and Beyond (DOH, 1989a); and the NHS and Community Care Act (DOH, 1990) and the Health of the Nation (DOH, 1992). These had a profound effect on the shape of social care over the next decade. All emphasised the need for greater influence by the individual in how they wished to live their lives and what services they should receive to help them to achieve this. User involvement extended to the planning, management and delivery of services in order that the quality of care received be improved (after Raynes 1999).
In terms of residential care, the 1980s also saw the publication of the DOH good practice guidance ‘Homes are for Living In’ (1989b) which aimed to build on the requirements of the 1984 Registered Homes Act and the widely adopted code of practice Home Life (Avebury 1984) which stated the importance of residents being routinely involved in decision – making about how the home is run to form a genuine partnership (2.3.4, p21). This was supplemented in 1996 by Avebury’s’ ‘A Better Home Life’ which emphasised the need for full and open communication, the place of advocacy and reiterated its forerunners emphasis on residents ‘committees ‘in influencing the running of the home (4.11, p37). The close of the 1980s was marked by the major study that resulted in the Wagner Report (1988). This expressed similar recommendations, focussing on the ‘rights’ of residents to be consult on all matters within the home and for the periodic review of practices to establish performance against agreed goals,(p57). This principle was incorporated into the Wagner Development Group’s subsequent ‘Code of Conduct’ (Wagner 1993).

The implementation of the NHS and Community Care Act (1990) created a revolution in the social care world. SSD’s introduced the purchaser/provider split and directives on the costing of care packages, care management entailing detailed written assessments and care plans, multi-disciplinary reviews and service user involvement in their own care planning.

The pace of change has quickened since a Labour government was elected in 1997. At a strategic level the compunction to talk to older people about what they want from their support services and how they want them delivered has never been greater. Consultation has become a local authority and health sector mantra. With the introduction of Joint Investment Plans, Health Improvement Programmes, Best Value Performance Plans and, most recently, Local Community Plans, the notions of full involvement in assessment and care planning, promoting access to advocacy services and respect for individual preferences are central to policy and repeatedly emphasised in these documents.

Philosophies and principles of empowerment, involvement and consultation are embedded in local authority policies and practice guidance nationwide. From 1998 the Better Government for Older People Programme, ‘Beacon Council’ schemes and ‘Best Value’, encapsulated within the Local Government Act (DTLR, 1999), which imposes a duty to consult service users, the wider local community and their representatives (section3[2],
were followed by the NHS Plan (DOH, 2000) and the National Service Framework for Older People (NSF), published March 2001 (DOH), which have continued to build upon these principles. The NSF illustrates this, Standard 2: ‘…the NHS and social care services treat older people as individuals and enable them to make choices about their own care’ (p23). It is arguable that individuals have never held such a strong hand in terms of their rights to appropriate care support and entitlement to considerable influence as to the form and quality of their support.

Before considering this further, it is necessary to explore parallel developments in attitudes to residential care, with recent contributions building on a series of very influential studies undertaken since the 1960s. The most notable of these was Townsend's The Last Refuge (1962). His findings were shocking and shaped the nature of the debate for the last 40 years. Chronic understaffing, over-authoritarian staff, widespread ignorance of the global or holistic needs of the residents, which he attributed to a lack of training, were commonplace. When graded for “quality”, he rated all the former workhouses and 75% of other residential homes in the study as poor, very poor or bad (pp 225-226).

Townsend also noted marked gender separation, isolation from friends and community, loneliness, loss of privacy/dignity, little control over decision-making and the poor material condition of the buildings. He argued that communalisation and routinisation militated against homeliness, independence and the expression of individuality. Change came slowly as illustrated by a DHSS Census of Residential Homes (1975) that found all to be “inadequate” or “seriously inadequate” based upon government guideline standards of the day.

In the late 1980s, a number of studies attempted to measure the effects of new legislation, and national research with the aim of improving residential services. One of the most notable of these was Wilcocks et al’s (1987) Private Lives in Public Places. In focussing on the period of transition into residential care they found:

- Staff in homes had difficulty in coping with diversity amongst the residents
- Flexibility was limited, with an over-emphasis on control.
- A culture of dependence prevailed.
- Communal living created ongoing tensions with the expression of individuality.
Bland et al (1992) found major improvements in physical facilities, design and practice within homes, but identified serious barriers to normalisation:

- Lack of choice in everyday life
- Lack of control over one’s environment
- Lack of continuity in transition.

The factors influencing successful placements in residential homes are today quite clear: involvement from the outset in identifying needs through meaningful consultation; the proposal of genuine choices; support through the decision-making process; and control located with service users during this process. Associated with a positive experience of living in a home are: privacy; autonomy; maintenance of prior social network or the generation of new community links; and control of one’s physical and social environment. The extent to which these can be realised in their entirety in residential care homes in their present form however, poses a major question in itself.

Current research reveals that progress across this sector has been slow and patchy. Studies carried out in the early 1990s showed similar findings in a number of respects to those carried out in the early 1980s, 1970s and Townsend’s study in 1964, though somewhat tempered by increased regulation. The progress of ideas and appropriate philosophies to enact them has not been matched by the discontinuation of more traditional practices associated with institutional living.

It is important to appreciate the major effect this succession of negative research findings and their subsequent publicity has had on the attitudes of policy makers, much of the research community, the wider caring professions and the consequences this has had for policy formulation. To many, residential forms of care are the antithesis of the predominant ethos of the promotion of independence and promotion of ‘community care’ options, for example, the recent government Green Paper ‘Quality and Choice for Older People’s Housing: A strategic framework’ (DETR 2001) has largely discounted residential care as part of that continuum. In pursuing
this argument I do not wish to give the impression that all is well in the rest of the community care field, we know the reality of resource constraints and lack of regulation impact heavily here.

**Contemporary Experiences**

One of the consequences of such marginalisation of residential care is that it makes changes in attitude and outcomes for service users even more difficult to achieve than across the rest of the social and health care spectrum. That this is so, is evidenced by two strands of contemporary research.

Some recent studies into life in residential care have shown the presence of factors whose familiarity is concerning. Peace et al (1997) revisited residential care and found that though disability levels amongst residents had risen, staffing levels had not. Low status, poor wages and poor skills levels amongst care staff still remained. They also acknowledged the gap between intent and outcome. Noting that the homes were an essentially controlling environment in which caring was task-orientated, empowerment of residents was still a long way off and the full expression of self was still subordinated to the needs of the institution.

Dalley and Denniss (2001) carried out an extensive survey of training levels amongst residential home care assistants. They found ambivalence towards the perceived benefit of embracing any large-scale training initiative. Staff in around half of the homes in the survey had missed out training in basic care, health and safety and lifting techniques. Earlier Reed and Stanley (2001) had found evidence of older people’s continued passivity in decision making processes when moving to residential care where they describe themselves as having little choice or control over care decisions.

Even research that reveals a generally positive outcome about the experience of being a resident such as A Choice Well Made (Kellaher, 2000), a study of a number of Methodist Homes establishments, acknowledged that residents reported familiar problems of the negative impact of increasing dependency, larger homes and the dilution of the central role of shared religious beliefs, all of which reduced the sense of community amongst the residential group.
Two major recently published studies lend support to the position being outlined in this paper. The first is Melanie Henwood’s report for the Kings Fund, ‘Future Imperfect’ (2001). The part of the report focussing on the residential care sector concluded:

- That the care sector is seriously under-funded;
- The power shift from purchasers and providers to users to help them achieve their goals has not taken place;
- There is a damaging preoccupation with price at the expense of quality;
- Serious problems with staff recruitment and retention were apparent, incentives to providers to train staff are required;
- Management infrastructure and capacity have been seriously undermined by financial constraints;
- The best use of resources on care spending is linked to effective strategic management.

The second of these studies is the report of the Chief Inspector of the Social Services Inspectorate, ‘Quality On The Way’ (Platt 2001). Though promoted as evidence for ‘cautious optimism’, there are inevitably other interpretations of some of the material contained within the report. Many frontline staff and managers were unclear as to their contribution to the delivery of quality services. Few departments had operational ‘unmet need’ recording systems, and many failed to listen to service users’ views in planning services. Many examples of councils’ reluctance to take up the recommendations of their Registration and Inspection units and to apply service contract standards to in-house provision were gathered. There were serious shortcomings in monitoring service access for minority ethnic groups and the development of culturally sensitive services. Any references amongst the many good practice examples to long-term residential care for older people were noticeably absent.

**Discussion**

The material presented paints a picture of a growing consensus of the need for person-centred services, rights of citizenship (active participation and consultation) and the accountability of public services to both central and local government as well as the people they serve. It also charts a move towards a valuing of independence,
family models of care and the need to focus social and health care services towards prevention and rehabilitation. Whilst one cannot take exception to these goals one of the consequences of such a position is that residential care has increasingly come to be seen by government, local policy makers and much of the research community as an anachronism, to have reached the end of the road conceptually (after Fisk, 2000). As a result, the intellectual energy and financial resources that have been dedicated to other areas of the health and social care sector have almost entirely bypassed residential and nursing home care (after Davies et al 2000). This lack of progress, though possibly less surprising, is only a more extreme example of how policy messages are not being routinely translated into day-to-day practice to change the way social care services are experienced.

Given the nature of the place of residential care services within the spectrum of social care options, residents are the most frail and invariably among the most vulnerable of groups within a community. They face a triple jeopardy of:

- An often dis-empowering assessment and care management system which results in;
- A partially cash determined process of care home selection, followed by;
- Admission to a service where perhaps more than any other sector, the cultural shift to user-centred services has made the least inroads.

It is the subject of much debate as to whether the residential home model is fundamentally flawed, inhibiting its ability to embrace and make operational such person-centred practices, or whether the state of the sector is a reflection of the low value placed on this form of support to older people, themselves marginalized and under-resourced within the social care sector.

What is clear is that the widespread lack of innovation is unlikely to be remedied if policy developments continue as described. One of the potential beacons on the horizon is the Care Homes for Older People: National Minimum Standards (DOH, 2000) which attempt to remedy many of the shortcomings in both practice and process raised in this paper and begins to tackle the issue of staff training. Financial or other assistance to achieve these goals, however, is not included, with the exception of a recent announcement from TOPSS of the injection of £15 million across the sector for 2002/3 (DH 2002). The opportunity to address the status and regulation of the workforce is also present with the setting up of the General Care Standards Council (England)
and its equivalents in other parts of the UK, though decisions around the registration of unqualified care staff have yet to be made.

Finally, residential care is not undergoing the necessary major changes, not on the scale required and not as quickly as is needed. Other models for accommodation with care are developing around it – extra-care housing, integrated care schemes, retirement communities, and the beginnings of co-housing communities in the UK (e.g. Brenton 1998). Radical action is required. I would echo Melanie Henwood in arguing that investment in the staff delivering frontline services and training to bring about both ownership and day-to-day implementation of the government’s ‘rhetoric’ is an essential and immediate requirement, but this alone is not enough.

The required cultural shift that has taken root in other areas of community care provision and joint approaches to working must be driven through into this sector, as must changes in the power relationships between staff and residents. This is of course a matter for senior local authority managers, policy makers and trainers. But it is also a matter for all frontline care staff and residential unit managers. There are many things that can be done day-to-day, decision-by-decision, for individual residents that contribute to chipping away at the old models of practice which have proved so dis-empowering, despite the constraints within which this work is carried out. Perhaps the abandonment of the term ‘residential care’ is a necessary step in beginning to redefine the nature of staff and residents relationships in communal forms of accommodation, and to break away from the legacy of negativity that the label carries with it.

References


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