Residential care: the professional view
Chapter 12

Residential care: the professional view

The lives of older people living in residential care homes have been the subject of a great deal of research over the years. In fact no discussion of the development of community care policies for older people can ignore the history of the workhouse and the bleak lifestyle offered to many who have lived out their lives in institutions (see Sinclair, 1988 for a review of the literature). During the 1960s and 1970s ‘quality of life’ studies dominated research in this area, although the circumstances which may lead an older person first to consider and then to move into residential care has also received much attention (Lawrence et al, 1987; Neill et al, 1985). However, as reviews of the research have shown, much of what we know about the residential life of old people relates to admission to and life within public sector homes and does not wholly address the changing realities of provision in the late 1980s. Small-scale studies of private sector provision carried out in the mid 1980s have begun to explore the realities of private residential care as a business and the balance of profit and care (Weaver et al, 1985; Phillips & Vincent, 1986).

The 1980s have seen a massive growth in private sector residential care. In 1975, figures for England showed that the ratio of places in public sector homes to private sector homes was 5:1; by 1982 this had changed to 3:1, and by the mid 1980s the pendulum had swung with private and voluntary provision providing the majority of places. There were various reasons for this growth but as Kellaher et al (1988) show, the main factors included the changing demography of an ageing population, with an increase in people aged 75 years and over; changes in the nature of family care; a need to develop alternative forms of long-term care as increasing pressure was placed on hospital beds, and perhaps the most important stimulus of all, the public funding of independent sector provision through the introduction in 1980 of Supplementary Benefits regulations which enabled people entering private residential care to obtain financial support through board and lodgings payments. In many areas of the country these changes have resulted in multi-sector residential provision, and in some areas it means the predominance of private sector residential care (see Larder et al, 1986; Peace, 1987; Kellaher et al, 1988, for a discussion of changing patterns of provision).

The massive changes in the provision of residential care for elderly people in the 1980s have resulted in a number of important developments which have a
direct bearing on how care professionals assist those older people who decide that residential care is the best option for them. The growth of private sector provision in the early 1980s resulted in the need to develop a system of regulation which would maintain standards of care. The Registered Homes Act 1984 set out procedures for the registration and inspection of the independent sector ie. voluntary and private, residential care homes. Since the implementation of the 1984 Act, social services departments have seen the development of a new professional worker – the registration and inspection officer (see Kellaher et al, 1988; Kellaher & Peace, 1990). The extent to which a regulatory function has been developed depends very much on the size of the independent sector within any one authority. Regulation of independent sector care, however, has served to focus attention on the lack of regulation and monitoring within public sector facilities. Since 1985 we have witnessed a number of well-publicised scandals in both public and private sector homes (for example ‘Cold Comfort’ – Granada TV, 1987), and these served to fuel the debate about the setting of standards and the need for a system of regulation in residential care for all sectors.

While these debates were taking place, an in-depth review of residential care – the Wagner Review – was underway. In essence the Wagner Report Residential Care: A Positive Choice tried to raise the profile of residential care reasserting its value (NISW, 1988). Its very title, ‘A Positive Choice’ sought to shift the emphasis away from the view that residential care is the ‘last resort’ and to value its role as a vital part of community care. The principles for residential care set out in the Wagner Report place great emphasis on the importance of choice and participation by the prospective resident in decisions about a move into residential care: ‘People who move into a residential establishment should do so by positive choice. A distinction should be made between need for accommodation and need for service. No one should be required to change their permanent accommodation in order to receive services which could be made available to them in their own homes.’

Every person who moves into a residential establishment retains their rights as a citizen. Measures need to be taken to ensure that individuals can exercise their rights. Safeguards should be applied when rights are curtailed. (NISW, 1988 p114)

The recommendations of the Wagner Report could have important implications for future practice within residential care and the quality of life for residents if they receive support not just in terms of rhetoric but also in terms of resources. Currently, the Caring in Homes Initiative, launched by the Department of Health in 1989, is considering a range of issues concerning staff training; the development of internal systems of quality assurance; the relationship with the wider community, and the information base regarding residential care.

The Wagner Report was published at a time when the debate concerning the future of both residential and community care was being widely discussed (Audit Commission, 1985; Firth Report, DHSS, 1987; Griffiths Report, 1988). Deliberations on community care were reported subsequently in the White Paper
Caring for People (Department of Health, 1989), which also sets out a number of reforms in the area of residential care. Local authorities will be responsible for carrying out assessments of people who may be supported in private residential care homes and nursing homes through the social security system. Social services departments will be expected to make maximum possible use of independent sector providers when arranging to place a person in a residential care home or nursing home.

Again emphasis is placed on consumer choice: ‘The government believes that, subject to the availability of resources, people should be able to exercise the maximum possible choice about the home they enter. The preferences of relatives and other carers should also be taken into account. If relatives or friends wish, and are able, to make a contribution towards the cost of care, an individual may decide to look for a place in a more expensive home. The arrangements made by the social services authority should be sufficiently flexible to permit this’ (Department of Health, 1989, para 3.7.8).

Caring for People places great emphasis on the use of the independent sector as the provider of residential care, and authorities are encouraged to ‘review the extent to which they need to maintain homes of their own in these circumstances’ (Department of Health, 1989, para 3.7.11). Indeed, the new regulations act as a disincentive to local authorities to continue to provide residential homes.

The monitoring of quality within residential care homes is seen as an important issue and the white paper proposes that ‘local authorities should set up independent inspection units, under the Director of Social Services, charged with inspecting and reporting on both local authority and registerable independent residential care homes’ (Department of Health, 1989, para 5.18). Guidance on the role of the independent inspection units was issued by the Department of Health in 1990.

Residential care in the three study authorities

Whilst the recommendations contained in the White Paper had not been published formally at the time the study began, many of the ideas were well-developed and well-known. The views of those professionals interviewed in the three authorities therefore have to be set against these current debates. We have already noted that these three authorities were very different in terms of geography, demography and political influence, and this was reflected in the organisation of services and personnel. This variation was also reflected in the size of private sector residential provision within each authority and in the development of systems of registration and inspection.

While the balance between different types of provision varied between each of the authorities, the three options of public, private and voluntary sector residential care were available in all three. This study sought to find out what kind of information professional care workers gave to older people and their relatives concerning residential care and to what extent they were involved in the decision-making process about a move to care and the practicalities of that move.
We also asked heads of homes/managers/proprietors in both private and local authority homes for their opinions about residential care and its future (see Appendix).

Moving into residential care: the care worker as facilitator

It is worth reflecting on Sinclair’s comments concerning the degree of control older people have over decisions about entering residential care and their attitudes towards this move. At the time of his review of research in 1988 most of his evidence came from studies of local authority provision. This is how he summarises the position of most elderly people:

1. The idea of residential care often begins with someone else and referrals for residential care are not usually made by the applicant.
2. Applicants have often not been given, or have not taken in the information they need to make informed choice (for example, on what they can take with them). Most have not visited the home.
3. The majority of applicants appear to be resigned or ambivalent about the idea of going in or to reject the idea entirely. Only a minority appear to make a positive choice. (Sinclair, 1988, p264)

These rather grim reflections paint the old person as a powerless victim of someone else’s decisions over a move into residential care. Is this still the case, or has the growth of the private sector really opened up the options available to older people? We have examined the experience of elderly people and their carers. Do professional care workers still see residential care as a ‘last resort’ or do they view it as one of many options?

When asked under what circumstances they would support or encourage an elderly person to proceed with a request for residential care, the social workers, team managers and domiciliary care organisers we spoke to were broadly in agreement. More than a third of each group stated that if that was what the old person wanted and if they had made the decision then they would support them. These views were fairly consistent across the three authorities. One domiciliary care organiser said: ‘It’s entirely their decision, entirely up to them themselves. We talk about it and I ask if they have ever thought of it, and then I leave them to think. They will either come back to you or say, “no”. A social worker from the north put it this way: ‘If they request it they have the right to that choice whether they need it or not. They might be quite fit but suffering from loneliness. If they insist, I’ll let them have a choice’.

Team managers were more likely to express the conflicts which arise around resource constraints and choice over services. A manager from the London borough commented: ‘I hope residential care is not a last resort. Some people benefit from residential care, they want to be cared for and they are paying for it. We are constrained by resources – but if their decision is out of choice and not out of necessity then they may not be a priority, but we can try private care. With other people we have been providing home care services and we may not be able
to increase them due to resource constraints, so we may explore residential care, but if they decide "no", then they remain at home. Some people just decide to give up after being at home. They can’t cope any more.’

However, all groups were likely to qualify their views on the individual’s right to choose with a concern over the ‘level of risk’. They felt that residential care should only be supported or encouraged if the old person could not cope at home owing to a range of factors such as their own poor physical health, mental frailty, loneliness or the fact that a carer was under stress. These views were particularly expressed by social workers like this one from the northern authority: ‘Sometimes you have to be very directive – if you’re sure what’s going to be in the best interests of the person. I’m not playing God, but I’m a pragmatic social worker. I have a mentally ill client who went into residential care. I had to be directive and they were unable to make decisions. But I don’t like leaning on people to sign, that’s when they give up and die.’

A ‘natural’ progression

The DCOs interviewed were not involved in carrying out assessments for residential care although they did organise short term care. In some cases the transition to residential care arose because the elderly person had been attending day care or short term care within a home and wanted to go and live in that particular home, and some workers actively encouraged this progression.

A social worker from the south also used day care and short term care as an important part of the process of ‘making your mind up’. She said: ‘Personally, if someone asks for residential care then I have a duty to let them see it and experience it, and if they still want it then they should proceed. If I was still unhappy but they still wanted to proceed then I would ask them to stay for a longer time. Experience would mean coming for a day and then short stay for a week. If the old person is not requesting residential care, but I think it’s appropriate then I also suggest day care and short stay, and after that I talk to them again. I would be unhappy to push anyone this way unless they had experienced it and were sure – it’s a major life decision they are making’.

At the time of the study the social workers and DCOs interviewed were most likely to be involved in the planning surrounding a move to a local authority residential home rather than a private or voluntary home. Social workers, in particular, saw what some still termed ‘assessment for Part III’ as a major part of their work with elderly people who wished to move to a residential care home.

Making decisions: having a choice

The role of information has been a central theme in this study. People cannot be expected to make informed choices unless they have information, and, as we have noted earlier, there appears to be a paucity of written or verbal information given to elderly people and their carers. What role did the social workers and domiciliary care organisers play in giving information about residential homes, both in the local authority and in the private and voluntary sectors?
Local authority homes
The vast majority of social workers and domiciliary care organisers said they gave elderly people and their carers information concerning local authority homes. Only two domiciliary care organisers referred such cases straight to social workers as they did not feel that it was their responsibility.

But what was meant by information giving? Ten of the social workers said that they gave written information about the homes, whereas a further 16 respondents (11 social workers and five domiciliary care organisers) commented that there was little or no written information available. Only one social worker from the London borough mentioned that the authority had compiled a booklet about the authority’s own homes. She said: ‘We have a “Homes Book” which tells you about homes in the borough, a handbook, but it needs updating. It tells you where they are, the time of meals etc. A lot of homes have their own booklet now. It’s a good idea.’

Many social workers and domiciliary care organisers relied on personal impressions to give the elderly person and their carer an idea of what homes were like, and it was also common for them to take people on visits or to suggest that they try short term care within a home as a trial run. The following comments also suggest that care workers would value more written material about homes to supplement their personal opinions. One domiciliary care organiser said: ‘There’s nothing written down. We have a general discussion and I take them to look. Most people don’t know what they are talking about, they think of the workhouse.’ And another held a similar view: ‘It would be nice if we had a booklet. I tell them what I know and I take them to look around and see the place.’

Social workers gave a more detailed view of life in residential care than the domiciliary care organisers. One from the south said: ‘I tell them about the various places, where they are situated, the financial side of going into a residential home, and that it’s not all gloomy. There are outings and functions in the homes, and they are free to go and stay with their relatives.’

As workers who have direct contact with old people and their carers, social workers, in particular, should be well placed to see that their wishes are respected. Yet the availability of places in local authority residential homes at any one time can place limitations on choice, and, at best, care workers may only be able to lobby on behalf of their client.

The responses to questions concerning the influence of the worker in decisions over which local authority home a person was admitted displayed the contradictions inherent in wanting to offer choice while limited by the constraints on local services. While just over half of social workers and domiciliary care organisers interviewed said there were limitations on choice (such as location), two-thirds also said that they would take account of where there were vacancies.

So does the elderly person really have a say in decisions made about going into a local authority residential home? Is there really any choice? Twelve of the 40 social workers and four of the 11 domiciliary care organisers said that elderly people could state a preference for which residential home they went into. Smaller proportions commented that the old person always made the decision or...
could refuse to go into a home they did not like and could always choose to put their name on the waiting-list. To a degree, however, these responses relate to planned admissions and there was a recognition, especially amongst social workers, that choice was more limited when an old person had to be admitted in an emergency.

**Private homes**

We might expect social workers and domiciliary care organisers to know more about public sector residential provision than that provided by the private and voluntary sectors. But was this the case? The vast majority of respondents said that they gave elderly people and their carers information about private residential care homes in their area. The most common information provided was a basic list of names and addresses which they had either compiled themselves or had obtained through registration and inspection staff.

Domiciliary care organisers gave little more than this basic information, but, not surprisingly, financial advice was also mentioned by almost a third of social workers. In the southern county, where knowledge of the private sector appeared most developed, eleven of the twenty social workers interviewed gave such advice. Information given concerned costs and charges as well as advice on DSS funding. A social worker from the south said: ‘If they want to know, I explain the DSS system. I give them a list of homes and the DSS leaflet and telephone number, and a list of nursing homes as well. I’ll also give them some idea of what might be useful ways of proceeding with the DSS; how much money they need to have to be eligible.’

There was clearly some concern over just how much information social workers and domiciliary care organisers should give about private residential care homes. Most respondents did not see it as their role to go beyond a list of homes, financial information, and arranging or suggesting a visit. However, some made recommendations or referred the elderly person on to their GP or the registration officer. One social worker from the south said: ‘We’re not supposed to recommend, but I do say, “I have clients in there who are happy” and whether the owners are good with people with poor sight. They also ask their GPs.’

Others, like this worker from London, were more cautious: ‘I don’t give much more than the basic information – addresses, location, cost. I never recommend anywhere, though sometimes I will say which individual homes to avoid. I make it clear to relatives where to avoid. Everybody does this. But I can’t recommend anything.’

Only one social worker from the southern county and one domiciliary care organiser from the north said that they did not give any information concerning private care. The domiciliary care organiser referred all such cases to a social worker, while the social worker stated: ‘It’s up to them if it’s private.’ Attitudes therefore can have a strong influence on information giving.

Of course, giving information concerning private residential care is one thing. But under what circumstances was the private sector suggested? Thirty-one of the 40 social workers and eight of the 11 domiciliary care organisers
interviewed said that they had at some time suggested that an old person should go into a private home, and almost all the social workers in the London borough had done so. Over a third of social workers and domiciliary care organisers said that this was an option for those old people with financial resources, and, once again, this was particularly true in the London borough. One social worker commented: ‘If they’ve got money, I’d rather they did that than go into local authority accommodation – we haven’t got the places. Local authority provision is for those people who haven’t got £70,000 to £80,000.’ And another social worker from London said: ‘Where they can pay I would recommend it, especially where I know they will be a long time on a waiting list for Part III.’

The lack of availability of local authority provision and a feeling that private sector provision might better suit the needs of the individual were also important factors. A social worker from London said: ‘I’ve got one lady going into a private nursing home. Her family own her property. She’s in one of our short term care beds at the moment but wants something more luxurious.’

And a domiciliary care organiser responded: ‘If they want something smaller and they have looked at the local authority homes, then I suggest private, especially if they felt that the local homes were too big. Price doesn’t come into it. The DSS pays – local authority or private are the same.’

A number of respondents commented that some elderly people were not physically or mentally fit enough for local authority homes and if they needed nursing care, then a private nursing home should be suggested. Alternatively, three respondents suggested that some old people might be too fit for local authority provision.

Recommendations to private care were also made by workers where an elderly person knew a particular home in a specific location. A social worker from the southern authority said: ‘You discuss all the options. It really depends so much on their wishes really. If they know a particular home then you take them on a visit. You have to point out about the finances. A lot of elderly people know of a home but don’t think they can afford it, but a majority of homes will accept DSS support. We may not like a home but we leave it up to them. They have a list and we go through it with them.’

In exceptional circumstances a worker would assist with a move to private care where the old person was not happy with local authority provision, as this social worker also from the south described: ‘I’ve arranged for someone to move from one of our homes because she wasn’t happy. She couldn’t cope with sharing a room. I have suggested it to one or two.’

Nine social workers and three domiciliary care organisers said that they had never suggested private sector residential provision to any of their clients. Most of these respondents felt that the situation had never arisen or that they had mentioned it as an option but did not suggest it.

However, a few did not see it as their role or did not feel confident discussing the private sector. One social worker from the north said: ‘I think it’s wrong – a private home is a private arrangement. It’s up to them. Things could go wrong if the social services suggested a home. I’d suggest they looked around on their
own. I wouldn’t give them a list, I’d suggest the telephone book.’ Such a comment highlights some of the tensions surrounding the new roles of regulator and giver of information compared with the traditional roles of field social work, especially in areas where there is a tradition of strong public services.

**Voluntary sector provision**

Although it appeared that many of the social workers and domiciliary care organisers did not know a great deal about private sector residential care in their areas, surprisingly perhaps, they knew even less about the voluntary sector. However, there was a marked difference between the areas. Whereas over two-thirds of the social workers in the London borough and the southern county said that they gave their clients some information about voluntary sector residential care, this was true of less than one-fifth of the social workers and domiciliary care organisers in the northern authority where admittedly voluntary provision was very limited.

Of the 24 social workers who did give information of this kind, ten said that they gave a list of names and addresses compiled by the local authority, and fourteen gave information about those they knew personally. The latter was usually very specific and concerned one or two organisations, well-established in the area. A social worker from London said: ‘I tell them about the Methodist Homes – where they are. A lot of their homes are like our sheltered housing’ and one from the south added: ‘Abbeyfield Extra Care – I’ve got two residents in there. I put relatives in touch with Counsel and Care for the Elderly.’

Of the 16 social workers and nine domiciliary care organisers who did not give any information, some felt that they did not know enough about the voluntary sector, whereas others said that there were no voluntary homes in the area, and six social workers said that they just had no experience of the voluntary sector.

The lack of knowledge about voluntary sector residential provision in the northern authority was reflected in the fact that most social workers and domiciliary care organisers had never suggested that an old person move into this type of provision, although two-thirds of social workers in the London borough and nearly half of those from the south had done so. The two main reasons given for suggesting a voluntary home were first, that the home may be more suited to the elderly person’s needs and second, where a home offered a particular religious or group affiliation.

A social worker from the south, referring to a scheme that operated as very sheltered housing, said: ‘I’d suggest it if it seemed like the right kind of thing for the elderly person. Part two and a half can be just the right thing. It gives them more independence.’

The main reasons for not recommending voluntary homes centred around a lack of experience and knowledge, especially amongst domiciliary care organisers. A few respondents commented on bad experiences which had coloured their perspective of the voluntary sector. A domiciliary care organiser...
commented: ‘I tried to get a lady into a voluntary home but it was like a closed shop. You had to have so much money and be ambulant and not too confused. The elderly person had mentioned this home. She had asked me but they wouldn’t take her.’

Moving into independent sector care
But what is the role of the care worker if an elderly person does decide to move into a private or voluntary residential care home? It can be argued that the social worker has an important role to play, and that simply because the old person ceases to be a ‘client’ in the community, it does not necessarily mean that no further help is needed from statutory workers.

With this in mind, we asked social workers and domiciliary care organisers whether they gave further help or advice to old people who had decided to go into a private or voluntary residential care home. Views were divided on this issue. The presence or absence of carers or family members was crucial. If there were carers or family available then it was usually seen as ‘their business’, with the local authority to fall back on only if something went wrong. In the northern authority it appeared that the domiciliary care organisers had been informed that it was not their role to assist in these cases. One domiciliary care organiser said: ‘It’s not normally our role, it’s up to them or a relative. It has happened in the past. Someone once helped. But the problem is that if the money runs out, we’re responsible. If the elderly person didn’t have any help I’d do it, but in my own time – not as part of my job.’

Another commented: ‘It’s not normally my job, they and their families are responsible. I did help once; she was desperate and I rang around and took her in. The district manager knew but we were asked why we were involved and have now been told not to help people go into private homes.’

Social workers were more inclined to comment that, if the old person was alone, they would support them during this period of transition, taking them to visit homes, helping with the move and making sure they settled in their new home. One social worker from the north said: ‘It depends on the client. If they have no relatives or friends I’ll assist. I’d phone up and go with them to look around. I’d ask the head of home to visit the person at home. It’s a function that the social worker has to take on if no-one is around. I tread very warily though so that they make the final choice.’

A social worker from the southern authority said: ‘If they are on their own I will help them pack and arrange a home help to clear their house. I help to support them through the transition, but I advise them never to give up their own home immediately. I try to get them to go for a short stay so they can weigh it up. You can organise a four week trial period in a private home but it’s a bit more difficult as they want to keep the beds full. Private day care is costly, but is available.’

The task of assisting someone who does not have a family member or friend to support them through this period can leave the local authority with a great deal of work to do in helping the old person settle their estate, as this comment from a social worker in London shows: ‘It depends on whether they have any family.
If they don’t have anybody I’ll take her into the home and will continue to visit. Of course there is the house to sell and the contents to dispose of. If there is no family at all and they have no-one else to help then it falls to us to handle everything.’

**Views on residential care**

The information, advice and support given by social workers and domiciliary care organisers in relation to residential care may be coloured by their own impressions of the role of residential care as a service for elderly people. Because of this we sought the views of a range of workers including team managers and heads of homes in both the private and statutory sectors (see Appendix), on a range of issues concerning current provision and the changes which were taking place within residential care. First, we asked what they saw as the advantages and disadvantages of the three different sectors of provision.

**Advantages and disadvantages of local authority, private and voluntary residential homes**

**Local authority homes**

Respondents made a wide range of comments but we focus here on comments made by at least 10 per cent of each group of workers. While team managers, social workers, domiciliary care organisers, local authority heads of homes and private home proprietors ranked the advantages of local authority homes in a slightly different order, in the main they focused on issues of accountability; standards of care; security of tenure; staffing and staff training and particular aspects of the service such as review systems. The domiciliary care organisers interviewed who were not involved in assessing for Part III had less to say about residential care than the other respondents and were likely to comment in more general terms.

Many respondents felt that local authority residential homes offered residents security and were more closely monitored by the authority to whom they were accountable. A social worker from London said: ‘If you’ve got a good borough and live in a caring local authority then homes will be run according to the letter of the law and more.’

The head of a home from the London borough agreed: ‘I think our homes offer better value for money, better care and more staff. It must be better because the borough is not out to make a profit. You have to cut corners don’t you in the private sector. Also if your money runs out you have security in a local authority home.’

This theme was also found in comments from team managers and domiciliary care organisers, like this team manager – ‘We have better monitoring and evaluation of what’s going on. I can walk in any time and look at the paperwork...’ – while a domiciliary care organiser from the north said: ‘The local authority home is more answerable if anything goes wrong. The people are also more likely to complain and the problems are picked up in that way.’
The quality of staff was another key theme. A team manager from London said: ‘They’ve got professionally trained competent care staff whose aim is to maintain good standards.’ And there was a view that care practice in the local authority was also of a higher quality than the independent sector, as this social worker from the southern area noted: ‘They can review the old person’s progress. You couldn’t necessarily do that in a private home. You can monitor and review each person. Local authority homes are also locked into other facilities available in the area. Private homes are not.’

A proprietor from a private home in the southern authority felt that better pay was at the root of better staff: ‘They (the local authority) are able to pay staff higher wages and attract better staff. They are allocated money which allows them to have more facilities than private homes.’

Team managers commented on an advantage which local authority home had over the private or voluntary homes in being able to plan the transition to residential care at a pace which allowed the elderly person to change their mind: ‘We can be more flexible in what we can offer. For example short term care is not easy in a private home. Short term care may be part of the process of familiarisation for someone we see as a future candidate for residential care. The other use, of course, is for regular support of a person with caring relatives. We are prepared to wait a great deal longer with someone making up their minds about whether to stay in residential care – a month, six weeks. Then we can sit down and talk about it. Private homes as a rule are not prepared to do that. The old people sell up their homes. With us debt can accumulate, we say don’t sell up your house until you’re sure.’

The local authority home was seen in all three areas as the local community home, a place people were familiar with and where they could go regardless of their ability to pay. A team manager in the south commented: ‘We have access to them and know when there’s a vacancy. You can pay according to your means. They tend to be regarded as local homes, which people tend to know quite a bit about. They have visited the home or a neighbour works there. It’s in your own locality as well.’

However some private sector heads of homes saw no advantage in public sector provision. One from the north said: ‘There are no advantages apart from probably the money – but many private homes take DSS fees now.’

The disadvantages of local authority homes focused strongly on the physical environment. The issues raised here were shared rooms, poor physical standards, buildings that were too large with too many residents, and the institutionalisation and routinisation which is often a common feature of large establishments.

A domiciliary care organiser said: ‘They are too big, built a long time ago and a little bit institutionalised. There are no individual rooms or living areas for clients...’ and a social worker also from the north commented: ‘They are bigger – 30 to 40 people and they have been around a long time. There are institutional patterns of caring, people getting up and going to bed at ridiculous hours for the convenience of staff. There’s not much to choose from between different homes.’
A social worker from the London borough also felt that local authority homes still needed to raise their standards: ‘They are rather large and impersonal and not "home". The furniture is all the same. They are altering the number of people per room, but it’s still rather bare. People are not able to take many of their personal belongings with them, though this does vary and some are more flexible.’ A team manager from the same authority supported this view: ‘Our homes are fashioned in a "bring as many people in as you can" way. We can only afford to decorate them every ten years. Some standards are very low.’

However, a head of home from the public sector felt that a lack of resources was the main problem in upgrading buildings: ‘Money comes into it. There’s always a shortage of money from the local authority. We would like to enhance the surroundings but we are restricted by money.’

Other disadvantages mentioned by individual respondents included the stigma still attached to statutory provision. A domiciliary care organiser commented: ‘Stigma. There are a lot of private homes in my area and people say "My mother’s not going into the local authority home, she’s going private". They like to think they are in a private home and the old person would often not go in a social services home.’

The bureaucratisation which may pervade some local authority homes was also an issue. A team manager from the north said: ‘The home can become part of the bureaucratic system from the administration down to the staff who think, "I’ve got a nice safe local authority job"....’.

And a proprietor from a home in the north felt that staffing was an issue: ‘They are understaffed. They have 30-40-50 residents per home. They have also not got the niceties eg. serviettes, cups and saucers, tablecloths, foot-stools. They haven’t got the funding or the staff.’

**Private homes**

Whereas the advantages of public sector provision centred around issues of accountability, security, staff training and standards, those relating to the private sector focused on size, physical environment, atmosphere and choice. In fact, they closely mirrored the disadvantages of local authority homes. Thus private homes were seen to be small in size, with a more homely atmosphere where residents could feel part of a family group.

This was the view most commonly put forward by the managers and proprietors of private homes. Seventeen of the 24 respondents from private homes mentioned that their home offered something akin to family life. A head of home from the south made a typical comment: ‘Private homes are usually like a family. The residents relate to the owners. They are smaller with more of a friendly atmosphere. They are one of six rather than one of forty-four and they can be friends amongst each other.’

However, this proprietor from the north also recognised the diversity of the private sector: ‘There are two distinct sectors – small, family run homes and large conglomerate businesses. The small family homes have a reasonable atmosphere, while the large ones have less atmosphere but are better decorated, better
environment. It leaves people the choice of being lonely or having nice decorations.’

A social worker from the south said: ‘In the good ones, the smaller ones, you do get this terrific family feeling. They do get to know each other and residents may feel that they retain a bit more of their individuality.’ A domiciliary care organiser felt that a smaller home meant that the residents got more personal attention: ‘Private homes are small and can be run better. The old people get more attention. When the private industry came here I couldn’t believe the difference. When work is private they bother.’

A head of a local authority home in London felt that smaller homes were more easily integrated into the community: ‘They have a domestic scale and converted houses allow them more flexibility. The domestic nature makes them more part of the community. There is less stigma attached to them.’

There was also a feeling that in some areas the numbers of private homes available gave elderly people more choice. A team manager from the south said: ‘You’ve got more private homes to choose between – more choice. Whether you’ve got more choice within each establishment depends on the home, the staff and the philosophy.’ And a social worker from the south commented: ‘For some people the feeling of “I’ve chosen to come here” – “I’m spending my money” is a feeling of choice. They haven’t been dumped, although they can be dumped there too’.

Interestingly, the commonly used indicator of privacy in residential care – having a single room – was highlighted as an advantage by only a small percentage of all the respondents, whereas shared rooms and multiple occupancy rooms was seen as a more common disadvantage for local authority homes, especially among social workers. The disadvantages of private homes mentioned by our respondents centred on issues of security, both financial and in relation to health care; the need for greater regulation and the lack of accountability; the perceived lack of staff training and cost. Strong feelings were expressed by those in the public sector that elderly people could be very vulnerable in private homes, especially if they ran out of money or needed nursing care. The view was that they could easily be turned out of a private home and that this was the main danger where profit and care were brought together. There was a general feeling that the need to make a profit would always outweigh the needs of the elderly person.

One team manager described what happened in his authority: ‘To make money, profit must come first. Profit is your master, and care may come second. If the elderly person runs out of money the manager rings me up and says I’m responsible, or carers ring up crying on the phone. If it’s the officer in charge I say to them that they took the person on and I say you are morally obliged to keep them. I refer them to the DSS. Throwing them out on the street wouldn’t look good. So they keep them on. But if a carer rings up I sit down with them and explain the situation and that they are unlikely to kick them out because it looks bad.’
A social worker from the north put it more bluntly: ‘If they can’t meet the payments they kick you out and if you need nursing care they don’t hold your bed.’ And another from the south reported this experience: ‘Pricewise there are some problems with financial security. I’ve even had a home which moved an elderly person to a very inferior room in another home. She was used just like a package. She got up in the morning and that afternoon was moved.’

The heads of local authority homes were more sympathetic to their counterparts in the private sector. One from the south said: ‘There is the ultimate threat of eviction when fees go up. We approach charities to get top-up over the DSS money. If not, then people are forced to move to county council homes. The private sector holds people for a period while we sort something out. They are suffering from crippling interest rates.’

It is interesting to note at this point that when we asked the heads of private homes, ‘What would happen if an elderly person could no longer afford to pay the fees?’ respondents were adamant that they would not make elderly people move. They would apply to the DSS for support; pursue an attendance allowance; accept reduced fees and "carry" people if they could not meet the fees. The following comments were typical: ‘We will not take anyone in unless we can foresee them paying our fees for four to five years. If then they can no longer afford it we take what they can afford. We subsidise them or the other residents subsidise them’....‘We don’t throw them out. We get in touch with the social services department and we try and devise a plan of what we can claim for. They usually get their pension taken and then they get "pocket money" like in local authority homes. The proprietor will also carry people, so if fees go up and someone can’t pay she’ll carry a number’... ‘We have got one case -- a lady ran out of money and said she’d have to move as she didn’t want to go on the DSS -- as she was too proud. We’ve allowed her to stay for the rest of her life and pay what she can. She’ll probably live to be 200!’

At the time of the study -- nine of the 24 heads of private homes interviewed had experienced such difficulties with one resident and four with two residents in the past year. Two heads of home commented that four residents had had financial difficulties within the past year. There was a general comment that they could only take so many residents at the DSS level before standards fell although they were prepared to carry some people.

Comments made by community and residential workers about the regulation of private and voluntary residential care showed that they either knew little about the practice of registration and inspection in their authorities or felt that it was not effective. One domiciliary care organiser said: ‘They aren’t being monitored closely enough; monitoring only physical facilities, not enough on the quality of care.’ A social worker, also from the north, responded: ‘Accountability – I’m not sure how good our registration officer is. I don’t know what they are monitoring or what standards he invokes.’ And a team manager from London commented: ‘A registration officer can’t sleep overnight in a private home and poke around among the paperwork.’
Other disadvantages mentioned by a smaller number of respondents included problems of access to other services. A domiciliary care organiser said: ‘Sometimes people think they can’t go to a day centre or get a walking frame because they are in a private home. They should be able to have all the services and amenities.’

The perceived selectivity of private homes over which residents they took was also highlighted. Again a domiciliary care organiser stated: ‘Private homes can say who they want, the worst go into local authority homes.’ And the lack of basic staffing was an issue for this social worker from the south: ‘Quite often, if they need night cover, they may have to employ someone specifically to take charge.’ This theme was taken up by this head of a local authority home from the north: ‘I don’t think that the staff get the training that is offered in local authority homes. There is too much part-time work, lots of YTS and a huge turnover.’

**Voluntary homes**

The comments made about residential care in the voluntary sector were very limited compared with those for local authority and private provision where very definite views were held. Over a half of social workers and team managers and all the domiciliary care organisers interviewed could not comment on the advantages or disadvantages of voluntary sector residential provision in their areas and many said they did not know anything about them or said there were none in the area. This was also true of a third of the heads of homes and proprietors interviewed.

The main advantage of voluntary homes were seen in providing an environment which either met an elderly person’s particular needs as a member of a fraternal or religious group, or enabled them to engage in a more independent lifestyle. The head of a private home in the south said: ‘In church homes like the Methodist homes they cater for the needs of the church-goer. They are among their own people; there’s bonding.’ A team manager from the southern authority commented: ‘I think of Abbeyfield as more independent – half-way between with some communal care and some private. It’s more than sheltered housing. They are filling a gap that we don’t fill’.

Another from the north thought there were pros and cons: ‘A good voluntary home can combine the advantages of private care and local authority care. However, they are not as advanced in caring for the elderly as they are with other client groups where there are many innovations.’

Other respondents agreed that homes run by the voluntary sector could demonstrate features of both the public and private sectors. Some saw them as offering the intimate family care characteristic of small private homes, while others, like this local authority head of home felt they might benefit from being part of a large voluntary organisation: ‘Voluntary homes which are part of an organisation often offer better practice and maintenance of standards than one-off private homes.’
However, there was a feeling that the voluntary sector could be selective in whom they admitted and that some did not like taking elderly people who they felt were too physically or mentally frail, as this social worker from the southern area noted: ‘They can’t tolerate anyone with any physical need such as incontinence...’ A team manager from the same area agreed: ‘With their current level of care, if you become frail then you have to leave. It’s not their provision, it’s a lack of staffing and care.’

Heads of homes made more varied comments. Waiting lists for the voluntary sector were said to be too long; staff training not as good as the public sector and it was felt that an aura of charity might still remain in some. A proprietor of a private home felt that the style of management common in the voluntary sector could be restrictive: ‘You get restricted by a committee – it’s impracticable. The needs of old people change from day to day, but it’s all got to go through a committee. It takes forever.’

The impact of the growth of private residential care homes
We asked respondents to reflect on the impact of the growth of private residential care on services for elderly people as a whole. Not surprisingly, given the variation in the development of the private sector between authorities, views were more or less coloured by experience. Social workers, team managers and heads of homes were most vocal on this subject, whereas domiciliary care organisers made more limited comments.

The three main effects reported by social workers were first, that the growth of private residential care had given older people and their families more choice, second, that there had been a decrease in the demand for places in local authority homes, and third, that people were exploiting the elderly and making money out of them. A social worker from London said: ‘There’s an element of choice if you can afford it. My gut feeling is I don’t like them -- making money out of old people. But I can see the need. I don’t like the high fees involved though’.

In the north, there was a feeling that the private sector had increased the range of alternatives for older people: ‘There are more vacancies in local authority homes. People have been given more choice and that’s a good thing.’ This view was also found in the south where one social worker said: ‘It has offered people more choice and I get the impression that we have more vacancies’. And another added: ‘I think it’s taken a lot of pressure off local authorities to provide residential care. But it’s given carte blanche to people who aren’t in that kind of business and it’s given a lot of elderly people misery and not enough is being done about it.’

In the southern authority, where there was a lot of experience of private sector care, social workers also commented on the importance of location, the influx of people from outside the county and the dominance of residential care in service provision for the elderly. A social worker said: ‘We’ve got lots of people moving in from the cities, an influx from the rest of the country. There’s not a lot for local people, not real local people.’
This social worker felt that the dominance of residential care made the development of domiciliary services more difficult: ‘I think it’s certainly changed our homes. It’s taken away the queues. It’s creamed off some of our staff too. Also you can have too many and that has an effect on an area and on the expectation that you’ll end up in a home. It tends to deplete our efforts in trying to persuade people to stay at home because the expectation is that you will go into a home because there are so many around.’

Some of these issues were taken up by the team managers. Their most common concern was that there had been an overall increase in the number of elderly people going into residential care, particularly in the southern and northern authorities where the private sector was well established. One team manager from the south made these comments on the balance of services between community care and residential care and the financial incentive which had led to the growth of residential care: ‘The effect has been that many more elderly people have thought of private care because money has been available to them, and they consider residential care much more readily because that money is not available for them at home. I don’t necessarily think that’s what people really would have thought about. If finance had been available for them to buy in community care to support them it would have been better.’

There was a general feeling that the growth of the private sector had provided more choice and had certainly taken the pressure away from local authority services. However, there was also a concern that choice had been given to carers rather than to elderly people and that elderly people might be going into residential care at earlier stages in their lives than they might wish too. A manager from the south said: ‘I think it provides a dumping ground for elderly people. I can see that one beneficial effect is that we are not running a great long waiting list and it has reduced pressure on us, but it has given informal carers the opportunity to bundle people into private residential care. It’s very difficult. People are not always consulted about whether they could manage at home’.

A team manager from the north agreed, feeling that carers now had more control over the outcome for elderly people: ‘I think a lot of people are in homes now who’d still be in their own homes if there were no private homes. Carers have now got too big a say. They are looking at what is provided by the local authority and saying that it’s not enough. Families would like mum or dad cared for 24 hours a day. We don’t have those resources, but private homes do.’ Another manager said: ‘Some elderly people are going in too early or directly from hospital when there should have been a more concerted effort to provide domiciliary care’.

The local authority heads of homes agreed with many of these views, but they were concerned about staff numbers and staff training. A respondent from the south commented: ‘The main effect is with staff. It has made a big difference. We used to advertise and the paper would come out and the phone would not stop ringing. Now we are lucky if we get six applicants’.

There was also a general view that the growth of the independent sector was leaving the local authority to care for the most dependent elderly people. The
words ‘creamed off’ were used by many, like this head of a home in the north: ‘They have creamed off the elderly – they only take a certain type of elderly person – those who are mentally alert, fit and active. We’re finding when we get people in they are very advanced with senile dementia. They are physically "shot" really.’ A head of home from London agreed: ‘I think that residential homes have had to broaden their criteria for admission – residents are coming into local authority home who are much frailer. This involves the growth of private care and hospital policy’.

The views of the domiciliary care organisers also reflected these concerns: ‘It’s changed the status of local authority homes. The more easily cared-for clients go to private homes, and you end up with quite senile people in local authority homes’. Another agreed: ‘The type of resident in our homes has changed dramatically with the increase in private homes. Private homes choose carefully – mobile, continent people. Local authority homes get the dregs who need nursing care. When a resident becomes incontinent in a private nursing home they go to hospital and then they refuse to have them back. It’s terrible.’

**More choice or less?**

While the majority of respondents thought that the growth of private residential care had increased the amount of choice that old people had, most added a further qualification. Seven of the 11 domiciliary care organisers said that there was an increased choice simply because it was no longer just a case of local authority provision: ‘It’s given people a wider choice. Well it must have done, we’ve gone from three or four private homes to about thirty.’

Eleven of the 40 social workers felt that choice had really only been increased for those with money. One from the north said: ‘It’s opened choice up to people with financial means, with a home they can sell. They can sell the home and go into a private home, and they can go in quicker. They’d have to wait for a place in ours.’

A social worker from the southern authority agreed: ‘It only increases choice where they have got money to pay for it. If they or their family have top-up money, then, yes it does.’ And a colleague added: ‘It has if they’ve got money. If you haven’t got money I’ve a horrible feeling you’ll end up with less choice – unless you find a charity to top you up, but they’re drying up.’

Other respondents mentioned a choice of location, a particular issue in rural areas or where old people wished to live near their family. A social worker from the south said: ‘It has increased choice and made it more feasible for people to go where they want to be, not going just to the county home. It makes visiting easier especially where we have small villages.’ Whereas another social worker from London said: ‘You can choose the location. More people can go and live nearer relatives. It is difficult to arrange for someone to live in a local authority home in another area. Possible, but difficult.’

Once again team managers were more likely to comment that the increase in choice was really only one of degree, between residential care and more residential care, and that you could not always be certain that it would be better
quality residential care. A team manager from the north said: ‘They now have the choice of more of the same. Real choice is about staying in the community and having access to day care or whatever.’

However another from the south felt that the private sector could be incorporated into the overall pattern of services providing it was of a high standard: ‘You can only be sure about increasing choice over the amount of care people receive if you’re sure about the level of care the private homes are providing. I’m fairly confident about the level of inspection here. In some authorities it would be against the policy to use private homes. Our policy is that you look at the needs of the elderly person. They must have advice on the whole range of services. We’ve got to provide comprehensive options.’

Some heads of homes or proprietors in the private sector felt that more choice was available for relatives and for professionals. A respondent from the south said: ‘I don’t know that residents actually have a choice – the family have a choice. It’s always a crisis situation. Since we’ve been operating we’ve only had one lady say, ”I need care”. She looked around. But she’s the only one. It’s increased the choice for the family, GPs and social workers – not for elderly people.’

However, other heads of homes from both sectors were more positive about the range of accommodation now available to older people. A proprietor from the north commented: ‘Oh yes, definitely, very much so. People can decide if they want to live with three, five, eight, 15, or 40 people, local authority or private, facilities, areas, styles of management. A vast choice’. And this head of home from the south felt that the status of residential care had changed: ‘Oh yes, to a lot of old people, the old people’s home was the workhouse. To be in a private home is a bit different, not the workhouse. They have a better class of residents. We get the working class, people with only their pensions.’

Changes in residential care

Finally respondents were asked whether there were any changes in general that they would like to see in the provision of residential care for elderly people. As expected, this question generated a wide variety of comments. At the top of the social workers’ list was the physical environment. Ten of the 40 respondents thought that residential care should offer self-contained flats, and eight commented on the need for single rooms. A quarter of the social workers highlighted the need for more activities in homes, and other concerns included resident participation within the running of the home, increased monitoring of standards of care, greater community involvement, and more choice of how people lived their lives.

A social worker from London said: ‘A lot of homes are changing. It goes without saying that I’d like individual rooms with their own bathroom and toilet. I think residents should have more say in what goes on. Also more activities; something to do, rather than feeling they’re a useless part of the community - not dumped to die.’
And a worker from the south described the link between residential home and community: ‘I’d like to feel that there was more of a flow out to the community. They feel that’s the end of their contact with the village and the community. When the doors are shut there’s a cutting off. "That’s it, that’s the final part of my life." I want more flow. We’ve had further education classes in one home. I’d like to see a two way flow. People could come out to day centres or for holidays – even in another home. There should be more varied use of the homes, for example for night care. They should be used more as a community centre.’

The priorities of team managers, while similar to the social workers, also raised issues of the need for more staff training and supervision, the development of review systems for residents and the need for more individualised care. A team manager from London said: ‘There’s a huge group of staff there, unqualified and untrained, with senior staff with no qualifications either. I’m not a nurse but a social worker, but I’m aware of the health needs. Perhaps some of the staff should have nursing qualifications. I’m against nursing staff as officers in charge, but some staff need nursing skills.’

A team manager from the north felt there should be a more radical reappraisal of how elderly people paid for local authority care: ‘People should actually pay rent for their accommodation. This would help to maintain their dignity, self-esteem and individualism. We should create a situation where the elderly person can be as independent as possible.’

Finally the domiciliary care organisers, while having less to say about changes to residential care in general, did comment on the need for more individualised care, more choice over how residents spent their days, the need for higher staff:resident ratios and changes in the physical environment. In particular, they mentioned the importance of interactions between staff and residents. One said: ‘There are not enough staff to do the jobs that are important, such as talking to residents. This is just not possible if the ratio of staff to residents is too low.’

The views of heads of homes and proprietors were very different from the fieldworkers and managers interviewed. The local authority heads of homes were most concerned about the need for increased facilities for elderly people suffering from mental illness, the need for more staff and staff training, and, particularly in the southern authority, the integration of residential and community care: ‘I’d like to see us have greater links with the community as a resource. We can offer permanent beds and I’d like to be more flexible in terms of what we can offer – short-stay, intermittent care, all day care and day care.’

In contrast, private sector heads and proprietors had very different priorities. There was a great concern over the level of DSS payments to residents, the need for closer monitoring of private care, and for greater discussion over the divide between residential and nursing home care and between the different sectors of provision. This proprietor from the north wanted more rigorous inspections: ‘More inspections. I’m not afraid and so don’t see why anybody else should be.
We need to improve residential care and provide more choice for elderly people. Also good staff – my maxim is good staff equals good business.’

A proprietor from the south wanted more links with social services: ‘I would like to be used by social services as a day centre home. I’ve got the facilities which could be used. Also the Red Cross or bridge clubs could use the home as a meeting place for community activities. It feels very us and them.’

Conclusion
The views of the professionals interviewed indicate that if the growth of private residential care has increased choice within residential care then it has done so for specific groups of people. It has given more choice to those elderly people with financial resources who may have a choice over location and the type of accommodation and care they require. In spite of the financial support given to elderly people within private care through the DSS, there was some evidence that those relying on state support may fall prey to falling standards of care within the private sector if costs cannot be met.

The growth of private residential care was also seen to have given more choice to relatives and to professionals who feel that their elderly relatives or clients are at risk within their own home, particularly if they do not have the capacity in terms of informal or formal support to maintain them at home. In addition, respondents tended to agree that certain groups of heavily dependent elderly people will remain within the statutory sector and that in some areas, without further financial investment, statutory sector provision will deteriorate.

For those making choices about residential care in any sector, the information given by professionals appeared inadequate. There was a paucity of written information, and ignorance, as well as hostility, regarding other sectors of provision still prevailed among some local authority workers.

The majority of respondents, while they did not deny the value of, or necessity for, residential care, found much to criticise in terms of current provision. Within homes across all sectors there was still thought to be a need for improving the physical environment; increasing staffing and developing staff training; developing systems of accountability – regulation and monitoring; enhancing standards, and finding ways of ensuring security of tenure for residents in all sectors.

This is an important point given that 60 per cent of the elderly people we interviewed in residential care thought that living in a residential home was better than they thought it was going to be. In particular, the elderly people mentioned the importance of companionship, care and security within care settings. While these are points which a younger generation of professionals recognise, they may not be at the forefront of their minds when discussing residential care with elderly people. This raises the controversial point of whether ‘helping people to stay at home as long as possible’ should be the aim, an issue discussed in the next chapter. While recognising the importance of our own homes in maintaining our self-identity as we age, we must also recognise that this relationship has been
developed within a culture where the individual privacy of family life is dominant. Here stress is placed on individual or family rather than collective solutions to our needs. Given the diversity of accommodation plus care for people in later life currently being developed (see Mackintosh et al, 1990; Oldman, 1990), perhaps greater energy should be placed on extending these options to the widest possible audience, and ensuring that residential care becomes truly a part of community care which is integrated, accountable, welcoming and not ‘out of sight, out of mind’. So while residential care was seen as a ‘positive choice’ for a minority, it was still portrayed by professionals as a ‘last resort’ for the majority.