

**The Changing Landscape of Residential Care:
Care Homes and Alternative Forms of Housing
with Care**

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Abstract

This thesis draws together a series of publications that were based on research studies conducted between 1981 and 2011, covering care homes and alternative forms of housing with care. The majority of the studies were funded by the Department of Health or its predecessors, and were aimed at responding to policy issues, particularly for local authority grant funding. However, the funding provided the opportunity to collect information for broader purposes, and a central feature linking the studies was the collection, as far as possible, of consistent information about the characteristics of residents over time. The thesis includes 12 pieces of work, based on information collected in ten studies, and illustrates the changes in care home provision from 1981 onwards, and the potential role of alternative forms of housing with care.

The aim of the thesis is to explore the following themes: the changing role of care homes and the development of the independent sector, particularly the private sector; factors associated with care home costs; changes in the relative role of residential and nursing homes, including changes in the characteristics of residents over time; changes in the quality of provision; the impact of care home closures; provision for self-funders and the expectations of residents; and the development of alternative forms of housing with care, and the degree to which specialised housing can provide an alternative to residential care.

Care homes in the UK provide around 470,000 places and account for over half the expenditure on social care for older people in England. However, information about care facilities and residents is very limited. The papers presented here aimed to fill some of the gaps in understanding residential care and possible alternatives by making use of data collected in a unique series of related research studies conducted over a period of 30 years.

This thesis is dedicated to the memory of my parents, Roy Vincent Darton (1920–2005) and Jean Mary Burn Darton (1919–2006).

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Finally, I would like to acknowledge the support of my partner, Angela Tippett, and particularly her tolerance of my erratic working hours.

Contents

Index of Tables.....	5
List of Abbreviations	6
Supporting Statement	7
1. Introduction	7
1.1. Terminology	8
2. Research Projects and Publications	9
2.1. Research Projects	9
2.2. Publications	12
2.3. Responsibilities.....	12
3. Commentary	18
3.1. Introduction and Policy Background.....	18
3.2. Thesis Themes	23
3.3. Changes in Provision Over Time.....	23
3.4. The Factors Associated with the Costs of Residential Care.....	25
3.5. Changes in the Role of Residential and Nursing Homes.....	28
3.6. Quality of Provision.....	30
3.7. Care Home Closures	31
3.8. Self-Funders and Resident Expectations	32
3.9. Specialised Housing – An Alternative to Residential Care?	36
3.10. Conclusions	39
4. References	43
Appendix 1: Publications	55
Appendix 2: Supporting Statements	59

Index of Tables

Table 1: Projects.....	14
Table 2: Project Responsibilities.....	16
Table 3: Publications and Responsibility for Publications	17

List of Abbreviations

BMRB	British Market Research Bureau, now TNS BMRB
DH	Department of Health
DHSS	Department of Health and Social Security
DSS	Department of Social Security
Estabs	Establishments (table 1)
Indivs	Individuals (table 1)
LAs	Local authorities (table 1)
NatCen	National Centre for Social Research
NOP World	Formerly National Opinion Polls, subsequently GfK NOP
PSSRU	Personal Social Services Research Unit
RNHA	Registered Nursing Home Association
RSL	Research Services Ltd, now Ipsos MORI

Supporting Statement

1. Introduction

This thesis draws together a series of publications that were based on research studies conducted between 1981 and 2011, covering care homes and alternative forms of housing with care. The majority of the studies were funded by the Department of Health or its predecessors, and were aimed at responding to policy issues, particularly for local authority grant funding. However, they provided the opportunity to collect information for broader purposes, and a central feature linking the studies was the collection, as far as possible, of consistent information about the characteristics of residents over time. This has enabled changes over time to be identified more reliably and comparative results drawn out. Examples of how the information collected over time supported broader research purposes were the studies of care home closures and extra care housing. The thesis includes 12 pieces of work, based on information collected in ten studies, and illustrates the changes in care home provision from 1981 onwards, and the potential role of alternative forms of housing with care.

The ten studies include a series of national surveys of care homes and their residents begun in 1981, 1986, 1992, 1995, 1996 and 2005, and a recent evaluative study of extra care housing conducted between 2006–2010. A recent study of the views of residents and their relatives, conducted during 2008–2009, and a previous study of the expectations of self-funders, conducted during 1999–2000, provide information about the factors involved in choosing residential care. In addition, a follow-up in 2001 of the homes included in the 1996 survey provided the basis for a comparison of homes that had closed with those that remained open. The majority of the studies were only conducted in local authorities in England, although three included local authorities in Wales and two included local authorities in Scotland. Accordingly, the focus of the thesis is on care homes in England, although the publications included were based on the data collected from all the local authorities included in the corresponding study, or studies.

The 12 papers were selected to highlight the analyses of the sequence of empirical studies of care homes and, latterly, extra care housing, together with a few papers providing a broader view of these facilities.

The aim of the thesis is to address the following themes: the changing role of care homes and the development of the independent sector, particularly the private sector; factors associated with care home costs; changes in the relative role of residential and nursing homes, including changes in the characteristics of residents over time; changes in the quality of provision; the impact of care home closures; provision for self-funders and the expectations of residents; and the development of alternative forms of housing with care, and the degree to which specialised housing can provide an alternative to residential care.

1.1. Terminology

Prior to the implementation of the Care Standards Act 2000 in April 2002, nursing homes and residential care homes in the independent sector were regulated separately by health and local authorities, and local authority-managed homes were not regulated (Netten et al., 2005). The Care Standards Act defined a care home as an establishment that provides accommodation, together with nursing or personal care. The term ‘care home’ is used here to cover both residential care and nursing homes, but the former terminology has been used for clarity, where necessary. The general term ‘residential care’ is used to refer to care homes as a whole, unless the context indicates otherwise.

2. Research Projects and Publications

Table 1 identifies the ten studies on which the thesis is based, and table 2 identifies my level of responsibility for eight broad activities within each study. Table 3 lists the 12 publications, and identifies my level of responsibility for the analysis, where relevant, and for the authorship of each paper.

2.1. Research Projects

All but one of the studies were funded by the Department of Health, or its predecessor, the Department of Health and Social Security (DHSS). The study of self-funded admissions (study 6) was funded by the Department of Social Security, now the Department for Work and Pensions. The study of residents' and relatives' expectations and experiences (study 10) was jointly funded by the Department of Health and the Registered Nursing Home Association (RNHA). Four of the studies were funded as part of the core funding of the PSSRU from the DHSS or the Department of Health, as indicated in table 1. The remaining studies were specifically-commissioned projects, and I was a named investigator in each case.

Study 1

The 1981 survey covered residential homes in the public, private and voluntary sectors in 12 local authorities in England and Wales (Darton, 1986a). It had three main objectives: to collect information on the dependency of residents and to examine factors related to and influencing levels of dependency; to investigate factors explaining variations in the costs of residential provision; and to describe the changes on characteristics of homes, resident dependency and standards of provision since 1970.

Study 2

The 1986–1987 survey was designed to examine the similarities and differences between nursing homes and residential homes for older people. It was commissioned by the DHSS as one of a number of studies into the payment of supplementary benefit, subsequently

income support, to residents in non-statutory (independent sector) residential and nursing homes, and was conducted in 17 local authorities in England, Scotland and Wales (Darton et al., 1989; Darton and Wright, 1990). The survey was designed to provide similar information to the 1981 survey.

Study 3

The 1992 study was designed to contribute information to assist local authority planners and care managers in the planning the support of residents in residential and nursing homes (Darton, 1992). The study was carried out in three of the four local authorities that were involved in a broader PSSRU project funded by the Department of Health.

Studies 4 and 5

The longitudinal survey of residents admitted to care homes conducted between 1995 and 1999 (study 4) and the 1996 cross-sectional survey of care homes (study 5) formed two parts of a study funded by the Department of Health. The longitudinal survey collected information on residents admitted to homes in 18 local authorities, including their personal characteristics, health, dependency and charges at the time of admission, their prior circumstances, and their subsequent moves, survival, health and dependency (Bebbington et al., 2001). The cross-sectional survey included information on residents in homes in 21 local authorities, and focused on the characteristics of the homes and their residents, and on the relationship between costs and dependency (Netten et al., 2001).

Study 6

The 1995–1999 longitudinal survey focused on residents who were supported by the local authority. The 1999–2000 study was designed to provide comparable information about the circumstances of self-funded admissions to care homes, and included information on residents in homes in 28 local authorities or groups of local authorities in England, Scotland and Wales (Netten et al., 2002).

Study 7

In response to concerns about the decline in the number of care home places, the Department of Health began an analytical study of care home supply in 2000 (Department of Health, 2002b). The PSSRU was commissioned to undertake research focusing on the closures of care homes, including this study, which compared homes that closed between 1996 and 2001 with those that remained open by following up the homes included in the 1996 cross-sectional survey (Darton, 2002).

Study 8

In 2004 the Department of Health commissioned the PSSRU to undertake a study of social services for older people, as one of three studies to produce options for improved and updated formulae for allocating funding to councils with social services responsibilities. The study included both individual-level and small area analyses, and the data collection for the individual-level analysis included a sample of admissions to care homes, following the approach used in the 1995–1999 survey (study 4), and a sample of people receiving home care (Darton et al., 2006). The survey of admissions to care homes included residents admitted to homes in 16 local authorities.

Study 9

In 2003, the Department of Health announced a new fund, the Extra Care Housing Fund, to support the development of extra care housing (Department of Health, 2003b,c). The Department recognised that there were considerable variations in the design of extra care schemes. However, the research for the Royal Commission on Long Term Care (Cm 4192-I, 1999) had not attempted to discriminate between different models of provision. In addition, evidence was needed as to whether extra care housing should be seen as part of a continuum or as a replacement for most residential care (Department of Health, 2003b). Participation in an evaluation was a condition of receiving support from the fund, and the PSSRU was commissioned to undertake the evaluation, which included 19 extra care housing schemes (Darton et al., 2011a; Netten et al., 2011). In 2003–2004, prior to the main evaluation (study 9b), the PSSRU was commissioned to undertake a preliminary evaluation (study 9a).

Study 10

The 2008–2009 study was commissioned by the RNHA to examine residents' views of living in care homes. It was also supported by the Department of Health, in particular to examine concerns about abuse in care homes. The study involved an interview at the time of moving in and a subsequent follow-up interview. Where residents were deemed unable to participate, a relative was invited to take part in a telephone survey. Information was obtained from 69 residents and 33 relatives of residents in homes in 18 local authorities (Charlton et al., 2010; Darton, 2011).

2.2. Publications

The 12 pieces of work are identified as papers A–L, as shown in table 3, and copies are included in appendix 1. The papers have been listed in order of publication. However, the discussion of the papers does not entirely follow the same sequence because some papers provide a more general introduction to particular themes. In the text below, references to the papers are highlighted in bold type to assist the reader. Table 3 also shows the specific study or studies on which each paper was based. Papers C and I were not based on empirical studies, but were undertaken within specific projects and are listed accordingly. In addition, table 3 identifies my level of responsibility for the analysis, where relevant, and for the authorship of each paper.

2.3. Responsibilities

With the exception of studies 3 and 10, the projects were undertaken by a research team at PSSRU or in collaboration with colleagues elsewhere. However, I had a role in most aspects of each project, from the design stage to the preparation of final reports, as shown in table 2, and I took particular responsibility for sample design, questionnaire design, data preparation, data management and data analysis, as well as contributing to the preparation of reports for all of the projects.

Table 3 identifies my level of responsibility for the analysis, where relevant, and for authorship of each paper. In most cases I undertook the majority or all of the analysis, in consultation with the co-authors, where relevant. In two cases (papers F and J) the analysis was divided into separate sections, and I undertook the analysis for specific sections of the paper. For six of the nine jointly-authored papers, I had joint responsibility for authorship (papers A, C, E, F, G and J), and for the remaining three (papers B, I and K) I was the lead author. Supporting statements from the co-authors are included in appendix 2. For papers E, F, G, J and K, Professor Ann Netten agreed to provide a supporting statement on behalf of the co-authors, as Principal Investigator.

Table 1: Projects

No.	Main study period	Title of study	Type of facility	Type of information	Funder	Fieldwork agency	Response		
							LAs	Estabs	Indivs
1	1981-1983	The PSSRU Survey of Residential Accommodation for the Elderly	Residential homes	Homes & residents	DHSS (core)	In-house	12	456	14,007
2	1985-1987	PSSRU/CHE Survey of Residential and Nursing Homes	Residential & nursing homes	Homes & residents	DHSS	In-house	17	605	6,636
3	1992	Length of Stay of Residents and Patients in Residential and Nursing Homes	Residential & nursing homes	Homes, residents & admissions	DH (core)	In-house	3	281	7,137
4	1995-1999	The 1995/96 National Longitudinal Survey of Publicly-Funded Admissions	Residential & nursing homes	Admissions	DH	RSL	18	–	2,544
5	1996-1998	1996 Survey of Care Homes for Elderly People	Residential & nursing homes	Homes & residents	DH	RSL	21	673	11,899
6	1998-2000	Self-Funded Admissions to Care Homes	Residential & nursing homes	Admissions	DSS	NatCen	28	292	921
7	2001-2002	1996 Survey of Care Homes for Elderly People: Follow-Up of Home Closures (The Rate, Causes and Consequences of Home Closures)	Residential & nursing homes	Homes	DH (core)	In-house	20	624	–

Table 1: Projects (cont'd)

No.	Main study period	Title of study	Type of facility	Type of information	Funder	Fieldwork agency	Response		
							LAs	Estabs	Indivs
8	2004-2005	The 2005 PSSRU/NOP Survey of Admissions to Care Homes (Resource Allocation Formulae for England: Study of Relative Need for Social Care for Older People)	Residential & nursing homes	Admissions	DH	NOP World	16	–	826
9a	2003-2004	Evaluation of the Extra Care Housing Initiative	Extra care housing	–	DH	In-house	–	–	–
9b	2006-2011	Evaluation of the Extra Care Housing Initiative	Extra care housing	Admissions	DH (core)	In-house	18	19	1,248
10	2006-2011	Study of Care Home Residents' and Relatives' Expectations and Experiences	Residential & nursing homes	Admissions	RNHA, DH	BMRB	18	46	102

Table 2: Project Responsibilities

No.	Year(s)	Title of study	Activities							
			Design	Negotiation/liason	Sampling design	Questionnaire design	Data preparation	Data management	Statistical analysis	Report writing etc
1	1981-1983	The PSSRU Survey of Residential Accommodation for the Elderly	C	P	C	S	S	S	C	C
2	1985-1987	PSSRU/CHE Survey of Residential and Nursing Homes	C	C	C	C	T	C	C	C
3	1992	Length of Stay of Residents and Patients in Residential and Nursing Homes	S	S	–	S	S	S	S	S
4	1995-1999	The 1995/96 National Longitudinal Survey of Publicly-Funded Admissions	C	C	C	C	S	S	C	C
5	1996-1998	1996 Survey of Care Homes for Elderly People	C	C	C	C	A	C	C	C
6	1998-2000	Self-Funded Admissions to Care Homes	C	C	S	C	A	S	C	C
7	2001-2002	1996 Survey of Care Homes for Elderly People: Follow-Up of Home Closures (The Rate, Causes and Consequences of Home Closures)	C	C	–	C	C	S	S	S
8	2004-2005	The 2005 PSSRU/NOP Survey of Admissions to Care Homes (Resource Allocation Formulae for England: Study of Relative Need for Social Care for Older People)	C	C	P	P	A	S	P	P
9	2003-2004, 2006-2011	Evaluation of the Extra Care Housing Initiative	C	C	–	C	C	S	C	C
10	2006-2011	Study of Care Home Residents' and Relatives' Expectations and Experiences	S	S	S	S	A	S	S	S

Key: A: Contracted to agency; C: Co-responsibility; P: Principal responsibility; S: Sole responsibility; T: Other project team member(s); –: not applicable

Table 3: Publications and Responsibility for Publications

Ref.	Publication	Study no(s)	Responsibility
A	Darton, R. and Knapp, M. (1984) The cost of residential care for the elderly: the effects of dependency, design and social environment. <i>Ageing and Society</i> , 4 , Part 2, 157-183.	1	Undertook analysis in collaboration with MK; joint responsibility for authorship
B	Darton, R. and Wright, K. (1992) Residential and nursing homes for elderly people: one sector or two? In Laczko, F. and Victor, C.R. (eds) <i>Social Policy and Elderly People. The Role of Community Care</i> . Aldershot: Avebury.	2	Responsible for analysis; lead author
C	Darton, R.A. and Wright, K.G. (1993) Changes in the provision of long-stay care, 1970-1990. <i>Health and Social Care in the Community</i> , 1 , No. 1, 11-25.	2	Joint authorship
D	Darton, R.A. (1994) Length of stay of residents and patients in residential and nursing homes for elderly people. <i>Research, Policy and Planning</i> , 12 , No. 3, 18-24.	3	Sole responsibility for analysis and authorship
E	Netten, A., Darton, R., Bebbington, A. and Brown, P. (2001) Residential or nursing home care? The appropriateness of placement decisions. <i>Ageing and Society</i> , 21 , Part 1, 3-23.	4	Lead responsibility for analysis; joint responsibility with AN for authorship
F	Darton, R., Netten, A. and Forder, J. (2003) The cost implications of the changing population and characteristics of care homes. <i>International Journal of Geriatric Psychiatry</i> , 18 , No. 3, 236-243.	5	Lead responsibility for part of analysis; joint responsibility for authorship
G	Netten, A. and Darton, R. (2003) The effect of financial incentives and access to services on self-funded admissions to long-term care. <i>Social Policy and Administration</i> , 37 , No. 5, 483-497.	6	Joint responsibility for analysis and authorship
H	Darton, R.A. (2004) What types of home are closing? The characteristics of homes which closed between 1996 and 2001. <i>Health and Social Care in the Community</i> , 12 , No. 3, 254-264.	7	Sole responsibility for analysis and authorship
I	Darton, R. and Muncer, A. (2005) Alternative housing and care arrangements: the evidence. In Roe, B. and Beech, R. (eds) <i>Intermediate and Continuing Care: Policy and Practice</i> . Oxford: Blackwell Publishing.	9a	Lead author
J	Darton, R., Forder, J., Netten, A., Bebbington, A., Holder, J. and Towers, A. (2010) Slicing up the pie: allocation of central government funding of care of older people. <i>Social Policy and Administration</i> , 44 , No. 5, 529-553.	8	Lead responsibility for part of analysis; joint responsibility with JF for authorship
K	Darton, R., Baumker, T., Callaghan, L., Holder, J., Netten, A. and Towers, A. (2012) The characteristics of residents in extra care housing and care homes in England. <i>Health and Social Care in the Community</i> , 20 , No. 1, 87-96.	8, 9b	Lead author and responsible for analysis
L	Darton, R. (2012) Great expectations: feedback from residents and relatives. <i>Nursing & Residential Care</i> , 14 , No. 10, 534-538.	10	Sole responsibility for analysis and writing-up

3. Commentary

3.1. Introduction and Policy Background

The 1981 study covered residential care homes in the public, private and voluntary sectors, and was conducted when different legislation applied to local authority homes (the public sector) and to independent (private and voluntary) homes. Local authorities were responsible for managing their own residential care homes under Part III of the National Assistance Act 1948. Independent residential care and independent nursing homes were regulated by the Residential Homes Act 1980 and by the Nursing Homes Act 1975, respectively. Local authorities were responsible for registering and inspecting independent residential homes, and health authorities were responsible for registering and inspecting nursing homes.

A key element in the economic policy of the Conservative Government elected in 1979 was the reduction of public expenditure (Cmnd 7841, 1980). This, combined with a substantial projected increase in the number of people aged 75 and over, led to an emphasis on informal and voluntary sources of support and care (Cmnd 8173, 1981). In 1978, the House of Commons Expenditure Committee had recommended that the DHSS investigate whether any lessons could be learned from the private and voluntary sectors, following comparisons of the relative unit costs for residents in local authority homes and in homes run by other organisations (House of Commons, 1978). This was reinforced by the new government, which indicated that the expansion and improvement of services would require the use of innovative approaches, including greater use of the voluntary and private sectors (DHSS, 1981a).

A central principle underlying the policy of successive governments has been to help people maintain their independence in their own homes for as long as possible, and this was regarded as reflecting people's preferences (Cmnd 8173, 1981). There had been a significant increase in the level of provision of community-based services, but the proportion of elderly people in long-term residential and hospital care had remained fairly constant, although the age on admission to residential care had increased and levels of dependency also appeared to have increased (DHSS, 1981b). Results from the 1981 PSSRU survey supported this (Darton, 1984, 1986b).

At the time of the 1981 survey, local authorities were required to set a standard charge for accommodation provided under Part III of the National Assistance Act 1948, based as closely as possible on the true economic cost (DHSS, 1978). Residents were required to pay up to the standard charge, depending on their resources, subject to a minimum corresponding to the basic state retirement pension, with an allowance for personal requirements. Similar arrangements applied for residents supported by local authorities in voluntary or private homes, but residents who were not supported by a local authority could apply for supplementary benefit through the social security system.

Prior to November 1983, social security claimants in residential and nursing homes received an amount for board and lodging, subject to a local maximum, and an allowance for personal expenses (DHSS, 1980). There was some discretion to meet charges above the limit, but this was abolished in 1983 due to concern about exploitation of the system and rising expenditure. However, the changes received substantial publicity and reinforced existing trends: charge levels rose towards the local limits; the growth of private homes accelerated; local authorities withdrew sponsorship for new residents and sometimes for existing residents; and the number of people entering homes without any assessment of their need for such care increased (DHSS, 1985a). As a result, expenditure continued to rise, an effect not entirely expected by the Government (House of Commons, 1984). A new system of national limits relating to the type of care being provided was introduced in 1985 (Secretary of State for Social Services, 1984; DHSS, 1985b), and the arrangements were consolidated in the Social Security Act 1986, which replaced supplementary benefit by income support.

The 1984 Registered Homes Act combined the regulation of residential care homes and nursing homes, although local authorities and health authorities retained their respective registration and inspection responsibilities. Residential care homes were intended to provide board and personal care, whereas nursing homes were intended to accommodate patients requiring constant or frequent daily nursing care (National Association of Health Authorities in England and Wales, 1985). However, in practice the boundary between nursing care and personal care and attention was often unclear (DHSS, 1982). In order to enable homes to provide both personal care and nursing care, the Health and Social Services and Social Security Adjudications Act 1983 included a provision for the dual registration of homes, and this was consolidated in the 1984 Act. Residential care homes

with fewer than four places were not required to register with the local authority until the Registered Homes (Amendment) Act 1991 removed this exemption.

During the 1980s, the overall number of individuals supported by local authorities in residential care declined slightly, and local authorities reduced their use of private and voluntary homes (DHSS, undated). However, despite community care being a longstanding policy objective, the total number of places available increased substantially as a result of the increase in places in private residential and nursing homes, and the use of social security funds, provided purely according to financial need, to support people in independent homes created 'perverse incentives' for residential rather than community care (Audit Commission, 1986).

In response, the Government appointed Sir Roy Griffiths to review community care policy. His report recommended a more coordinated approach to the funding and management of care, placing the responsibility for the allocation of funds, the assessment of need and the coordination of care with local authority social services departments (Griffiths, 1988). The majority of the recommendations were accepted by the Government (Cm 849, 1989), and were introduced in the 1990 National Health Service and Community Care Act, and implemented in 1993. Local authorities were to be made responsible, in collaboration with health care staff, for assessing the needs of new applicants for public support for residential or nursing home care and, where appropriate, for arranging a place in a suitable home. They were also expected to make maximum use of private and voluntary providers.

The 1997 Labour Government identified a need to establish greater consistency and fairness in charging for social care, and set up a Royal Commission to examine the funding of the long-term care of older people (Cm 4192-I, 1999). In addition, several problems were identified with existing arrangements for regulating care services (Cm 4169, 1998), and the Centre for Policy on Ageing was commissioned to advise on proposed national standards for residential and nursing homes for older people, which would apply equally to private, voluntary and local authority homes (Department of Health, 1999). In particular, the Government was concerned that some independent homes, which had previously catered for a more active population, would not be suitable for an increasingly dependent population and, secondly, that local authority homes had

not been maintained to a suitable standard. The concern about standards particularly related to the proposed standards for the physical environment, especially room sizes, both in terms of floor area and the number of occupants.

Opposition from providers focused on the requirement to have fixed staffing ratios and on the proposed physical standards, particularly for bedrooms (Laing & Buisson, 2001), and the national minimum standards were published with a number of amendments (Department of Health, 2001). Prior to the common standards there had been no equivalent regulations for nursing homes, although most health authorities advised that most beds should be in single rooms (Laing & Buisson, 1997). However, places in homes decreased between 1998 and 2001, and revised guidance was issued about the implementation of the standards, following concerns that they could lead to good quality homes closing (Department of Health, 2002a). Continued concern about the ability of existing homes to meet the standards led to the issue of an amended set of standards (Department of Health, 2003a). The Care Standards Act 2000 established a National Care Standards Commission to apply the new national minimum standards for care homes from 2002, and also removed the legal distinctions between residential care and nursing homes, which became ‘care homes’, as noted above. A new system of regulation was introduced in 2010 under the Health and Social Care Act 2008. This focused on outcomes and essential standards of quality and safety, although the room size requirements were retained (Care Quality Commission, 2010), and the approach has been continued by the Coalition Government (Cm 8378, 2012).

The importance of appropriate housing in helping people to remain in the community has long been recognised (Cmnd 8173, 1981; Cm 849, 1989; Cm 4169, 1998). Measures to improve and adapt ordinary housing and measures to help older people downsize to smaller, more manageable accommodation play important roles in helping people remain in their own homes (Department of Health and Department of the Environment, 1997; Department for Communities and Local Government, 2008; HM Government, 2011). However, more specialist forms of integrated housing with care have been developed for those for whom adequate care and support cannot be provided in mainstream housing. A variety of terms has been used for such provision in the UK, but ‘extra care housing’ has become the most widely used term, largely replacing ‘very sheltered housing’. Extra care housing has been viewed as providing an alternative to care homes, at least those

providing personal care (Laing & Buisson, 2013b), and the Commission on Funding of Care and Support (2011) identified it as providing a means by which people might be able to plan ahead and move to more suitable accommodation before developing a significant care and support need.

There has been significant growth in extra care housing during recent years, increasing from about 43,300 dwellings in England in 2009 to about 55,300 in 2013 (Elderly Accommodation Counsel, 2009, 2013), but there are still far more care home places. In 2012, care homes provided 269,400 personal care and 204,500 nursing care places in the UK (Laing & Buisson, 2013a). In contrast, there were about 463,000 sheltered housing dwellings in England in 2013, compared with nearly 480,000 in 2009 (Elderly Accommodation Counsel, 2009, 2013).

Furthermore, it is not clear whether people moving into extra care do have similar levels of physical or cognitive impairment, although local authorities have increased eligibility criteria for social care (Commission for Social Care Inspection, 2008) and there is some evidence that local authorities are aiming to place increasingly frail residents in extra care (Murphy and Miller, 2008). Recent proposals to standardise the threshold level of eligibility at the 'substantial' level (Department of Health, 2013) are likely to reinforce the pressure to accommodate more dependent residents. In addition, the costs of providing current models of extra care raise questions about its long term viability as a form of housing and care. For example, some providers have considered the removal of on-site catering and on-site 24-hour staff cover (Hanover Housing Association, 2009; Bentham, 2013).

The majority of extra care schemes are free-standing developments, typically with 40 or more units of accommodation. However, some larger retirement villages, typically with 100 or more units (Evans, 2009a), have also incorporated extra care provision, either for the entire development or in conjunction with other types of sheltered or retirement housing or a care home.

3.2. Thesis Themes

The 12 papers included in this thesis were selected to explore the following themes: the changing role of care homes and the development of the independent sector, particularly the private sector; factors associated with care home costs; changes in the relative role of residential and nursing homes, including changes in the characteristics of residents over time; changes in the quality of provision; the impact of care home closures; provision for self-funders and the expectations of residents; and the development of alternative forms of housing with care, and the degree to which specialised housing can provide an alternative to residential care.

3.3. Changes in Provision Over Time

The following discussion suggests that care home provision for older people has exhibited four broad phases during the last 40 years.

Paper C provides an overview of changes in the provision of long-stay care for older people and younger adults over the period 1970–1990. During the 1970s and early 1980s the number of places available in residential care homes increased in line with the growth in the population of older people. During the 1980s, however, the private sector expanded dramatically, and the overall provision of care home places increased from approximately 70 places per thousand people aged 75 and over in 1983 to 85 places per thousand in 1990. In contrast, local authority residential care declined during the 1980s, while voluntary sector residential care declined between 1981 and 1986, before showing a small recovery in the number of homes, but not in the total number of places, between 1986 and 1990. Thus, the average size of voluntary sector homes was lower in 1990 than in 1986.

The separate regulation of residential care and nursing homes was accompanied by separate systems of data collection. The information available on nursing homes was not disaggregated by type of home, although Laing & Buisson (2013a) show that private homes accounted for approximately 90 per cent of all nursing home beds in the UK between 1987 and 2012. **Paper C** indicates that long-stay beds for patients aged 65 years and over in independent hospitals and nursing homes in England and Wales grew by at

least 20 per cent per annum for each year from 1982 to 1990, and Figure 2 in the paper shows that the relative provision of nursing home beds also grew substantially during the 1980s. However, the paper also documents the decline in continuing care beds in hospital departments of geriatric medicine during the 1980s.

Associated with the growth in the provision of independent homes during the 1980s was a dramatic increase in the support of residents by the social security system, as noted above. Changes in the supplementary benefit system were regarded as having stimulated the growth in private sector provision (DHSS, 1985a). Supplementary benefit, subsequently income support, expenditure grew from £10 million to £1,390 million per year between 1979 and 1990, as shown in Table 7 in **paper C**.

During the 1990s private and voluntary residential care provision increased at a more modest rate, but local authority provision halved (Laing & Buisson, 2013a), resulting in a decline in provision relative to the population. From 1998, the overall number of places in both residential care and nursing homes started to decrease, as shown in Netten et al. (2005), and at a greater rate in nursing homes than in residential homes, as noted in **paper H**. From 2005, private residential and nursing home care provision started to increase, but in 2012 residential care provision in the UK had only reached the 1985 level, and nursing home provision had only reached the 1994 level (Laing & Buisson, 2013a). Despite the gradual changes in provision, projections of future demand based on demographic change far outweigh the likely changes in provision (Wittenberg et al., 2001). In particular, the number of people with dementia is projected to double between 2005 and 2041 (Alzheimer's Society, 2007).

The reduction in levels of provision has been consistent with government policy of maintaining people in their own homes for as long as possible. More intensive home care services have enabled frail older people to live in their own homes for longer. However, the reduction in care home provision from 1998, resulting from closures of homes, generated considerable concern among policy-makers, providers and residents and their relatives. A large proportion of residents in care homes have been admitted following a stay in hospital, and intermediate care services have been developed to help people return home following hospital treatment. However, recent government proposals to standardise the threshold level of eligibility at the 'substantial' level, and the reduction in the number

of people receiving packages of care (Health and Social Care Information Centre, 2013), raise questions about the support available for the policy of a greater focus on prevention (Department of Health, 2013).

3.4. The Factors Associated with the Costs of Residential Care

As noted above, the 1979 Government encouraged greater use of the private and voluntary sectors, partly in response to comparisons of relative unit costs. However, variations in unit costs are likely to be related to factors that differ between the sectors and over time, for example the structure and clientele of homes, and so simple comparisons of unit costs are not ‘like-for-like’ comparisons.

A principal objective of the 1981 survey was to investigate factors explaining variations in the costs of residential provision. **Paper A** reports the results of cost function analyses for local authority homes. A separate study focused on the comparative costs of public and private homes (Judge et al., 1986). Five categories of potential cost-influencing factors were examined in **paper A**: the characteristics of homes; the characteristics of staff; the non-residential services provided; the characteristics of the residents; and the characteristics of the area. In addition, the paper included the results of a preliminary analysis of the relationship between costs and features of the social environment.

The final equation explained 76 per cent of the variation in average cost between homes, and included variables representing each of the five categories of potential cost-influencing factors. In particular, the equation identified economies of scale at rather larger sizes than the average home size, the costs associated with non-residential services, and the increase in costs associated with higher levels of resident dependency. Average costs were significantly higher in homes in London and the South-East than would have been expected from salary weighting alone. The paper also examined how changes in design and in the characteristics of residents were likely to have contributed to changes in costs over time.

The 1981 survey did not collect detailed information about quality of care and the social environment using standard measures. However, indicators of seven dimensions of social

environment were constructed from the data collected. These were only able to explain a small amount of the residual variation in average operating cost, indicating that high costs were not associated with high quality of care, as measured by the social environment. However, variations in costs were associated with physical features of the home, which could have an influence on residents' quality of life.

Paper B followed up the analysis by Judge et al. (1986) using the data collected in the 1986–1987 survey. Residents in nursing homes paid higher charges than those in residential homes, as expected, and, with the exception of voluntary residential homes, mean charges for those in receipt of supplementary benefit were higher than the corresponding allowance. In residential homes, mean charges were higher in private than in voluntary homes, and mean charges were higher in London than elsewhere in private and voluntary residential homes and private nursing homes. Residents who were supported privately paid higher mean charges in both private residential and nursing homes. In private nursing homes, but not private residential homes, residents in single bedrooms paid higher mean charges. Conversely, in residential homes but not in nursing homes, mean charges were higher for more dependent residents.

For private residential homes these individual relationships were also captured in multiple regression analysis of the factors associated with mean charges. In addition, homes with a high proportion of proprietors relative to other staff, suggesting greater day-to-day involvement of the proprietors in running the home, and homes which had been operating under the same management for longer, had lower mean charges. Fewer voluntary residential homes and private and voluntary nursing homes were included in the survey, and fewer significant factors were associated with mean charges.

Simple ratings of various aspects of the physical and social environment by registration officers were used to assess the quality of the environment within the homes. The relationship between these assessments and the residual component of the mean charge from the regression analyses was examined in a similar way to the approach used in **paper A**. For private residential and nursing homes, a positive assessment of the physical condition of the home was associated with a higher residual mean charge, but there was no corresponding association for the assessments of good physical care, good social care or a good atmosphere.

The study reported in **paper J** focused on the development of the Relative Needs Formula for allocating central government funding to local authorities for home care and care home services for older people. Two approaches were examined, based on individual-level data from the 2006 survey and a companion study of home care, and on small area data, and my responsibility was for the individual-level data and analysis. The methodology involved the use of survey data to construct an equation to predict the need for care, and then the application of the equation to nationally-available data to determine the allocation to each local authority. The formula is therefore limited by the availability of data at a national level, for example from the Population Census, and cannot include more detailed information such as information on resident dependency. The allocation formula selected was based on the results of the small area analysis, although both analyses produced very similar results.

Within the restrictions imposed by the methodology, the following factors were identified as being associated with the receipt of care in the individual-level analysis: age; living alone or being single and living with others; renting; having a limiting long-standing illness; and being in receipt of social security benefits. While unsurprising, these results demonstrate the relationship between demographic variables and the allocation of care home places, and identify factors that would need to be considered in the provision of alternative forms of care. For example, domiciliary care services are likely to provide limited relief from loneliness among those living alone.

The analysis of factors associated with costs and charges demonstrate the importance of taking structural and resident characteristics into account when making comparisons between and within sectors. Judge et al. (1986) concluded that private provision did represent ‘good value for money’, with the caveat that this was based on an assumption about the comparability of the final outputs produced by public and private homes. The analyses of the 1986–1987 survey followed up the earlier analysis and included both residential and nursing homes. In particular, charges tended to be higher than the amount paid by social security, and residents who were supported privately effectively subsidised those who received public funding, issues that remain current (Laing & Buisson, 2013a), albeit in a slightly different form, given that local authorities are now responsible for supporting publicly-funded residents.

A particular finding of both the 1981 and 1986–1987 analyses was the lack of a relationship between measures of the quality of care and costs or charges, although variations in costs and charges were associated with physical features of the home which may affect residents' quality of life.

3.5. Changes in the Role of Residential and Nursing Homes

Paper B also drew on data collected in the 1986–1987 survey to examine the similarities and differences between nursing homes and residential homes for older people. Although the survey was restricted to private and voluntary homes, the paper also included data collected about local authority residential homes in 1988 (Department of Health Social Services Inspectorate, undated). As noted above, the boundary between nursing home care and personal care and attention was often unclear (DHSS, 1982), and overlaps in disability levels were reported in a number of studies. However, there had been relatively few studies that had collected information about both types of home.

Under the new arrangements introduced in April 1993, local authorities became responsible for the assessment, placement and financing of all adults in publicly-funded residential and nursing home care. Existing residents were given 'preserved rights' to income support, and a formula was developed for transferring social security funds for new applicants to local authorities, as described in **paper D**. The study described in **paper D** was designed to contribute information to assist local authority planners and care managers in the planning the support of residents in residential and nursing homes. Underestimates of length of stay, and corresponding overestimates of turnover would be likely to lead to problems of finding sufficient places, while the converse would be likely to lead to the under-use of facilities and increased unit costs. However, most studies of residential and nursing homes had been cross-sectional studies, which estimated the average (uncompleted) length of stay for current residents rather than the completed length of stay for discharged residents. In addition, the uncompleted length of stay would be related to the age of the home, and thus would be underestimated in the expanding private residential and nursing home sectors.

As shown in **paper D**, there was no consistent relationship between the two measures of length of stay across the different types of home but, contrary to expectation, the mean completed length of stay for private nursing homes was statistically significantly lower than the mean uncompleted length of stay, and for private residential homes the mean completed length of stay was lower, but not significantly so. For both measures of length of stay, mean length of stay was greater for local authority homes than for private residential homes. As shown in **paper B**, levels of physical disability, incontinence and confusion (cognitive impairment) among residents of local authority homes were intermediate to those recorded for private residential and private nursing homes, and antisocial behaviour was more prevalent in local authority homes. **Paper D** suggests that one possible explanation for the difference in length of stay between local authority and private residential homes could have been that residents with cognitive impairment might have had relatively long lengths of stay. If so, the reduction in local authority provision might lead to independent homes receiving more long-stay residents with cognitive impairment, with consequent implications for length of stay and turnover. This is supported by the findings in **paper F**.

Paper F compared the characteristics of residents in the 1986–1987 survey with those in the 1996 cross-sectional survey. In 1996, residents in nursing homes were substantially more dependent than those in residential homes, and levels of dependency were greater in all types of home than in 1986–1987, particularly for voluntary residential homes and nursing homes. Levels of cognitive impairment were greater in 1996, again particularly in voluntary residential homes and nursing homes, although there were substantial falls in the proportion of residents classified as mentally alert in all homes.

Paper E developed the comparison of residential and nursing home care for publicly-funded residents, against a background of considerable variation between local authorities in the proportions of residents placed in each type of home, drawing on the 1995–1999 longitudinal survey. However, using logistic regression analysis, characteristics of the individual residents explained the type of placement for over 80 per cent of admissions. Although the overall supply of places and the relative supply of residential and nursing home places were statistically significant, the inclusion of these variables did not improve the proportion of correct predictions of the type of placement.

Information on the location of the residents 30 months after admission indicated that those predicted to have been admitted to a residential place were less likely to have died than those predicted to have been admitted to a nursing place, whatever the place of actual admission. For those that had died, the mean length of survival was slightly lower for those predicted to have been admitted to a residential than to a nursing place, whatever the place of actual admission, but the differences were not statistically significant. The differences in survival between those admitted to the predicted and non-predicted type of care suggested that some unmeasured aspects of expected prognosis might have accounted for the unexplained variation. Overall, the results of the analysis indicated a reasonably high level of consistency between local authorities in nursing home placement decisions, but that some local authorities appeared to be more successful in maintaining older people at home. A number of factors were identified that were associated with increased probabilities of placement in residential care (arthritis, deafness, family breakdown living alone and lack of motivation). Thus, developing services to support older people with such conditions to remain in their own homes could help to reduce admissions to residential care.

3.6. Quality of Provision

Detailed design guidance for local authority residential homes was published in 1962 (Ministry of Health, 1962) and updated in 1973 (DHSS, 1973). However, with the growth in independent sector provision in the 1980s, guidance on standards had to be developed to cover a wide range of types of establishment. The DHSS commissioned the development of a Code of Practice for Residential Care (Centre for Policy on Ageing, 1984), as part of the measures introduced under the Registered Homes Act 1984. An updated version covering residential care and nursing homes was produced in 1996 (Centre for Policy on Ageing, 1996). However, separate registration and inspection arrangements applied to residential care and nursing homes until the Care Standards Act 2000 was implemented.

At the time of the 1986–1987 study, the Code of Practice for Residential Care indicated that single rooms were preferable to shared rooms and that special reasons should apply if more than two people occupied a room, although DHSS guidance emphasised that the

design recommendations related principally to new buildings (DHSS, 1986a,b). There were no equivalent regulations for nursing homes.

Paper B identified a number of differences between residential and nursing homes and between homes owned by private and voluntary providers in the 1986–1987 study. On average, nursing homes were larger than residential homes and voluntary homes were larger than private homes. The majority of private residential and nursing homes were run as small businesses, although nursing homes were more likely to be part of a chain of two or more homes. Very few private residential or nursing homes had been purpose-built, and only about 40 per cent of beds were in single rooms. However, the lack of recommendations for bedroom sizes in nursing homes was reflected in the proportions of beds in bedrooms of different sizes. Voluntary homes in the survey were more likely to have been purpose built; more beds were in single rooms; and around 90 per cent of voluntary homes provided a lift or used one storey for residents, compared with two-thirds of private homes.

As shown in **paper F**, the provision of single bedrooms in private and voluntary residential and nursing homes increased substantially between 1986 and 1996, although local authority and voluntary residential homes had a greater proportion of beds in single rooms than private residential homes or dual registered and nursing homes. In addition, three-quarters of local authority and voluntary residential homes met the criterion of a maximum of 20 per cent of beds in double rooms, which would be included in the subsequent national minimum standards as good practice for existing homes, compared with about 30 per cent of private residential homes, dual registered homes and nursing homes.

3.7. Care Home Closures

As explained above, a number of changes were made to the proposed national minimum standards, to be introduced under the Care Standards Act 2000, following opposition from providers, concerns that they could lead to good quality homes closing and concern about the ability of existing homes to meet the standards.

In **paper H**, homes that closed between 1996 and 2001 were compared with those that remained open, by following-up the homes included in the 1996 cross-sectional survey (study 5). Homes that closed tended to be smaller; to have had lower occupancy levels in 1996; to be the only home run by the organisation; to occupy converted buildings; to occupy multi-storied buildings and, if so, to have no lift; to have more shared bedrooms; and to have en-suite facilities in none or only some of the bedrooms. These factors were inter-related and the effect of these variables in combination was examined using multivariate (logistic regression) analysis. Among the homes that remained open, only 34 per cent provided at least 80 per cent of places in single rooms. A separate analysis of data on social climate found that homes with a more positive social environment were those occupying smaller, converted premises and having lower occupancy levels (Darton et al., 2003), exactly the types of home most likely to have closed. The findings supported the view that there was likely to be an increase in the importance of homes run by corporate providers relative to homes run as single, owner-managed homes, with a consequent reduction in choice for potential residents.

3.8. Self-Funders and Resident Expectations

Prior to the changes in local authority responsibility for the assessment, placing and financing of all adults in publicly-funded care in 1993, the availability of social security funds provided a means for people to move into residential or nursing home care without any assessment of need, subject to a means test and a capital limit (Audit Commission, 1986). From 1993, new potential residents could claim ordinary income support to make their own arrangements or receive a local authority assessment. The same capital limits applied in all cases: individuals with assets below the lower limit, £3,000 in 1993, were entitled to full support; those with assets above the upper limit, £8,000 in 1993, were not entitled to support; and those with assets between the limits were required to contribute on a sliding scale (Department of Health, 1992; Robertson, 1993). The Majority Report from the Royal Commission on Long Term Care (Cm 4192-I, 1999) recommended that personal and nursing care should be publicly funded, and the Government accepted the recommendation in relation to nursing care in nursing homes, but not in relation to personal care. The capital limits are reviewed annually and were last increased in 2010, to £14,250 and £23,250, respectively (Department of Health, 2010). The Coalition

Government retained the capital limits at these levels in order to enable local authorities to raise additional revenue until the implementation, in 2016, of the funding reforms following the recommendations of the 2011 Commission on Funding of Care and Support (Department of Health, 2014).

In the 1996 PSSRU survey (study 5) about one-third of residents in private residential homes and about a quarter of residents in private nursing homes were self-funded (Netten et al., 2001). In recent years the number of self-funded residents has increased while the number supported by local authorities has declined. In 2012 the proportion who were self-funded had risen to 43 per cent (Laing & Buisson, 2013a). The increase in number and market share is predicted to continue for at least two decades as a result of the increase in owner occupation among those at risk of entering a care home (Laing & Buisson, 2013a). However, Laing & Buisson also suggest that the proportion of self-funders is lower than would be expected from average property prices, and that substantial numbers of residents have divested themselves of assets in order to fall below the upper capital limit.

Information about self-funders is relatively limited, but studies that included both publicly-funded residents and self-funded residents, such as the 1996 PSSRU survey, suggested that a proportion of self-funded residents were less dependent than publicly-funded residents (Netten et al., 2001). Once the assets of self-funded residents had reduced to below the upper capital limit ('spenddown'), they would become the responsibility of the local authority. Such residents would be expected to survive for longer than average and thus be more likely to spend down, increasing the pressure on local authority finances.

Thus, local authorities would be expected to have a financial interest in the characteristics of self-funders and the types of home they moved into. This raised questions about the extent to which self-funders were entering care homes and whether this was through choice or due to a lack of alternatives.

Paper G examined the relative characteristics of self-funded and publicly-funded residents, their income and assets, the role of the local authority in the decision to move into a care home, and the support services received, drawing on the 1999–2000 study of the circumstances of self-funded admissions to care homes (study 6).

As was found in the PSSRU 1996 survey (Netten et al., 2001), self-funded residents had lower levels of physical dependency and cognitive impairment than publicly-funded residents overall, although aggregate levels of physical dependency were similar among those who moved into nursing homes. A smaller proportion of the self-funders were married, although a relatively high proportion of the married people were moving in with or joining their spouse, and those who were admitted together were significantly more likely to be entering a residential home. Although the majority for whom information was available were home-owners prior to admission, nearly one-fifth were not. Similar proportions of self-funded and publicly-funded residents were admitted to residential homes from hospital, but self-funders admitted to nursing homes were much less likely to have been in hospital.

As reported in **paper G**, just under 60 per cent of those for whom information was available had seen a social worker or care manager prior to admission, and a full assessment had been conducted in 54 per cent of cases. The majority of those assessed were recommended for admission. However, the assessment role was not necessarily seen as part of the final decision, and there was no evidence of any contact with social services for around half of those who had not been assessed. A small proportion of residents made the decision to move in alone, while in nearly 60 per cent of cases the decision was made by someone else, primarily the resident's children. Almost four-fifths of residents received community-based health and social care services before admission, but only 55 per cent had received any personal care.

The study also found that weekly income exceeded the fees of the home for only 16 per cent of residents. Thus, the majority of residents would have had to draw on their assets to meet their care costs.

The admission of self-funded residents at lower levels of dependency than publicly-funded residents could reflect preferences to choose to move into residential care. However, given the generally-reported preference for people to remain in their own homes, the expense of living in a care home, and the limited extent to which residents made the decision to move themselves, **paper G** suggests that residents were more likely to be admitted due to a lack of alternatives that could support them in their own homes.

Nonetheless, despite the general view that moving to residential care is a negative option of last resort, a decision by self-funders to enter residential care could be viewed as an expression of their preferences (Laing & Buisson, 2013a). Residential care can offer the opportunity to relinquish domestic responsibilities and provide a more sociable environment, particularly for people who are living on their own. In addition, while instances of poor quality of care in care homes have frequently appeared in the media, there has also been dissatisfaction with home care services, particularly in relation to the reliability and the length of home care staff visits (The NHS Information Centre, Adult Social Care Statistics, 2009; Angel, 2012). However, relatively little information has been obtained about residents' experiences of living in a care home, and obtaining residents' views is complicated by their tendency to express satisfaction with their home, either because of a reluctance to complain, or because they find it difficult to think of alternatives (Sinclair, 1988).

Paper L reports the findings of the study undertaken in 2008–2009 to examine the views of residents and relatives about living in a care home (study 10).

Residents' experiences of day-to-day life tended to be higher than their initial expectations, and the majority (over 80 per cent) indicated that they had a say in most aspects of their daily life. Fewer had control over aspects of the environment, such as their bedroom heating. Residents had relatively high expectations about the comfort and care provided in the home, but the proportions of positive responses were higher at the follow-up.

Relatives tended to expect that residents would have a greater say in the day-to-day life of the home than the residents did themselves, and they had higher expectations of the comfort and care provided and of the resident's control over their life. In general, relatives' experiences recorded in the follow-up were similar to their expectations, although fewer reported that residents had the choice of who would help them, or when.

The majority of residents reported that there had been no change or an improvement in their social life, and that they were happy with the amount of contact with their family and friends. The majority (70 per cent) reported that they had made new friends in the home. Similar results were reported by relatives, but both residents and relatives reported

that health and mobility problems affected residents' abilities to take part in activities in the home. However, both residents and relatives reported an increased use of chiropody services, suggesting that these might be more readily available in a care home setting.

Overall, residents and relatives expressed favourable views of the homes, and reported that the resident's quality of life had improved following the move into a care home. Although the study did not achieve the intended sample size, and the participating homes and respondents may have formed a self-selected sample, the positive responses indicate that care homes can provide welcoming and comfortable places to live for residents who choose to live in them. However, a number of particular areas of concern were identified by some respondents, including general housekeeping issues; the quality of the meals; and staff being too rushed to give sufficient attention to the residents or to organise activities.

Most importantly, and despite generally favourable impressions of the homes, both residents and relatives retained a belief that residents may be abused in care homes. Public perceptions of the relative level of abuse in care homes and private households may be influenced by media and other reports (Croucher, 2008). However, it was of concern that a higher proportion of residents in the follow-up survey believed that residents may be psychologically or physically abused, while substantially higher proportions of relatives in the follow-up believed that some residents had money or other possessions stolen, since these views may have been affected by their experiences of living in or visiting a home.

3.9. Specialised Housing – An Alternative to Residential Care?

The evaluation of extra care housing (study 9) included a preliminary study which led to the writing of **paper I**, while **paper K** compared the characteristics of residents in extra care with individuals who moved into care homes in 2005, using the information collected in study 8.

Paper I discusses the development of alternative housing and care arrangements and reviews gaps in knowledge. There has been a long history of specialised housing in Britain. However, the postwar reconstruction of housing led to the development of

sheltered housing by local authorities for letting. Sheltered housing still forms the majority of specialised housing, but most is now managed by housing associations (Laing & Buisson, 2013b). Sheltered housing, particularly housing intended for less active older people, was designed to minimise the burden of housework, but changes in expectations meant that bedsitting rooms and communal bathrooms and toilets were no longer considered acceptable (Tinker et al, 1995). Over time, sheltered housing with such facilities became difficult to let, and other reasons, such as the location, the lack of a lift, overprovision in some areas and high rents, also contributed to this problem.

Townsend (1962) viewed sheltered housing as an alternative to residential care for most residents, although there continued to be a debate about whether it should replace or be complementary to residential care (Butler et al., 1983). However, residents admitted to residential homes in Townsend's study included a substantial minority living in insecure accommodation and admitted for accommodation reasons rather than a need for care and attention. By the late 1990s, the overall levels of provision of sheltered housing dwellings and care home places were broadly similar, but essentially two different forms of communal living existed side by side (Oldman, 2000).

By the early 1980s, there were two separate trends away from the existing model of sheltered housing, towards greater support to people in their own homes, and towards the development of very sheltered housing (Butler et al., 1983). Very sheltered housing, which had enhanced design features and full-time warden cover, supplemented by domiciliary services, was actively promoted by Warwickshire County Council, with the aim of supporting residents as they became more frail and reducing admissions to residential homes (Reed et al., 1980). Other local authorities, for example Wolverhampton, also began to express increased interest in integrated care and housing as an alternative to care homes (Bailey, 2001). Such developments were stimulated by several factors: a greater need for care and support among people in existing sheltered housing; the unpopularity of some ordinary sheltered housing schemes; poor quality local authority residential accommodation; and developments in services and buildings enabling people to age in place (Fletcher et al., 1999). Local authorities also viewed very sheltered housing as good value for money (Baker, 1999), and the Royal Commission on Long Term Care encouraged its development (Cm 4192-I, 1999).

Gaps in knowledge about housing with care identified in **paper I** related to information on provision, information on costs and outcomes, information on the characteristics of residents and staffing. Information on the market for sheltered housing and extra care housing remains fragmented, and different classifications are used in different sources (Laing & Buisson, 2013b).

As noted in **papers I and K**, most recent studies of specialised housing schemes have concentrated on individual developments, and information collected has been specific to the particular study. Since extra care housing has been viewed as an alternative to care homes, comparative information is needed about both forms of provision. A core objective of the PSSRU evaluation was to compare costs and outcomes with those for residents moving into care homes, drawing on the results of previous studies of care homes (Netten et al., 2011). **Paper K** presents results from the evaluation, focusing on the characteristics of residents, and compares these residents with individuals who moved into care homes in 2005.

Overall, the people who moved into extra care were younger and much less physically impaired than those who moved into care homes, although a significant minority of residents in several schemes had high levels of physical dependency. Levels of severe cognitive impairment were much lower in all schemes than for residents of care homes, even among schemes designed specifically to provide for residents with dementia. Although extra care housing may have been operating as an alternative to care homes for some individuals, it appeared to be providing for a wider population, who were not reacting to a crisis but who had decided to make a planned move. While extra care supports residents with problems of cognitive functioning, most schemes appeared to prefer residents to move in while they were able to become familiar with their new accommodation before the development of more severe cognitive impairment, as had been reported in other studies (Croucher et al., 2007).

Paper K discusses the implications of the use of extra care to provide an alternative, or a replacement for, residential care, in relation to the competing demands on extra care places. Local authorities have increased eligibility criteria for social care and have exerted pressure on housing providers to increase the number of residents with higher care needs. However, extra care providers often aim for a balance of residents with high, medium and

low care needs, and thus only a proportion of places in extra care should probably be considered to be available as an alternative to care home provision, particularly in care villages which offer accommodation to a broader mix of age and dependency ranges. Part of the rationale for having a mix of residents is to encourage the development of a vibrant and active community. However, a number of studies have identified concerns about the level of care needs of some of the other residents (Croucher et al., 2007; Callaghan et al., 2009; Evans, 2009b), and an increase in the proportion of people with higher needs could discourage more active potential residents.

Furthermore, maintaining a balance between residents with different levels of need must take account of changes in needs over time, and maintaining this balance appears particularly difficult (Baker, 2002). A follow-up study of the residents over the first 30 months of the evaluation indicated that levels of physical frailty increased slightly among the surviving residents, while fewer problems of cognitive functioning were recorded, and the application of a survival model developed from a study of care home residents, which standardised for the differences between residents of extra care and care homes, predicted much higher death rates among the extra care residents than were recorded (Darton et al., 2011b). However, over a longer period there is a risk that extra care housing will become occupied by increasingly frail residents, without necessarily adapting staffing levels and facilities to support the change in the profile of residents.

3.10. Conclusions

Most studies of residential care have focused on a specific point in time, and relatively little large-scale research has been conducted in recent years. This thesis draws together material from a series of studies conducted over a period of 30 years, in which consistent information, as far as possible, was collected over time. This enabled a number of analyses to be undertaken in response to important policy and research questions, in particular: comparisons of homes and residents over time; the impact of care home closures on the types of provision available; comparisons between publicly-funded and self-funded residents; and comparisons between residents admitted to care homes and alternative forms of housing with care. Underlying the provision of care services is the

central question of cost, and the studies presented here include analyses of the factors associated with variations in costs and charges.

The period under consideration has seen a major change in the pattern of provision, from the initial dominance of local authority residential provision to residential and nursing home care provided mainly by the private sector. Care homes have responded to changes in demand and changes in dependency, and the physical quality of provision has improved in response to regulation and higher expectations. However, although the residents and relatives in the study of expectations and experiences were generally satisfied, it is not clear whether future generations will be, and respondents in that study remained concerned about the possibility of abuse.

The development of alternative forms of housing with care has provided residents with a superior standard of accommodation and the means to protect their assets. Commissioners have been keen to replace residential care with home care and extra care housing. However, there is still much more care home provision than extra care provision; and despite the potential advantages of extra care housing, it remains unclear how far this can provide an alternative to care homes, particularly given the upward pressure on eligibility criteria and a consequent increase in dependency. Some larger enterprises have tackled this by including a care home or nursing home as part of the scheme, but this requires substantial investment.

Some of the developments have been more accidental than planned, and responses to policy changes and financial pressures can have long-term consequences. A particular example is the response to the availability of social security funding in the 1980s. Many of the homes that opened in the 1980s were small operations in converted premises. While these may have been more attractive and offered greater familiarity to residents than more impersonal, purpose-built buildings, providers faced problems in updating them to meet changing design standards and expectations. However, Laing & Buisson (2013a) suggest that much of the steady recent improvement in facilities has been due to upgrading amenities in existing homes.

Among housing with care developments, financial pressures are likely to have important consequences for the design and facilities provided (All Party Parliamentary Group on

Housing and Care for Older People, 2012). However, changes to the facilities offered may make schemes less suitable for more dependent residents, for example where no communal dining facilities are provided, and also less attractive to future residents. An extreme example of the failure to meet changing expectations is the problem of difficult-to-let sheltered housing.

The Commission on Funding of Care and Support emphasised that people should make plans for their future rather than responding to a crisis, and this was endorsed by the Government. This is more likely to be achieved in housing with care than in traditional care homes, and also for residents who are self-funded. However, increases in eligibility criteria may result in more crisis decisions rather than planned moves. The studies of self-funded residents and of residents' expectations and experiences illustrated the relative lack of information available to people trying to make decisions about their future care and support, an issue frequently identified in other studies and policy documents. Although some forms of provision may decline in importance, the heterogeneous nature of care home provision and alternative forms of housing with care is unlikely to change. There are sources of information available to potential residents and their families, but much more information and guidance needs to be available to individuals and health and social care professional staff to help them navigate through the system.

Several factors are likely to increase the pressures on the provision of care and support, including increasing demand from an ageing population, with greater numbers of people living alone, greater numbers without family carers, and an increase in dementia; changes in eligibility criteria, resulting in more dependent residents; and developments in integrated health and social care and reductions in hospital provision. In addition, changes in the system of financing residents in care homes may have unexpected consequences.

However, information about care recipients and facilities is very limited, despite the financial importance of social care provision. In 2012-13, gross current expenditure on residential provision in England accounted for 53 per cent of the total for older people (Health and Social Care Information Centre, Adult Social Care Statistics Team, 2013). Community care reforms emphasised the needs of service users (Cm 4169, 1998), and information requirements focused on the needs of residents or clients rather than the services provided (Department of Health, 1997), but information collected about residents

was also reduced (Miller and Darton, 2000). More detailed research studies can complement the collection of national information (Department of Health, 1997), but residential care provision remains under-researched. Comparative studies are particularly important in understanding changes in the landscape of residential provision. The publications presented here aimed to fill some of the gaps in knowledge about residential care and possible alternatives by making use of data collected in a unique series of research studies conducted over a period of 30 years.

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Appendix 1: Publications

Final, pre-print or author versions of the publications have been deposited in the Kent Academic Repository (<https://kar.kent.ac.uk>). The following list of the publications includes the relevant links.

- A: Darton, R. and Knapp, M. (1984) The cost of residential care for the elderly: the effects of dependency, design and social environment. *Ageing and Society*, **4**, Part 2, 157-183 (plus correction). <https://kar.kent.ac.uk/26750/>
- B: Darton, R. and Wright, K. (1992) Residential and nursing homes for elderly people: one sector or two? In Laczko, F. and Victor, C.R. (eds) *Social Policy and Elderly People. The Role of Community Care*. Aldershot: Avebury. <https://kar.kent.ac.uk/26463/>
- C: Darton, R.A. and Wright, K.G. (1993) Changes in the provision of long-stay care, 1970-1990. *Health and Social Care in the Community*, **1**, No. 1, 11-25. <https://kar.kent.ac.uk/26751/>
- D: Darton, R.A. (1994) Length of stay of residents and patients in residential and nursing homes for elderly people. *Research, Policy and Planning*, **12**, No. 3, 18-24 (plus corrections). <https://kar.kent.ac.uk/26753/>
- E: Netten, A., Darton, R., Bebbington, A. and Brown, P. (2001) Residential or nursing home care? The appropriateness of placement decisions. *Ageing and Society*, **21**, Part 1, 3-23. <https://kar.kent.ac.uk/802/>
- F: Darton, R., Netten, A. and Forder, J. (2003) The cost implications of the changing population and characteristics of care homes. *International Journal of Geriatric Psychiatry*, **18**, No. 3, 236-243. <https://kar.kent.ac.uk/801/>
- G: Netten, A. and Darton, R. (2003) The effect of financial incentives and access to services on self-funded admissions to long-term care. *Social Policy and Administration*, **37**, No. 5, 483-497. <https://kar.kent.ac.uk/803/>
- H: Darton, R.A. (2004) What types of home are closing? The characteristics of homes which closed between 1996 and 2001. *Health and Social Care in the Community*, **12**, No. 3, 254-264. <https://kar.kent.ac.uk/798/>
- I: Darton, R. and Muncer, A. (2005) Alternative housing and care arrangements: the evidence. In Roe, B. and Beech, R. (eds) *Intermediate and Continuing Care: Policy and Practice*. Oxford: Blackwell Publishing. <https://kar.kent.ac.uk/26467/>
- J: Darton, R., Forder, J., Netten, A., Bebbington, A., Holder, J. and Towers, A. (2010) Slicing up the pie: allocation of central government funding of care of older people. *Social Policy and Administration*, **44**, No. 5, 529-553. <https://kar.kent.ac.uk/34401/>
- K: Darton, R., Bäumker, T., Callaghan, L., Holder, J., Netten, A. and Towers, A. (2012) The characteristics of residents in extra care housing and care homes in England. *Health and Social Care in the Community*, **20**, No. 1, 87-96. <https://kar.kent.ac.uk/32421/>
- L: Darton, R. (2012) Great expectations: feedback from residents and relatives. *Nursing & Residential Care*, **14**, No. 10, 534-538. <https://kar.kent.ac.uk/32420/>

**The Cost of Residential Care for the Elderly:
The Effects of Dependency, Design and Social Environment
Ageing and Society, 1984, 4(2), 157-183.
A Correction**

Robin Darton and Martin Knapp

On page 166 the sentence beginning "Operating costs are minimised ..."
should read as follows:

Operating costs are minimised (other things being equal) at a scale of 74
beds for homes designed on the group-living principle and at the slightly
smaller scale of 69 beds for other homes (including semi-group homes),
although average costs do not vary a great deal over a fairly wide
medium-size range (Figure 1).

Corrected versions of Figures 1 (page 166) and 2 (page 170) are available
from the authors. The corrected versions of these figures have essentially the
same shape, the differences being in the average cost for homes of different
sizes and the location of the cost-minimising points.

Publication D Corrections

Darton, R.A. (1994) Length of stay of residents and patients in residential and nursing homes for elderly people. *Research, Policy and Planning*, **12**, No. 3, 18-24.

Table	Type of home	Correction
1	Private dual registered	% females = 74 not 73
5	Private dual registered	% deaths:places = 24 not 25
7	Voluntary nursing	Hospital admissions: No. of individuals = 103 not 182 % private means = 13 not 32 % IS with topping up = 26 not 25 % IS without topping up = 58 not 40

Appendix 2: Supporting Statements

Professor J.E. Forder

Professor M.R.J. Knapp

Professor A.P. Netten

Mrs A. Towers (née Muncer)

Mr K.G. Wright

Dear Robin

I am very happy to confirm your statement of responsibility for the research that was reported in the following papers:

Darton, R., Netten, A. and Forder, J. (2003) The cost implications of the changing population and characteristics of care homes. *International Journal of Geriatric Psychiatry*, **18**, No. 3, 236-243.

Darton, R., Forder, J., Netten, A., Bebbington, A., Holder, J. and Towers, A. (2010) Slicing up the pie: allocation of central government funding of care of older people. *Social Policy and Administration*, **44**, No. 5, 529-553.

As regards the former, I agree that you had lead responsibility for part of analysis; joint responsibility for authorship. My contribution was more limited.

As to the latter paper, I also agree that you had lead responsibility for part of analysis and that we had joint responsibility for authorship.

Best wishes



Prof Julien Forder
Director PSSRU, University of Kent
<http://www.pssru.ac.uk/people-profile.php?id=2>
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25 April 2014

Department of
Social Policy

**Personal Social Services
Research Unit**

Director:
Professor Martin Knapp

To whom it may concern,

Re: Robin Darton, PhD Candidate, PhD by Published Works

I am happy to confirm that Robin Darton and I were jointly and equally responsible for the research that was reported in the following paper:

Darton, R. and Knapp, M. (1984) The cost of residential care for the elderly: the effects of dependency, design and social environment. *Ageing and Society*, 4, Part 2, 157-183.

The PSSRU conducts research and analysis on equity and efficiency in community care and related areas, from three institutions:

The London School of
Economics and
Political Science

Please do not hesitate to contact me if you require any further information.

University of Kent at
Canterbury
tel: 01227 827672
fax: 01227 827038

Thank you.

Yours sincerely,

University of Manchester
tel: 0161 2755250
fax: 0161 2755790



Martin Knapp, PhD

Professor of Social Policy
Director, Personal Social Services Research Unit
Director, NIHR School of Social Care Research
London School of Economics and Political Science
Professor of Health Economics
King's College London, Institute of Psychiatry

26 May 2014

Dear Robin

I am happy to confirm that the statement of responsibilities reported in table 3 is an accurate representation of your role in the analysis for and authorship of the following papers:

Netten, A., Darton, R., Bebbington, A. and Brown, P. (2001) Residential or nursing home care? The appropriateness of placement decisions. *Ageing and Society*, **21**, Part 1, 3-23.

Darton, R., Netten, A. and Forder, J. (2003) The cost implications of the changing population and characteristics of care homes. *International Journal of Geriatric Psychiatry*, **18**, No. 3, 236-243.

Netten, A. and Darton, R. (2003) The effect of financial incentives and access to services on self-funded admissions to long-term care. *Social Policy and Administration*, **37**, No. 5, 483-497.

Darton, R., Forder, J., Netten, A., Bebbington, A., Holder, J. and Towers, A. (2010) Slicing up the pie: allocation of central government funding of care of older people. *Social Policy and Administration*, **44**, No. 5, 529-553.

Darton, R., Baumker, T., Callaghan, L., Holder, J., Netten, A. and Towers, A. (2012) The characteristics of residents in extra care housing and care homes in England. *Health and Social Care in the Community*, **20**, No. 1, 87-96.

Best wishes



Professor Ann Netten

Professor of Social Welfare
Personal Social Services Research Unit
University of Kent
Canterbury CT2 7NF

Supporting Statement for publication I

This is to confirm that Robin Darton was the lead author on the following publication and that I am happy for it to be included in his PhD:

Darton, R. and Muncer, A. (2005) Alternative housing and care arrangements: the evidence. In Roe, B. and Beech, R. (eds) *Intermediate and Continuing Care: Policy and Practice*. Oxford: Blackwell Publishing.

A handwritten signature in purple ink, consisting of a stylized 'A' followed by a horizontal line.

Ann-Marie Towers (nee Muncer)

Ph.D by Published Works

The Changing Landscape of Residential Care

Care Homes and Alternative Forms of Housing with Care

R.A. Darton
Senior Research Fellow
Personal Social Services Research Unit
University of Kent
Canterbury.

Statement of Candidate's Contribution to Joint Work

K.G. Wright
Formerly Deputy Director
Centre for Health Economics
University of York
York.

Robin Darton and I worked together on a joint research project between the Personal Social Services Research Unit, University of Kent and the Centre for Health Economics, University of York on the residential and nursing home care of elderly people from 1985 to 1993. The project was funded by the Department of Health and Social Security (DHSS) and was concerned with the characteristics of the homes and residents and the level and sources of fees paid for and by residents. Mr. Darton played a major role in the design of the research and the submission of the successful research proposal to the DHSS.

After the research proposal was agreed we worked together with colleagues in both Units on the design of questionnaires and the recruitment of home owners to collaborate in the project. Mr. Darton played the main role in checking the questionnaires and in the analysis of the data collected. Given the policy interest in the results of the research, confidential reports were submitted to the DHSS as both interim findings and final reports. The responsibility for first drafts of these reports was taken by Mr. Darton.

The results of the project for wider dissemination are contained in the two publications labelled "B" and "C" in Table 3 - "Publications and Responsibility for Publications". Mr. Darton carried out the statistical analysis for these papers, completed first drafts of the papers and submitted them for publication.

It is my opinion that Mr. Darton's contributions to the research and the papers submitted for the thesis were of prime importance to the success of our joint project and to the acceptance of the papers for publication. I confirm that the description of his responsibilities for the project as set out in Table 2 and the responsibilities for publications as set out in Table 3 are accurate.

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