TEN YEARS ON

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Our vision is a world where all care homes are great places to live, die, visit and work.

Care homes cannot be seen in isolation; they are part of a system. To work well they need to be welcomed into and supported by the system.[11]

In this briefing we explore the current care home landscape in Scotland and some of the implications for future policy and practice development.

The Current Care Home Landscape in Scotland

In Scotland as of March 2015 there were 892 care homes for older people and 32,771 residents, of whom 96% (31,547) were long stay residents. 78% of residents were cared for in private homes, with 12% in local authority homes and 10% in homes with charitable status[1]. While these high level statistics are consistent with the general trend described above, they mask a more heterogeneous picture. Care homes vary widely in size, particularly private sector care homes, which tend to be larger with an average registered capacity of 47 places, compared to around 30 places for both local authority and charitable sector care homes.[2] As such, care homes with charitable status still account for around a quarter of the total number of care homes. The number of state-run homes also remains higher in Scotland than in England. In large rural areas where volumes are low and costs are high it is not viable for private providers to enter the market and state provision is likely to continue to play a significant role. Supply issues have also arisen in some urban areas where local property and labour markets have inhibited investment in care facilities[3].

Alongside the mixed economy of providers, a mixed economy of care home residents has also emerged. Free nursing care and personal care for older people living in care homes was introduced in Scotland in 2002, but so-called 'hotel' charges are means tested. Older people with capital, including property, worth £26,250 or more must meet this component of care home fees in full. In contrast, publicly funded older people contribute to care home fees from their pensions and any other income, and local authorities fund the balance[1].

Just under a third of older people living in care homes in Scotland (9,500) now self-fund their care[4] and so the majority of care homes still depend heavily on local authority funding. Care homes have however become the focus of targeted cost reduction efforts as part of austerity measures, both by driving down unit costs in real terms and decreasing the number of publicly funded places. At the time of the last census, the weekly contract rate for publicly funded residents was £508 without nursing care and £590 with nursing care[2], which does not cover running costs for small and medium sized homes[4]. This has resulted in the need for self-funding residents to cross-subsidise publicly funded counterparts. Care home fees for older people who self-fund are variable and also higher, averaging at £708 (without nursing) and £775 (with nursing) per week[1]. Some care homes, particularly in more affluent areas, are now catering solely for self-funding residents, sparking concerns about the emergence of a two-tier system.[4]

Implications for the Care Home Population

1 ISD Scotland (2014) *Care Home Census 2014: Statistics on Adult Residents in Care Homes in Scotland.;*
2 ISD Scotland (2015) *Care Home Census 2015: Statistics on Adult Residents in Care Homes in Scotland.*
3 Scottish Government (2014) *The Future of Residential Care in Scotland: Taskforce Report,*
4 Audit Scotland (2015): Accounts Commission for Scotland 2015

Older people living in care homes have widely differing needs, aspirations and priorities and there is often variability in individual functional abilities day to day. However, policy emphases on people being cared for in their own home for as long as possible, coupled with more recent moves to promote earlier hospital discharge, have resulted in people entering care homes much later, when they are older, more frail, often with complex, multiple and more advanced conditions and increasingly high levels of cognitive impairment[5]. Relatives, particularly spouses and siblings, may also be older and in declining health. Coming into the care home is often the final stage of an already traumatic journey through the health and social care system for the person and their family. Death is inevitably more commonplace, which has an impact on everyone within the care home, and the increasing presence of dementia has major implications for experiences of dying.

Responses to the Changing Care Home Population

Meeting the increasingly complex needs of older people living in care homes has asked more of care home staff, but this has not been reflected in staffing levels, skill mix, pay or conditions[6]. Care work remains the lowest paid sector and some care homes reliant on public funding have already been forced to make cut backs in staff pensions, sick pay and paid leave.

'Regulation' has largely been confined to inspecting what takes place inside the home rather than regulating the market as a whole, and has been subject to several revisions since the millennium. Managers and staff are expected to understand and implement each new round of increasingly complex legislation and protocols. In addition, record keeping detracts from direct contact time with residents and places unnecessary stress on workers[7].

The transfer of responsibility from hospital to community has taken place without significant reorganisation or funding of community NHS healthcare services. Consequently, older people living in care homes have inequitable access to NHS primary healthcare support.3 Furthermore, the difficulties faced in recruiting and retaining enough staff of sufficient quality undermines efforts to develop practice and establish caring relationships.[11]

Alongside this, the growing emphasis on independence, autonomy and consumer choice in policy gives little consideration to the everyday ethical and practical dilemmas encountered in trying to balance the duty to protect, the duty to care and the duty to respect autonomy, particularly in a group living setting. These developments have impacted significantly on the status and confidence of the sector.

Implications for Care Work

Working in a care home is not like working in a hotel. The care home as a community has to deal daily with loss, pain, anxiety and death. Do we recognise this? [11]

The complexity of care is further compounded when severe cognitive impairment is layered on top of an already physically frail body, whereupon everyday undertakings such as hair washing, brushing, nail cutting, shaving or changing a catheter may be misunderstood and resisted[8].

Going Forward

Care homes are, and look set to remain, a vital part of the care spectrum. Despite persistent systemic challenges, quality of care is improving and the care home sector is emerging as having the potential to enable our frailest citizens to live well in the changed circumstances of old age, and to die well. However, the complexity of care homes must be more widely recognised and the care home workforce must be better supported and valued.

My Home Life is working directly with care home managers and staff to facilitate positive culture change and enable them to professionalise and articulate their expertise.

5 *Later life in the UK*, Age UK, February 2016
6 Audit Scotland (2015): Accounts Commission for Scotland 2015,
7 http://www.ageuk.org.uk/home-and-care/care-homes/social-care-funding-changes/care-cap-and-means-test-changes/

8 Watson, J, E. (2015), Developing the Conceptual Underpinning of Relationship Centred Palliative Dementia Care: Doctoral Thesis

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