LONG TERM CARE FOR OLDER PEOPLE: HOUSING AND COMMUNITY CARE

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1. Community Care Policy

Community Care For Older People

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De-institutionalisation

- Older people continued to live in public institutions long after abolition of Poor Law in 1948.

- Powers for local authorities to provide home support services not mandatory until 1968.

Early policy 1948-1980

• By 1960s the ill effects of institutional care became a focus of concern –
  Townsend (1964) *The Last Refuge*
• Attempts to set targets for reductions in ‘geriatric’ beds *Hospital Plan 1962*
• ‘Community care’ meant care outside of long-stay hospitals (Care in the Community, 1981)
Emerging late 1980s is concern with balance of care:

• Move away from institution-based care
• Enhancement of home-based care
• Co-ordination and case management
Developing community care in the UK

1981-83 Care in the community/consultative document
- Funding incentives
- Joint finance
- Community care is ‘non-hospital care’
- Care packages – health/social
- Pilot projects

1986 Audit Commission – Community care
Organisational fragmentation
Perverse incentives (funding for care home places)
Failure to match resources to needs

1988 Griffiths Report
Coordination/integration of funding and management of care
Focussed upon assessment and coordination of care
Care management

1989 Caring for People (White Paper) - Community care seen as care outside hospitals, residential and nursing homes
Key Objectives:

- Promote development of day, domiciliary and respite services to enable people to live in own home
- Ensure service providers give high priority to carers’ needs
- Build on high quality assessment and case management
- Promote a flourishing independent sector alongside public services
- Clarify agency responsibilities
- Better value for money – reduce residential care incentive
Responsibility of Social Services Departments:

- Appropriate assessments of need
- Design packages of services tailored to meet needs - case managers
- Secure delivery of services through ‘enabling’ role
- Monitoring quality and cost-effectiveness involving health
- Assess capacity of client to pay costs of care

“Where an individual’s needs are complex or significant levels of resources are involved… a case manager for monitoring, reviewing and single point of contact”

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The need for care management

Fragmentation  Need for coordination

_Pre 1993:_ Within and between agency fragmentation (despite apparent monopoly providers)

_After 1993:_ Between providers fragmentation; Within and between agency fragmentation (loss of monopoly providers)

Cost Control

- Cap expenditure on nursing and residential care: 1979 £10m, 1989 £1000m
- End financial incentive in favour of residential and nursing home care
- Competition between providers, resulting in better value for money

Shift balance of care

- Enhance level and type of home care
- Enable people to remain at home
- Extend range of consumer choice
National Objectives for Social Services (1) Adult Services

- To promote the **independence** of adults assessed as needing social care support arranged by local authority, respecting their dignity and furthering their social and economic participation.

- To enable adults assessed as needing social care support to live as safe, full and as **normal a life** as possible, **in their own home** wherever feasible.

- To ensure that people of working age who have been assessed as requiring community care services, are provided with these services in ways which take account of and, as far as possible maximise their and their carers’ capacity to take up, **remain in or return to employment**.
National Objectives for Social Services (2) Adult Services

- To work with the NHS, users, carers and other agencies **to avoid unnecessary admission to hospital**, and inappropriate placement on leaving hospital; and to maximise the health status and thus independence of those they support.

- **To enable informal carers to care** or continue to care for as long as they and the service user wish.

- **To plan, commission, purchase and monitor** an adequate supply of appropriate, cost effective and safe social care provision for those eligible for local authority support.

- **To identify individuals** with social care needs who are **eligible for public support**, to **assess** those needs accurately and consistently, and to **review care packages** as necessary to ensure that they continue to be appropriate and effective.
• Putting people more in control of their own health and care

• Giving people more choice and control over their care services

• Enabling and supporting health, independence and well-being

• Rapid and convenient access to high-quality, cost-effective care

• Individual budgets proposed

• More specific about links with housing and extra care housing to permit independence
1. Hospital Discharge/ Length of Stay
L. S. Lowry – Ancoats Hospital
2. Integration of Health and Social Care

The Government has made it one of its top priorities…. to bring down the ‘Berlin Wall’ that can divide health and social services, and to create a system of integrated care…..

Modernising Social Services Cm4168, 1998, para 6.5
Integration of Health and Social Care

- *Lead Commissioning* - where the authority transfers funds to the other who will take responsibility for purchasing both health and social care.

- *Pooled Budgets* - where health and social services put a proportion of their funds into a joint budget to enable more integrated care.

- *Integrated Provision* - where one organisation provides both health and social care (e.g. Care Trust).

*Modernising Social Services Cm4168, 1998, para 8.10*
*The NHS Plan Cm4818-I, 2000.*

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Levels of Integration

- Interagency
- Interprofessional/multidisciplinary team
- Care coordination and care management
- Hands on care worker

But little evidence that higher order integration affects that at lower levels

Sources: Challis et al. 1995; 2006
Organisational Integration through Partnership in England

- Main focus of policy is inter-organisational working
- Currently only 8 Care Trusts in place in England (only integrated health and social care in Northern Ireland)
- Research indicates currently activity has focused on building new mechanisms and organisational processes
- Much less evidence of inter-professional integration or new service models
Joint Working between Health and Social Care – Housing?
3. Housing and Community Care Policy

The position and role of housing
Extra Care Housing

- New forms of sheltered housing and retirement housing in recent years, for older people who are becoming more frail and less independent. **No clear definition**

- Extra Care Housing is designed for frailer older people and has varying levels of care and support available on site. People who have their own self contained homes, their own front doors and a legal right to occupy the property.

- As well as the communal facilities in sheltered housing (residents' lounge, guest suite, laundry), Extra Care schemes often include a restaurant or dining room, health & fitness facilities, hobby rooms and computer rooms. Domestic support and personal care are available, usually provided by on-site staff.

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Hartrigg Oaks, York – Joseph Rowntree
Integrated Extra Care – Hartrigg Oaks

• Housing with the availability of care and support when needed is provided. Actuarial basis for funding – shared cost risk

• People aged 60 plus

• 152 bungalows and 42 en-suite bed sitting rooms within The Oaks Care Centre

• On entry, residents enter into a Care Agreement, which entitles them to care and support in their own home for up to 21 hours per week, based on assessed needs. This includes: Home help; Personal care; Support Visits; Respite care; Rehabilitation; and if needed permanent Care Home residency
Outcomes of Extra Care Housing

- Aim to compare residents’ sense of control in ECH and Care Homes
- Small study - 183 older people in care homes (89) and extra care housing (94)
- No overall difference in self perceived health between two groups
- ECH residents reported more **objective control** over their own lives but no difference in **subjective control** (ECH did not feel more in control of their lives)
- Subjective control was major determinant of well being
- ECH was not leading to better outcomes than **good quality** care homes

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Extra Care Housing in England

- New government funding 2004-2008 £376 million
- Study in 15 Local authorities in England. 13 participated and 68 housing schemes identified – 2500 dwellings
- Shared ownership/mixed tenure was uncommon
- Government funding has been key to establishing ECH
- Sometimes a base for “Intermediate Care” (Step down from hospital)
- Lack of links public and private developments
- Extra care housing relatively rare

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Disabled Facilities Grants

- Aim to provide adaptations or facilities to enable person to remain living at home
- Grant towards access, safety, mobility, heating
- Up to £25k in England, £30K in Wales!
- Administered through local government housing departments
- Important source of funding to enable people to age in place but

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A housing based initiative from Central Government

Housing related support is to develop and sustain an individual’s capacity to live independently in their accommodation

Support may include a home visit for a short period each week; on-site full-time support worker for a long period of time; benefit advice; home improvements; community alarms

Clear overlap with social care funding and goals – what is social care and what is housing related support?

Social Care and Housing Influenced through different central government departments (DH v DCLG)
Individual Budgets 2006 -

• Resources allocated according to individual assessed need
• Not just social care but housing support, DFG and other budgets
• Individuals who are eligible for these funds will then have a single transparent sum allocated to them in their name and held on their behalf, rather like a bank account.
• Funds can be a direct payment in cash, provision of services, or a mixture of both cash and services, up to the value of their total budget.
• Aims to offer the individual much more flexibility to choose services which are more tailored to their specific needs.
• But boundaries between budget sources raise problems – Supporting People (H) v Social Care (S)

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4. Balance of Care, Community Care and Housing

Balance of Care, Community Care and Housing
Key issues shaping community and long term care policies

- Demographic pressure of increasing aged population
- Growth in nursing/residential home costs and need for cost containment (balance of care)
- Need for new technologies of care – and new balance of care
- Patient/client preference – more flexible support
- Need to change balance between role of state support and family caregivers
- Labour supply – homecare and care homes
- Interdependence of health and social care; Bed usage in acute hospitals; A & E attendances
Balance of Care in Policy

- From Hospital Long Stay to Community (including nursing and residential homes) 1980s
- From Nursing and Residential Homes to Home Based Care 1990s to present
- Until very recently no significant mention of the role of housing (Cm 6737, 2006). Separate Government Departments for Health and Social Care (DH) and Housing (DCLG)
• Early balance of care was comparing institution v community
• As well as various community options need to also include housing options
• Spectrum of housing might include - General housing; Specialist elder housing; Housing with supervision; Shelter with care
• Hence balance of care approach can incorporate a set of options which include revenue based support (community services) and capital based support (housing options)
Conclusions

1. Community Care Development and Service Integration have neglected housing
2. Housing developments in the UK lag behind the expectations placed upon them
3. ECH is not a panacea for intensive community support and alternatives to nursing and residential homes
4. Balance of care planning can and should introduce a housing dimension alongside community options (links with other funding sources capital and revenue)