Care Homes for Older People

VOLUME 1 FACILITIES, RESIDENTS AND COSTS

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PSSRU
at the University of Kent at Canterbury,
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Preface

Care homes have always had a key role in the provision of care for older people. The most appropriate use and funding of care in care homes has been the subject of many important policy initiatives over the years. This is demonstrated most recently by the NHS Plan (Cm 4818-I, 2000) and the Government's response to the Royal Commission on Long Term Care. In part this is because of the vulnerability of the residents, the effects of demographic change on the numbers of older people who may need residential carte and the visibility of the high costs associated with this form of care. It is essential that we have a good understanding of this key aspect of care provision.

It has been argued that the lack of relevant research and data means that many policy proposals are based on what may not be well-founded assumptions across a range of issues (King's Fund, 1999). It is difficult to construct an overall picture when there are differences between the information available on residential and nursing homes, when the type of information collected varies over time, and where there are variations in practice between the different parts of the United Kingdom. In this context, the establishment in 2002 of a National Care Standards Commission (under the Care Standards Act 2000), whose regulatory responsibilities will include collecting data about services, should provide the opportunity to provide more coherent statistics nationwide in the future. But in order to avoid overburdening through data collection requirements those in the business of providing care, a balance needs to be struck between routine data collection and other sources of statistics, such as specially commissioned surveys. The latter fulfil a vital role in providing us with a detailed picture of care homes and their residents needed for policy development and planning.

Beginning in 1995, the Department of Health (DH) funded a two-part study of residential and nursing home care: a national, cross-sectional survey of care homes for older people, and a longitudinal follow-up of publicly-funded admissions. At the time the work was commissioned there were four key objectives:

1 to provide a baseline description of the use of residential and nursing home care by both publicly and privately-funded residents;
2 to provide data to feed into the development of the relevant Standard Spending Assessment formulae;
3 to increase understanding of outcomes of residential care, including mortality, changes in location and changes in dependency;
4 to increase understanding of the relationship between dependency and costs of care under the new arrangements for community care introduced in 1993.

The report of the study is in two parts. This volume reports on the cross-sectional survey which was carried out in autumn 1996, some time after implementation of the reforms introduced in 1993 by the NHS and Community Care Act 1990, which had extended local authorities' responsibilities for assessing and funding residents. This part of the study focused on the characteristics of the homes and their residents and on the relationship between costs and dependency. The survey covered 673 homes and 21 local authorities. Information was collected at two levels:

- In the homes, data were collected about occupancy, turnover, care policies, and costs.
- Information on personal characteristics, fees, source of admission and source of funding were collected at individual level from a sample of 11,900 residents, out of a total population in the homes at the time of 20,200.

Together with its companion report, which describes the longitudinal survey of publicly-funded individuals admitted to long-term care (Bebbington et al., 2001), *Care Homes for Older People: Facilities, Residents and Costs* is a valuable source of information for the future and will provide much information for the policy debate. The data from these projects will be made publicly available in due course.

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Deputy Director of Statistics
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Acknowledgements

This survey was funded by the Department of Health as part of a wider study of residential and nursing home care for elderly people commissioned from the Personal Social Services Research Unit (PSSRU). The research team at the PSSRU included Andrew Bebbington, Pamela Brown, Robin Darton, Julien Forder, Kathryn Mummery and Ann Netten, with secretarial assistance from Lesley Cox. This report was prepared by Annabelle May, in consultation with the authors, and responsibility for the report is the authors' alone. We are most grateful to the proprietors and staff of the homes for providing the information for the survey, and for the assistance of the staff in the local authorities which agreed to participate in the survey. The fieldwork for the survey was undertaken by Research Services Limited (now IPSOS-RSL), and additional work on the dataset was undertaken by Barry Baines. Finally, we are most grateful to the Advisory Group set up by the Department of Health for their contribution to the study as a whole.

1 The Homes and Their Services

Background

1. Before 1983 most publicly-funded care was provided by the public sector, by local authorities or the NHS. But changes made to the structure of social security funding in the 1980s contributed to rapid expansion in the residential and nursing home market. In 1983, separate social security payments became available to pay for residential or nursing care in voluntary or private sector homes — but not for day or home care — and between 1983 and 1986 the number of independent sector residential and nursing beds increased by 242 per cent. The number of local authority (LA) residential beds fell by 43 per cent during the same period (Audit Commission, 1997).

2. Since April 1993, following the implementation of the 1990 NHS and Community Care Act, local authorities in Great Britain have been responsible for the assessment, placement and financing of all adults in publicly-funded residential or nursing home care. With this responsibility came the requirement to decide, in collaboration with health care staff, whether individuals would be more appropriately placed in residential or in nursing home care. The present Government's Performance Assessment Framework and Best Value regime (Cm 4014, 1998; Cm 4169, 1998) emphasise the importance of reducing costs, increasing the downward pressure on prices paid by local authorities for care home places. At the same time, there are pressures to increase the standards of care provided.

3. Prior to the implementation of the Care Standards Act 2000, local authorities were responsible for registering and inspecting independent residential homes, while health authorities were responsible for registering and inspecting independent nursing homes. Separate standards of provision applied to the different types of home. More detailed national standards were set for residential homes, for example on bedroom sizes. However, local authority residential homes were not covered by the same legislation as independent residential homes, and independent providers resented being required to adhere to higher standards than the registering local authority (Avebury, 1997; Laing & Buisson, 1997). Under the Care Standards Act, a National Care Standards Commission will be established to apply a common set of standards to residential and nursing homes, and in future the same regulations and standards will be applied to local authority homes (DH, 1999).

4. This chapter looks at the ownership of homes and the various organisations involved, and sets out findings on the size, staffing and facilities of different types of nursing and residential homes. The study also investigated the quality of the caring environment. Through using a series of scales to explore staff perceptions, significant differences emerged in what is defined as the 'social climate' between different types of home.

5. Box 1 gives summaries of three earlier surveys, carried out in 1981, 1986 and 1988. The present study was designed in such a way that the results would be

comparable to these previous studies. Selected to reflect the national distribution of different types of homes, the 21 participating local authorities covered a spectrum of inner and outer London boroughs, metropolitan districts and counties. These were further subdivided in order to take into account geographical factors, socio-economic groups, migration and population density. The final list was a representive cross-section of local authorities; within these, probability samples of homes and of residents were drawn. For a detailed account of the selection and weighting procedures for the samples of local authorities, homes and residents and a description of how the responses were analysed, see the Appendix. More detailed tables of information from the survey are contained in a separate report (Netten et al., 1998).

Box 1: THREE EARLIER SURVEYS OF RESIDENTIAL AND NURSING HOME CARE

PSSRU Survey of Residential Accommodation for the Elderly, 1981
Commissioned by the former Department of Health and Social Security (DHSS) and conducted in autumn 1981, this survey covered 456 residential care homes run by local authorities, voluntary organisations and the private sector. The 12 participating authorities in England and Wales included four London boroughs, four metropolitan districts, three English counties and one Welsh county.
Dependency levels in the voluntary sector homes were lower than those in private sector or local authority homes. While both the latter had similar proportions of highly dependent residents, the private sector also had a higher proportion of less dependent people and relatively fewer with intermediate levels of dependency. In voluntary homes, 72 per cent of beds were in single rooms, compared with 53 per cent in local authority accommodation and only 41 per cent in the independent sector. An analysis of costs in local authority homes did not identify any significant association between care costs and measures of care quality. (See Judge, 1984; Darton, 1986a, b.)

PSSRU/CHE Survey of Residential and Nursing Homes, 1986
This survey was conducted during the autumn of 1986 and the spring of 1987 in 855 private and voluntary registered residential care and nursing homes in 17 local authority areas in England, Scotland and Wales. These included four London boroughs, four metropolitan districts, six English counties, one Welsh county and two Scottish authorities. Also commissioned by the former DHSS, the survey covered homes catering for older people, people with learning disabilities, people with mental illness and people with physical disabilities.
Although the number of private residential homes had grown substantially since 1981, levels of dependency were similar to those found in the previous survey. In voluntary sector residential homes dependency levels were higher than in 1981, but residents there were still less dependent than people in the private sector. Dependency levels were substantially higher in nursing homes. The proportion of beds in single bedrooms in private residential homes was similar to that in 1981, but in 1986 there were fewer larger rooms (i.e. with three or more beds). Nursing homes had similar proportions of beds in single rooms, but higher proportions of larger rooms than private residential homes. An analysis of fees found no significant association with physical and social care assessments.

Social Services Inspectorate Survey of Public Sector Residential Care for Elderly People, 1988
Undertaken by the Department of Health Social Services Inspectorate (DH SSI), this study was part of a national inspection of management arrangements for public sector residential care for older people. The inspections were carried out in 14 local authorities in England, including five metropolitan districts and nine counties. A separate study was conducted in four London boroughs. Three residential homes for elderly people were visited in each authority, and the same information was recorded about each resident as in the 1981 and 1986 surveys. Dependency levels tended to be higher than in 1981. The study is described in a report by the DH SSI (1989).

Who owned the homes

6. Figures 1 and 2 show the number of homes per organisation and the length of ownership, by home type. Approximately 90 per cent of the private residential homes were run by organisations which owned only one or two homes. This compared with half of the voluntary registered homes and about two-thirds of dual registered and nursing homes. This concentration of ownership in small organisations had decreased slightly since the 1986 survey, while ownership by major providers — defined as those owning three or more homes — had grown. Figures from market surveys comparing 1988 with 1996 show an increase in ownership by major providers: from 2.5 to 7.5 per cent of places in private residential homes; from 22.7 to 39.2 per cent of places in private dual registered homes; and from 15.5 to 37.4 per cent of places in private nursing homes (Laing & Buisson, 1996, 1997).

7. In 1986, private residential homes were more likely to have been started from scratch than taken over as a going concern, although the reverse was true for private nursing homes (Darton et al., 1989). However the increase in the proportion of the latter started from scratch — from 41 per cent in 1986 to 56 per cent for all nursing homes in 1996 — was likely to be related to the growth in ownership by major providers, noted above. Approximately 60 per cent of the voluntary residential homes were started from scratch, while the majority of homes transferred from local authority ownership became voluntary homes, accounting for 20 per cent of that sector.

8. Over 70 per cent of the independent sector homes had been run by the present owners for over five years, and approximately one-third for over 10 years. For voluntary residential homes, nearly 60 per cent had been run by the owners for over 10 years. As the 1986 survey found that a higher proportion of private sector residential and nursing homes had been acquired during the previous five years, the 1996 findings suggest that private sector ownership had stabilised.

Figure 1: Number of homes owned by organisation, by home type (%)

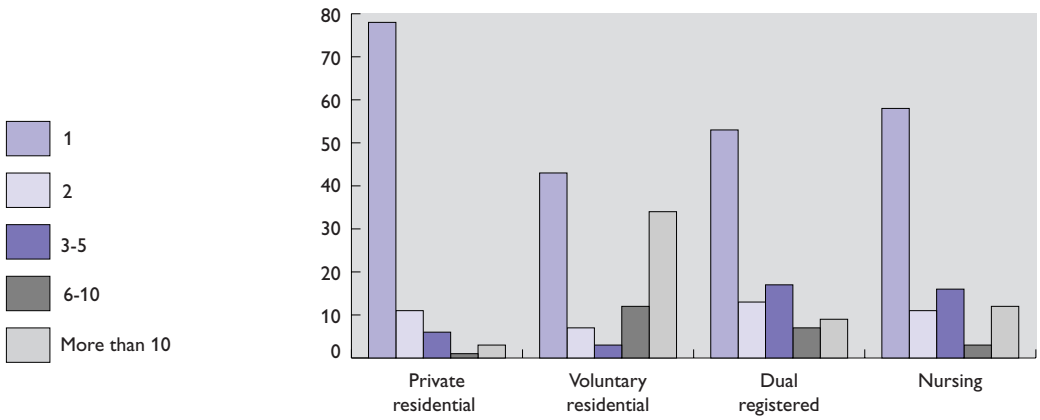
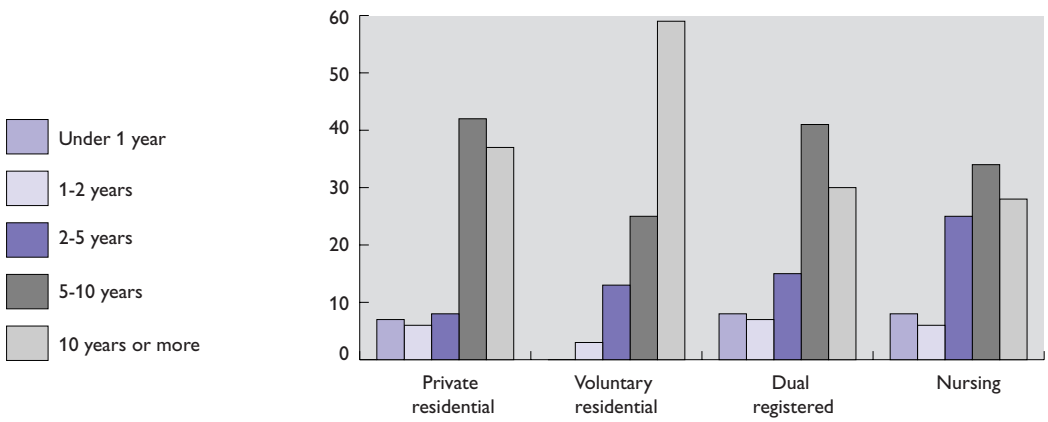


Figure 2: Length of home ownership, by home type (%)



The size of homes

9. Figures 3 and 4 show the distribution and the minimum, mean and maximum numbers of residential and nursing places, by home type. Compared with the results of the surveys conducted in the 1980s, the average size of local authority homes had fallen and that of private residential and nursing homes had increased. Voluntary residential homes, on average, remained the same size. In 1996, independent sector nursing and dual registered homes were found, on average, to be larger than residential homes, while voluntary residential homes were larger than their private sector counterparts. Local authority homes tended to be concentrated in the range of 30-50 places. Those in the private sector were concentrated in the 10-25 place range; over 30 per cent had between 15 and 19 places.

10. Previous surveys carried out in 1986 (Darton and Wright, 1992) and 1988 (DH SSI, 1989) found private residential homes with an average of 17 places and nursing homes with 29, while local authority homes averaged 44 places.

11. The 1996 findings on relative sizes were largely consistent with the figures reported by the Department of Health (DH, 1997a). In 1997, the DH found an average of 35 places in local authority residential homes, 18 in private residential homes, 28 in voluntary homes, and 36 in nursing homes.

12. In this study, homes were asked whether they were planning to change the number of their places in the following six months. Local authority homes were slightly more likely to be planning to reduce them, while independent sector homes were more likely to be planning to increase them. Approximately 10 per cent of private and voluntary residential and dual registered homes and 18 per cent of nursing homes reported that they were planning to increase their number of places.

Figure 3: Distribution of number of places, by home type (%)

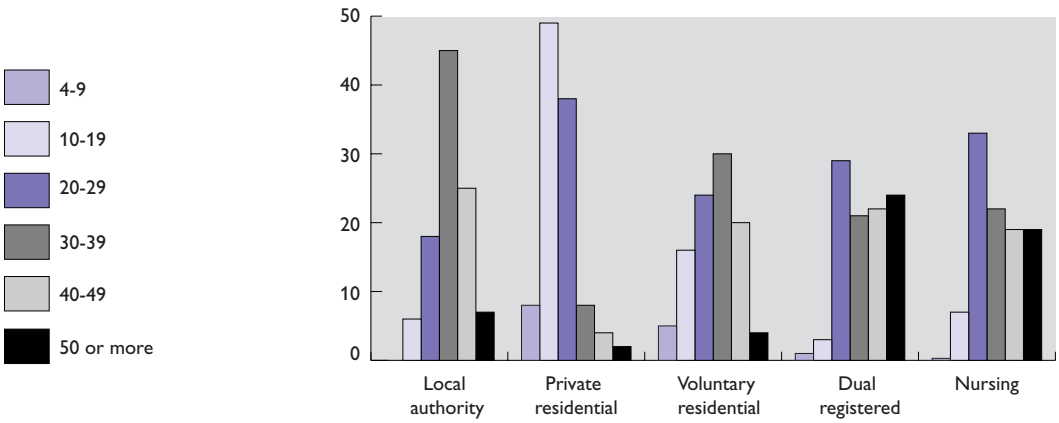
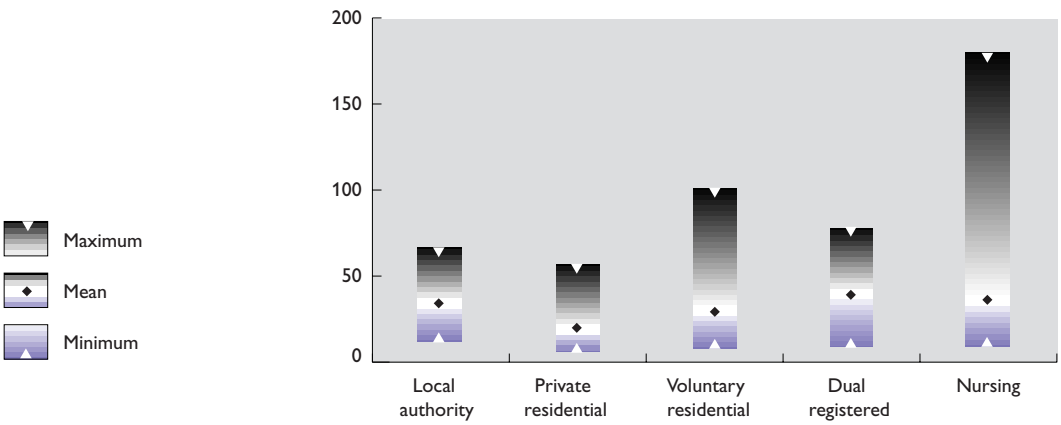


Figure 4: Number of places, by home type



Buildings and facilities

13. While the premises of nearly all local authority and half of the voluntary homes were purpose built, a majority of the private residential homes, dual registered homes and nursing homes occupied converted buildings, usually former private houses. Only 8 per cent of private residential homes were in purpose-built premises, although the percentages among dual registered and nursing homes were higher: 20 and 28 per cent respectively.

14. In the independent sector, these proportions had grown since 1986. Apart from voluntary residential homes, the purpose-built homes had mostly been built since 1985; again, this was likely to be related to the growth in ownership by major providers. The higher proportion of purpose-built premises among voluntary sector residential homes was probably because these had been transferred from local authorities. Although 18 per cent of them had been built since 1985, the majority were likely to have been built more than 10 years before this study.

15. Virtually all the local authority homes, voluntary residential homes, dual registered and nursing homes either used only one storey or provided a lift for their residents. In private residential homes, the proportion was 89 per cent — a change from 1986, when approximately one-third of private residential and private nursing homes did neither. However, in 1986 only a relatively small proportion (10 per cent) of voluntary homes had no lift and used more than one storey.

Box 2: NATIONAL STANDARDS ON ROOM SIZES AND OTHER FACILITIES

1962 Ministry of Health Building Note says that at least 40-50 per cent of beds should be in single rooms, 30-40 per cent in double rooms, and no more than 10-20 per cent in double rooms. [1]

1973 DHSS Building Note for residential accommodation for elderly people recommends that most of the beds in residential homes for older people should be in single rooms, with a maximum 20 per cent of beds in double rooms. [2]

1984 Code of Practice for Residential Care from the Centre for Policy on Ageing states that single rooms are considered preferable to shared rooms and that special reasons should apply if more than two people occupy a room. [3]

1986 Two DHSS circulars emphasise that the design regulations mainly apply to new buildings and indicate that no specific ratio of single/double rooms is appropriate in every case, but the second circular reminds registration authorities of the 1984 Code of Practice regarding occupation of double rooms. [4]

1996 Updated version of the CPA Code of Practice declares that all residents should have single rooms unless their stated preference is otherwise. [5]

1997 Laing & Buisson's annual Market Survey notes that while there are no specific recommendations for bedroom sizes in nursing homes, the majority of health authorities advise that most beds should be in single rooms. [6]

2000 DH announces new national minimum standards on room sizes and other facilities. To ensure flexibility for existing good quality provision, specific criteria will enable some individual and communal rooms which do not meet the new standards to stay in use. From 2002, no more than 20 per cent of overall resident places can be in shared rooms. All residential care homes will be expected to meet the new standards by 2007. [7] Health minister John Hutton announces in November that the date for shared room ratios has been extended from 2002 to 2007. [8]

Sources:

1. Ministry of Health, 1962.
2. Department of Health and Social Security, 1973.
3. Centre for Policy on Ageing, 1984.
4. Department of Health and Social Security, 1986a, b.
5. Centre for Policy on Ageing, 1996.
6. Laing & Buisson, 1997.
7. Department of Health Press Release 2000/0447, 21 July 2000.
8. Department of Health Press Release 2000/0705, 30 November 2000.

16. A summary of national standards on room sizes and other facilities can be found in Box 2. Figures 5-9 show the survey findings. The provision of single bedrooms had increased substantially compared with the 1986 survey: 89 per cent of beds in local authority and voluntary residential homes were in single rooms. In private residential homes the proportion was 69 per cent, and in dual registered and nursing homes the proportion was 65 per cent. Laing & Buisson (1997) reported similar figures in their 1997 survey: 69 per cent of beds in private residential homes and 59 per cent in private nursing homes were in single bedrooms.

Figure 5: Bedroom size, by home type (%)

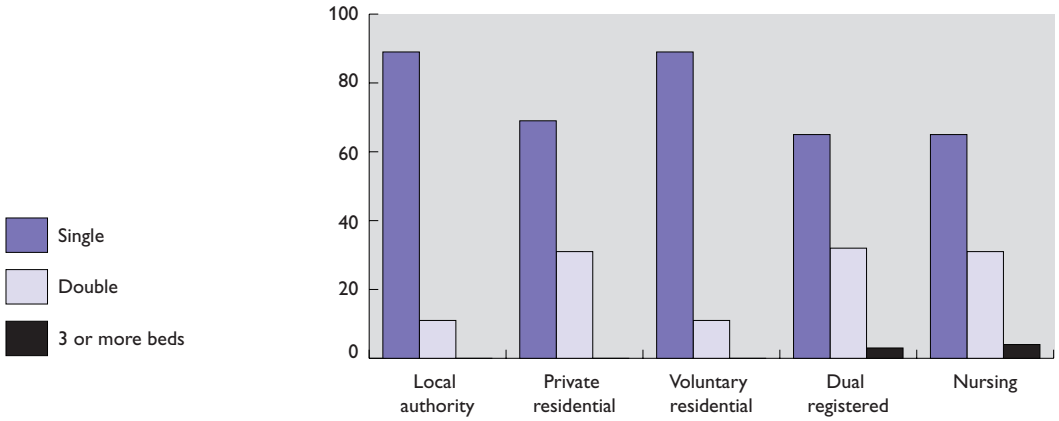


Figure 6: Bedrooms meeting Building Note standards, by home type (%)

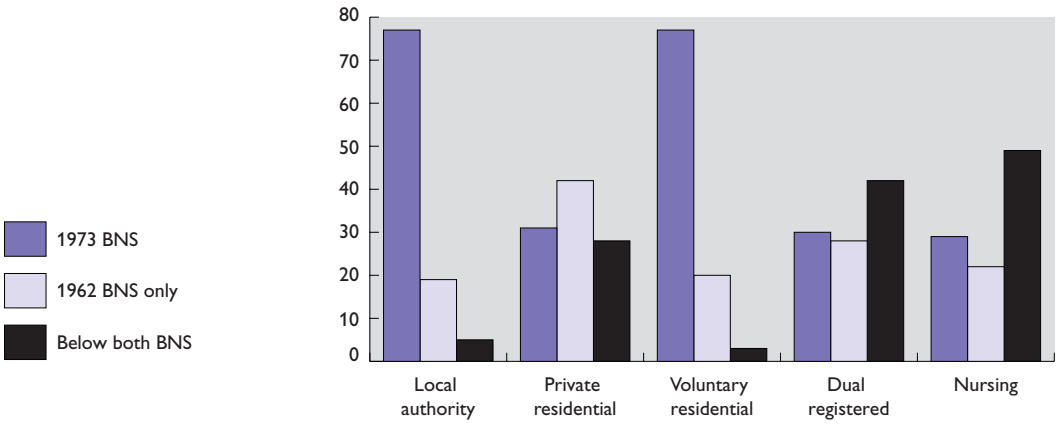


Figure 7: Bedroom washbasins, by home type (%)

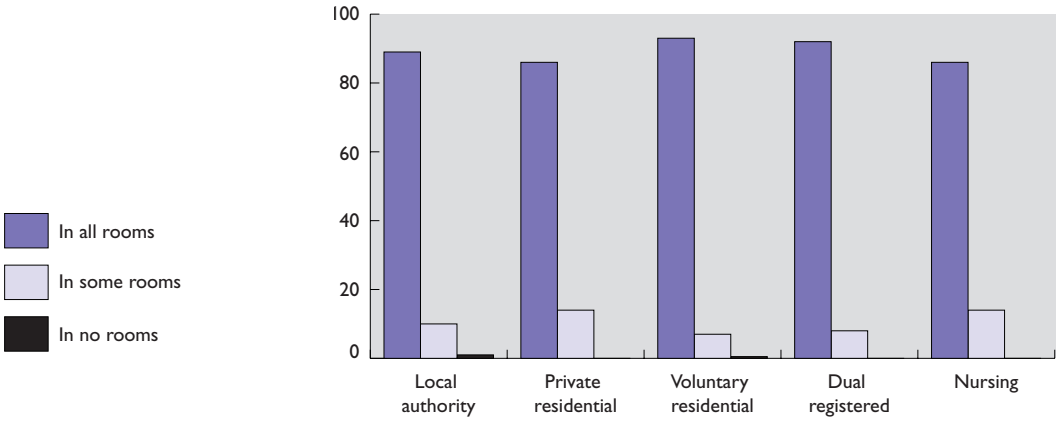


Figure 8: Bedrooms with en suite toilets, by home type (%)

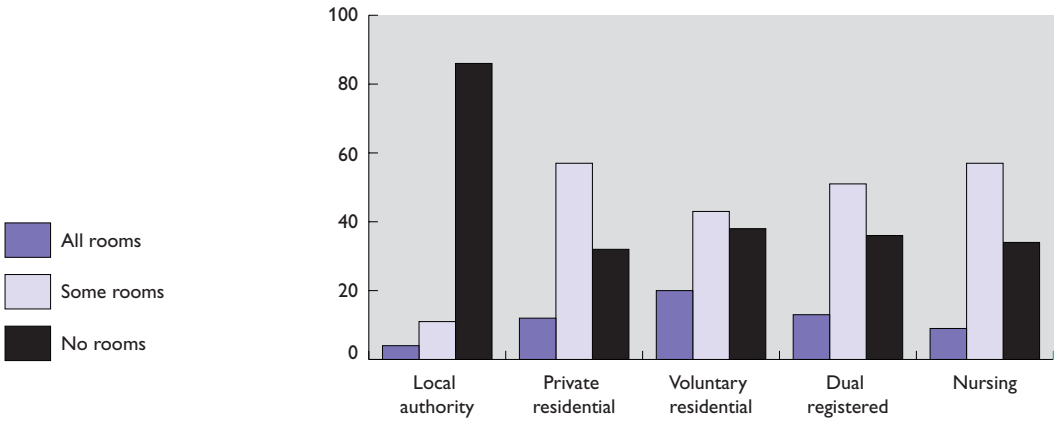
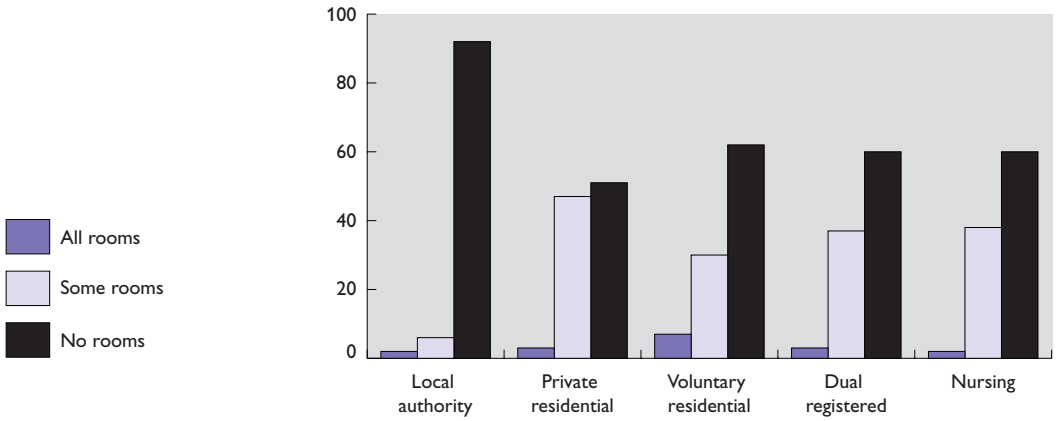


Figure 9: Bedrooms with en suite showers or baths, by home type (%)



17. Some of the dual registered and nursing homes — and a very few of the local authority homes — still had rooms with three or more beds. Private and voluntary sector residential homes had only single or double rooms. While a 77 per cent majority of the local authority and voluntary residential homes met the 1973 Building Note criterion (see Box 2), only about 30 per cent of homes in the remaining three categories did so.

18. Washbasins were provided in the bedrooms of 88 per cent of homes, and all homes — with the exception of a very few local authority and voluntary sector residential homes — had washbasins in at least some bedrooms. Approximately 50 per cent of private residential homes and 40 per cent of voluntary residential homes, dual registered homes and nursing homes in the sample provided en suite showers or baths in at least some bedrooms, compared with only 8 per cent of the local authority homes.

19. More of the homes had en suite toilets, particularly in the independent sector: the proportion there was between 60 and 70 per cent. But the number of local authority homes with en suite toilets was not much higher than the small proportion of those with en suite baths or showers. Laing & Buisson's 1997 survey reported that approximately one-third of beds in private residential and nursing homes were in rooms with en suite toilets.

Living arrangements

20. Group living arrangements, where homes were divided into units for eating, sitting and sleeping, were more common in local authority than independent sector homes. Over 50 per cent of the former had such arrangements, compared with between 10 and 20 per cent of the latter. The private sector residential homes were the least likely to be organised along these lines, but this could have reflected their smaller average size.

21. As might be expected from their greater use of group living arrangements, the local authority homes had more sitting rooms and dining rooms than homes in the independent sector. But independent sector homes still tended to have more sitting rooms and dining rooms than they had 10 years before. In 1986, 44 per cent of private and 23 per cent of voluntary residential homes, plus 53 per cent of private nursing homes had a single sitting room, while only 58 per cent of the latter provided a dining room. A further 4 per cent of these homes had no sitting room at all (Darton and Wright, 1992). In 1996, 24 per cent of private and 9 per cent of voluntary residential homes, and 13 per cent of nursing homes had a single sitting room.

Occupancy rates and turnover

22. Figure 10 shows the mean size of homes and the range of home sizes, together with the corresponding information on the number of residents. Figure 11 shows that occupancy rates were just over 90 per cent in local authority and voluntary and residential homes, and ranged from 83-87 per cent of places in other independent sector homes. This was lower than in 1986 when the mean rates for private residential homes were 89 per cent, with 93 per cent for voluntary residential homes and private nursing homes. Local authority homes had more short-stay residents — people with planned discharge dates — than the independent sector: approximately 11 per cent.

Figure 10: Number of places and number of residents, by home type

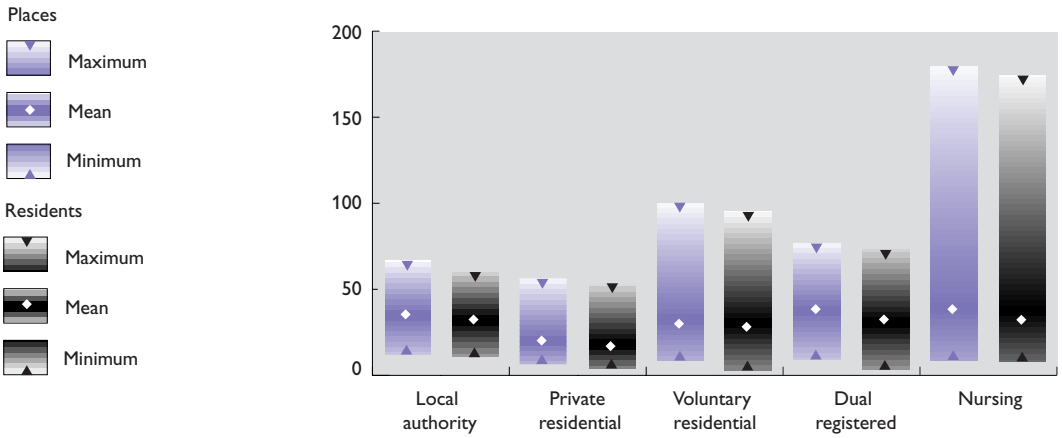
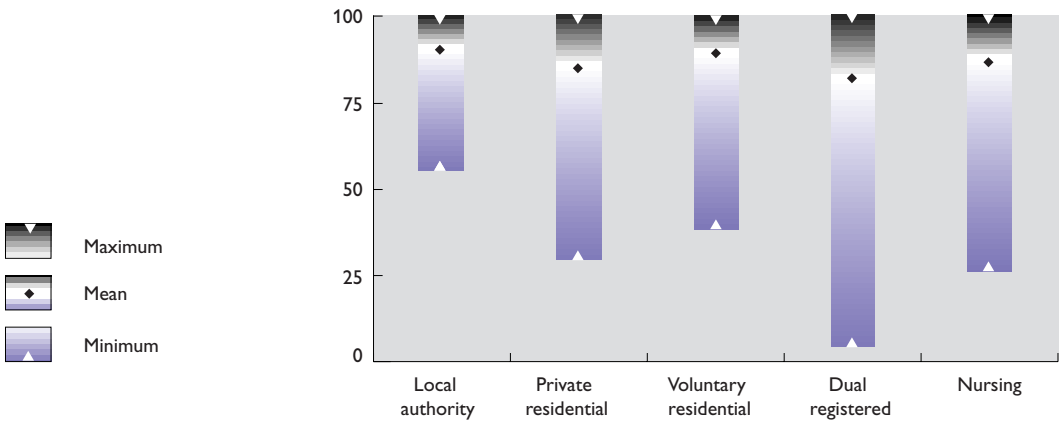


Figure 11: Occupancy (% of places), by home type



23. Turnover rates were calculated on the basis of the ratio of the number of admissions in the previous 12 months to the number of places; and, similarly, using the number of discharges. Independent sector homes had wider ranges of admission and discharge rates than the public sector; some were over 100 per cent. Dual registered and nursing homes had higher turnover rates than residential homes. Residential homes had slightly lower mean discharge rates — including deaths — than mean admission rates, but dual registered and nursing homes showed pronounced discrepancies between the two. Previous studies have recorded similar findings (Darton, 1994) and, although admission rates would exceed discharge rates in new or expanding homes, it is more likely that deaths and discharges were under-recorded compared with admissions.

Admissions and retention policies

24. Figures 12-14 show admission and retention policies. As previous studies have indicated (Challis and Bartlett, 1987; Phillips et al., 1988), independent sector homes were less likely than local authority homes to admit older people with behavioural or psychological problems. However, 75 per cent of local authority homes did not admit sectioned patients, compared with 82 per cent of homes overall, while 20 per cent did not admit older people with behavioural problems. Also, 27 per cent of them did not admit older mentally infirm people, compared with overall proportions of 41 and 49 per cent respectively.

25. Approximately 80 per cent of the residential homes did not admit older people needing nursing care, while 8 per cent of all homes did not admit those with incontinence. A slightly higher proportion of refusals for incontinence came from private and voluntary residential homes: 11 and 8 per cent.

26. While, by definition, dual registered and nursing homes catered for residents with a greater degree of disability than residential homes and were more likely to provide medical and nursing care, they were also less likely to report that they would continue to provide care if residents developed further problems after admission. Meanwhile, only 5 per cent of private residential homes said that such residents were usually or always required to leave, compared with 20 per cent of all other homes.

27. More than 90 per cent of homes in all categories — apart from voluntary residential homes — provided short-term care. The highest proportion of short-stay residents was found in the local authority homes, and these were also more likely to cater for older people with mental health problems or learning disabilities. Nursing homes recorded in the sample database as catering solely for people with mental illness were not included in the survey, and it is possible that the level of provision for such individuals has been underestimated.

Figure 12: Type of care provided, by home type (%)

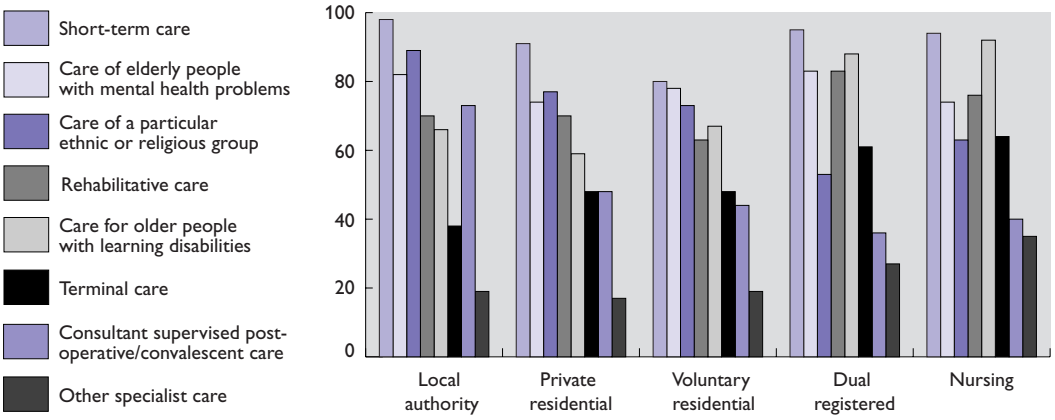


Figure 13: Type of care not admitted, by home type (%)

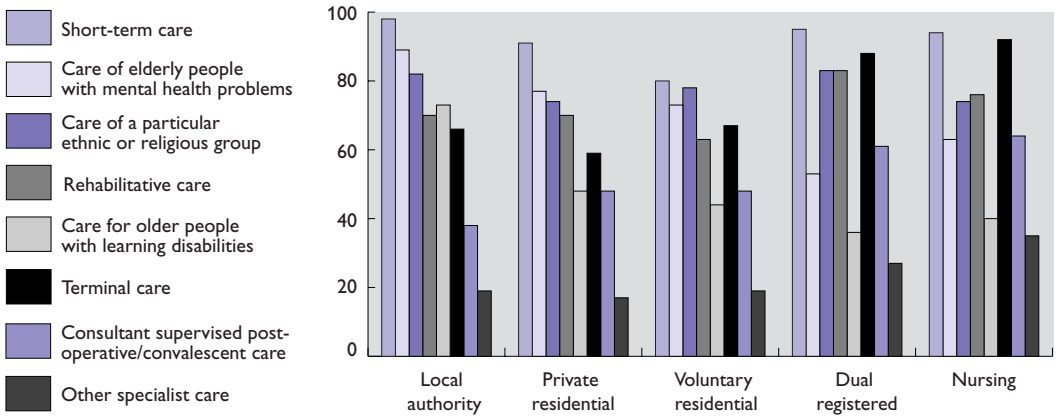
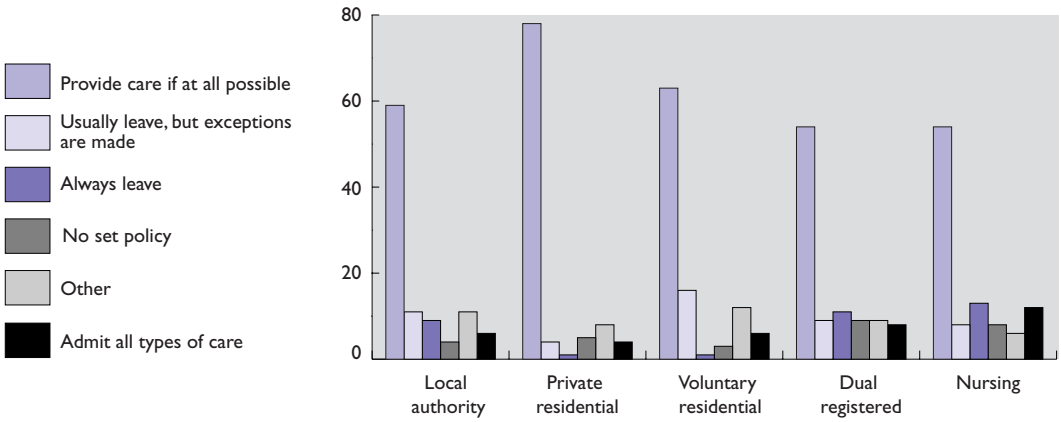


Figure 14: Policy for dealing with problems after admission, by home type (%)



Additional services and equipment

28. Laundry costs were almost always included in the standard fees; approximately 30 per cent of the homes also included dry cleaning. Residents of dual registered and nursing homes were less likely to make private arrangements to pay for hairdressing. This was often included, or else paid for as an extra. Similarly, nursing and dual registered homes, as well as private residential homes, were more likely to include the cost of a telephone in the resident's room than were local authority or voluntary residential homes.

29. Dual registered and nursing homes were also more likely to include additional medical services in their standard fees. The majority of such homes also included incontinence supplies in their fees. Local authority homes were twice as likely to obtain these supplies from the NHS as to include their cost in the standard fee. With the exception of the chiropody provided in private residential homes, the NHS was also the major source of finance for other medical services.

30. Over three-quarters of all the homes provided special baths and hoists, and half provided special beds. Approximately 80 per cent of dual registered and nursing homes provided these; around one-quarter of them also supplied special mattresses.

31. The availability of community transport meant that more local authority homes had access to a minibus for their residents, but overall 43 per cent of all homes had such access. Approximately 30 per cent of all types of home had access to dedicated transport, or access to a minibus shared with other homes.

Activities and services

32. Virtually all homes (96 per cent) organised activity programmes for their residents, although there were variations between the different sectors and between types of activity. In general, private homes were less likely to organise activities than others. In most homes these programmes were organised by staff, although 14 per cent used an outside volunteer or professional.

33. Local authority homes were more likely than the independent sector to provide services to non-residents. In 40 per cent of cases, local authority homes offered meals on wheels, laundry and bathing services, while 21 per cent of them provided home care for older people living in their own homes.

34. Across the sectors, 42 per cent of all the homes provided day care to non-residents. This ranged from 24 per cent of the nursing homes to 87 per cent of the local authority homes. Bathing services were the next most frequently reported: by 19 per cent of homes overall. Laing & Buisson (1997) found that 47 per cent of private residential homes and 34 per cent of private nursing homes were providing day care.

35. The same survey found that 20 per cent of voluntary residential homes were providing sheltered housing or 'close care': independent units of accommodation serviced by a residential or nursing home.

Proprietors' involvement in private homes

36. The majority of all types of private home operated with one or two proprietors, as shown in previous studies (Weaver et al., 1985; Challis and Bartlett, 1987; Phillips et al., 1988; Darton et al., 1989). The hours they worked ranged up to nearly 100 hours per week in the private residential and nursing homes and up to 65 in the dual registered homes. But on average proprietors were reported as working 45 hours a week in private residential homes, 31 in private dual registered homes, and 37 in private nursing homes.

37. The overall proportions of homes with no proprietors working in them were consistent with the figures on home ownership reported in paragraph 6, earlier in this chapter.

Staffing levels

38. Figures 15 and 16 show the median numbers of care and ancillary staff in the homes and mean estimated staffing ratios for care staff. 'Full-time' was defined as working 30 hours or more a week. When staff numbers were compared with place numbers (see paragraphs 9-11, above), residential homes had approximately one full-time member of care staff for every three places and one part-time care staff member for every 2.5 places. The dual registered and nursing homes had higher levels of full-time staffing — one full-time care staff member for just over every two places — but similar levels of part-time care staff to residential homes.

Figure 15: Median number of care staff, by home type

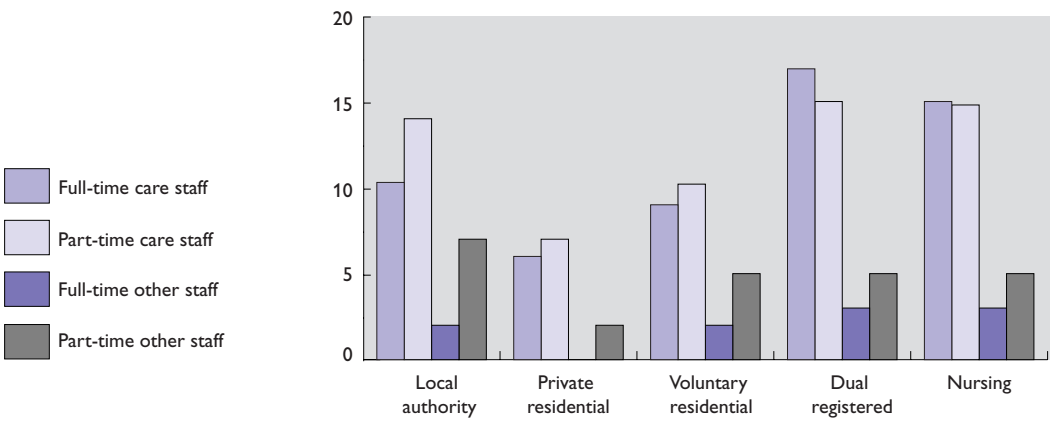
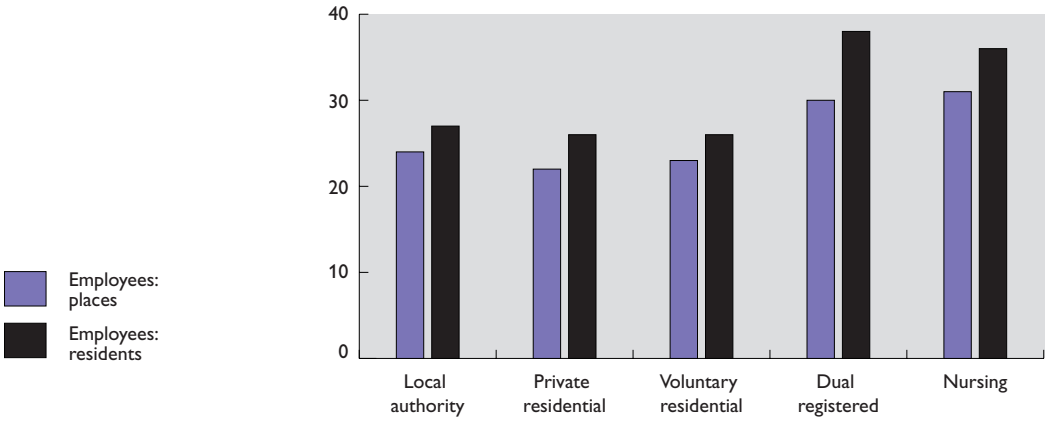


Figure 16: Estimated staffing ratios for care staff (hours per week), by home type



39. Even though the 1986 and 1988 surveys had included ancillary staff in their staffing ratios, the average ratios for care staff in local authority and voluntary residential homes appeared to have increased significantly. But the smallest average increase — approximately two hours per place per week — was found in private residential homes. The estimated mean staffing ratios for care staff in residential homes ranged from 22 to 24 hours per place per week, compared with about 30 hours in dual registered and nursing homes. Due to lower occupancy rates in the latter (see above), the gap was greater when staffing ratios were calculated in relation to residents.

40. Including the time spent by proprietors increased the mean staffing ratio for private residential homes by five hours, from 22 to 27 hours per place per week. This difference was smaller in dual registered and nursing homes, reflecting the lower level of proprietor involvement.

41. The 1986 survey included ancillary staff, and ratios were calculated from the number of hours staff worked per week. Excluding the proprietors' contribution in private homes, private and voluntary residential homes had similar staffing levels — 23 hours and 21 hours per place respectively — while the figure for private nursing homes was 34 hours per place (Darton et al., 1989). Ancillary staff formed 13 per cent of the whole time equivalent (WTE) staff in private residential homes, including the proprietors, and 18 per cent in nursing homes. The figure for voluntary residential homes was 30 per cent.

42. In the 1988 survey, the Department of Health Social Services Inspectorate (1989) reported an overall staffing ratio of 21.5 hours per week. However, when ancillary staff are excluded, the figure was only 15.1 hours per resident per week.

Staff availability and sickness cover

43. The majority of homes had one or two supervisory staff on duty in the mornings and afternoons. Almost all local authority homes had one supervisory staff member on duty in the evenings, but independent sector homes had either one or no such staff on duty. The majority of homes did not have a member of supervisory staff on duty at night: only 43 per cent of local authority residential homes and 38 per cent of nursing homes did so. The private sector residential homes were more likely to have two supervisory staff members on duty in the evenings (19 per cent) and at night (11 per cent) than other homes. These figures are likely to reflect the involvement of owner-managers.

44. In all types of home, staffing levels of both care and nursing staff were highest in the morning, falling off slightly in the afternoon and again in the evening. At night, all the dual registered and nursing homes had at least one member of staff on duty, with the majority having at least three. Private

residential homes had the lowest number: 51 per cent had only one staff member available at night. Most local authority and voluntary residential homes had two staff on night duty.

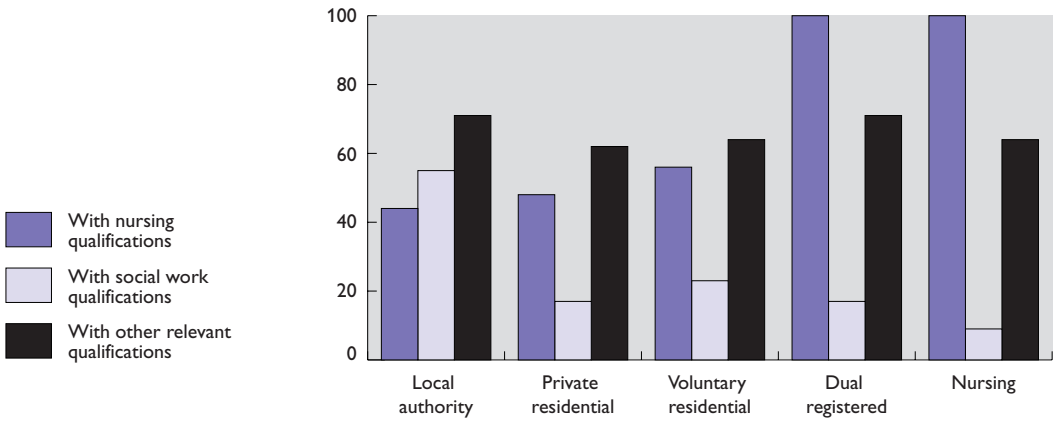
45. The main method employed for dealing with sickness cover involved the remaining staff working additional hours. Overall, 72 per cent of homes took this approach; in private residential homes, it was 83 per cent. Alternatively, on-call relief staff were used by approximately one-third of local authority and voluntary residential homes. Dual registered and nursing homes reported a wider range of options, including greater use of agency staff.

Staff qualifications and training

46. The ratio of the number of staff with nursing qualifications to the number of places gives an indication of the intensity of nursing provision. Dual registered and nursing homes had the equivalent of just over one nurse to every four places; private residential homes had one to 10 places; local authority and voluntary homes had one to 20.

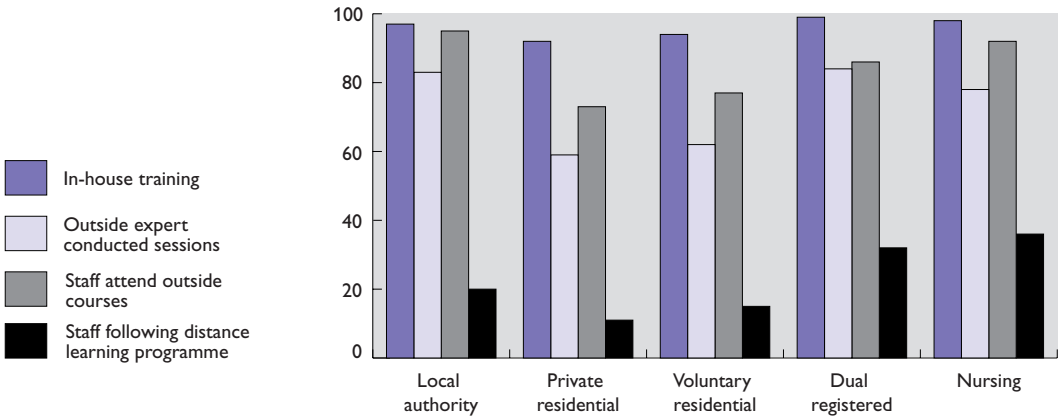
47. As shown in figure 17, approximately 50 per cent of residential homes had at least one staff member with nursing qualifications. But while 55 per cent of local authority homes employed one or more qualified social workers, they were less likely to employ nurses. For private and voluntary residential homes, the figure for employed social workers was approximately 20 per cent. Meanwhile, approximately 20 per cent of staff in dual registered and nursing homes were reported to be working towards nursing qualifications. Two-thirds of homes had staff with NVQs or BTEC awards, and a higher proportion reported that staff were working towards these.

Figure 17: Qualified staff, by home type (%)



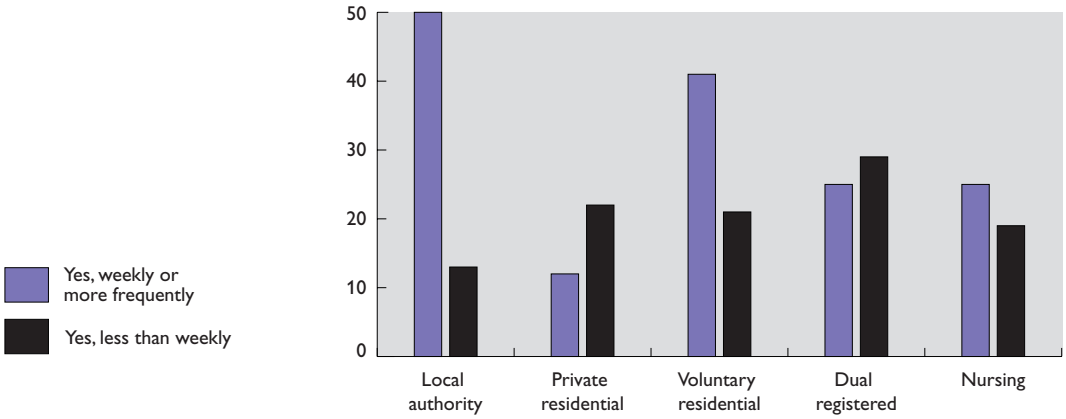
48. As shown in figure 18, the great majority of homes — 97 per cent — had used in-house training; staff from 83 per cent of homes had attended external courses; and 69 per cent had brought an outside expert into the home. Local authority residential homes, dual registered homes and nursing homes were more likely to employ such experts or to send staff on outside courses, although 75 per cent of private and voluntary residential homes also sent staff for external training. About one-third of dual registered and nursing homes reported that their staff had followed distance learning programmes.

Figure 18: Homes undertaking staff training (in six months before interview date), by home type (%)



49. As shown in figure 19, volunteers provided help at least weekly in 50 per cent of local authority and 41 per cent of voluntary residential homes. The corresponding figure for dual registered and nursing homes was 25 per cent. However, only 12 per cent of private residential homes received help at least weekly, and only one-third of these received any volunteer help at all.

Figure 19: Homes with volunteer helpers, by home type (%)



Social climate

50. In residential care, the social climate or atmosphere of the home is of paramount importance to the people living there. It profoundly affects their quality of life. However, while physical facilities can be listed and policies and practices evaluated to indicate the ethos of an organisation, it is notoriously difficult to measure the quality of the caring environment.

51. The Sheltered Care Environment Scale (SCES) was developed in the USA as part of a broader assessment procedure (Moos and Lemke, 1994) and it has been used to describe and evaluate communal living environments for older people in a number of UK studies (Benjamin and Spector, 1990; Netten, 1993; Schneider and Mann, 1997; Mozley et al., 1998). Based on respondents' subjective appraisal of the facility, the SCES aims to identify the social climate as distinct from the caring regime or other indicators of care quality. Respondents can be residents, staff or visitors.

52. The SCES consists of 63 yes/no items which are used to derive seven sub-scales: see Box 3. Figure 20 shows the scores for each sub-scale by home type. Significant differences emerged in the social climate reported in each type of home. Local authority homes had lower reported levels of Cohesion, Independence, Organization and Physical Comfort, and higher levels of Resident Influence and Conflict than other homes. Private residential homes had significantly higher levels of Cohesion, Independence, Organization and Physical Comfort than all other types of home. Nursing homes had significantly lower levels of Independence, Resident Influence, and Self-disclosure than independent residential homes. Voluntary managed residential and dual-registered homes did not differ significantly from other homes on any of the sub-scales.

Box 3: SHELTERED CARE ENVIRONMENT SCALE (SUBSCALE AND DIMENSION DESCRIPTIONS)

Relationship Dimensions

1. Cohesion	How helpful and supportive staff members are towards residents and how involved and supportive residents are with each other
2. Conflict	The extent to which residents express anger and are critical of each other and of the facility

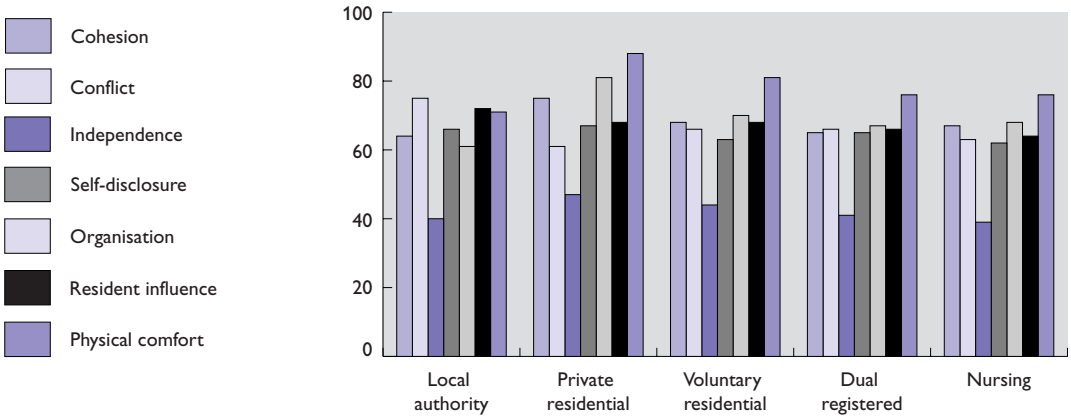
Personal Growth Dimensions

3. Independence	How self-sufficient residents are encouraged to be in their personal affairs and how much responsibility and self-direction they exercise
4. Self-disclosure	The extent to which residents openly express their feelings and personal concerns

System Maintenance and Change Dimensions

5. Organization	How important order and organization are in the facility, the extent to which residents know what to expect in their daily routine, and the clarity of rules and procedures
6. Resident Influence	The extent to which residents can influence the rules and policies of the facility and are free from restrictive regulations
7. Physical Comfort	The extent to which comfort, privacy, pleasant decor, and sensory satisfaction are provided by the physical environment

Figure 20: SCES scores, by home type



53. Assuming that the findings shown in Figure 20 reflected genuine differences in social climate, these results invite the question whether the differences were due to inherent characteristics of the sectors, characteristics of the homes themselves and/or to the nature of the residents in the homes. For example, it would be expected that the size of the home would affect the overall social climate, and smaller homes are more prevalent in the private residential sector. Smaller homes (10 places or less) are associated with significantly higher

Cohesion, lower Conflict, higher Independence, higher Organization and higher Physical Comfort scores. But this was also true within the private residential sector, and the relationship between private residential homes and social climate holds when small homes are excluded. This would suggest that both size and sector are important influences on social climate.

54. Other factors, such as multiple use of homes, where homes provide a variety of services for non-residents, initially appear to be associated with lower Cohesion, higher Conflict and lower Independence. But once the sector is taken into account — multiple use of homes was highly associated with local authority managed homes — the differences disappear.

55. The overall picture that emerges is of different styles of social climate. While these are associated with the providing sector, they may also be the result of characteristics of the residents cared for and activities undertaken by the home. Various theories could be explored. Local authority homes appeared to have higher levels of conflict, but this could be associated with the higher levels of resident influence, which may be given higher priority in the culture of local authority homes compared with the private sector. If people are encouraged to air their views, there may be more scope for conflict.

56. But the degree to which independence was encouraged appeared to be higher in private residential homes, which had similar levels of dependent residents to local authority homes. Nursing homes also showed similar levels of encouragement of independence, amongst a much more functionally dependent population than local authority homes. It is possible that private homes are more responsive to pressures from relatives and residents to ensure that there are activities available. The important question is whether higher levels of independence and resident influence (as measured by the scale) have beneficial long-term effects on residents' functioning and wellbeing.

Conclusion

57. The study provided us with a comprehensive picture of the characteristics, facilities and staffing of care homes. Clearly, care homes had changed during the decade that had elapsed since the previous survey of homes. Independent homes had become larger, were more likely to be purpose built and to have better facilities, including better access and more single rooms than in 1986. This is likely to be due in part to the increasing demands put on homes by local authorities in their role as the major purchaser of places as a consequence of the 1990 NHS and Community Care Act. However, the most important impact of the reform was likely to be on the characteristics of publicly funded residents of homes. It is to the characteristics of residents that we turn our attention in the next chapter.

2 The Population in Residential Care

Background

1. The political issues surrounding long-term care — who should fund it and who should receive it — continue to provoke debate. Even after the recent Royal Commission report (Cm 4192-I, 1999) made its recommendations for financial reform, it is argued that the incentives for the NHS and local authorities still favour placing older people in residential care rather than offering them support in their own homes. In addition, the all-important boundaries between nursing care and personal care still remain unclear.

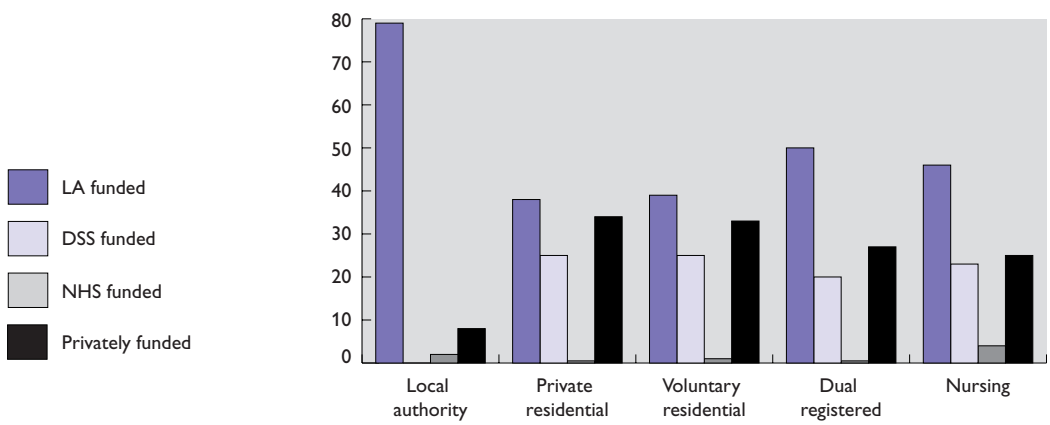
2. In the 1970s a quarter of older people receiving long-term care in a residential setting were being paid for by the NHS, but by 1995 this number had reduced to 10 per cent. Between 1976 and 1994 there had been a 33 per cent reduction in NHS beds for older people (Ginn and Arber, 1999). Since 1993, when the NHS and Community Care Act 1990 came into force, local authorities have been responsible for assessing all applicants for publicly-funded care.

3. This chapter describes the characteristics of the older people in the survey — people aged 65 and over — and compares their age, gender and dependency levels according to type of home, source of funding and the type of stay. As explained in the Appendix, the results were weighted to reflect the national picture. The findings were compared with those of previous surveys to indicate how the population of residential and nursing homes had changed in recent years.

Who pays?

4. Figure 21 shows the sources of funding for permanent residents by home type. Although some data about funding sources could be identified for 76 per cent of residents in the survey, the levels of information available varied considerably between the different types of home. The information given by local authority home managers had to be interpreted with particular caution: local authority homes could only identify sources of funding for 43 per cent of their residents, compared with a figure of 85 per cent or more in the other sectors.

Figure 21: Source of funding for permanent residents, by home type (%)



5. Nearly 70 per cent of all the residents in all homes were publicly funded and were there on a permanent basis. About one-third of all residents in private residential care and about a quarter of residents in private nursing homes were privately funded. This category included 12 older people who at the time of the survey were not being paid for by anybody.

6. Nationally, only 2 per cent of residents in the survey were funded by the NHS; 47 per cent of these were in nursing or dual registered homes. The remainder — the overall majority — were in various types of residential care. Thirty per cent of the residents with some NHS funding were funded jointly with local authorities.

7. Dual registered homes had a smaller proportion of residents funded through the NHS than nursing homes. Overall, 60 per cent of beds in private and 54 per cent of beds in voluntary dual registered homes were registered as nursing beds.

8. Taking reservations about the accuracy of local authority reporting into account, the proportion of residents described as wholly privately funded proved to be the same as that reported in an earlier study (Darton, 1992), which found that 6 per cent of 1,720 residents in local authority homes were paying full cost fees.

9. Private sector homes were able to offer the most information about those residents who had changed from being privately funded to being either partially or wholly publicly funded: the so-called 'spend-down' cases. This information was only available for 26 per cent of residents in local authority homes. Out of all the permanent, publicly-funded residents aged 65 or over at the time of the survey, 14 per cent had been admitted as wholly privately funded. (This does not include 154 residents who were privately funded at the time of the survey, but were in the process of changing from private to public funding.)

10. Data were available for 76 per cent of Department of Social Security funded residents, and for 73 per cent of those funded by local authorities. A higher proportion of the former than the latter had become publicly funded during their stay. On admission, 23 per cent of older residents supported by the DSS had been wholly funding themselves, compared with 11 per cent of those supported by local authorities. These figures excluded publicly-funded residents under 65, who were less likely to be spend-down cases.

11. Among the independent homes, 38 per cent (142) had spend-down cases. Private sector managers reported a total number of 280 individuals who had become publicly funded during the year of the survey; 32 of these were in one home. Overall, 52 per cent of them were 'preserved rights' cases: people funded by the DSS who had been admitted before April 1993. Nearly all these spend-down individuals were found to be in residential homes, and, although information about age was not collected, the distribution suggests that the majority of them would have been elderly. Their numbers were very small in relation to the total home population: less than 2 per cent.

12. At any one time, about 3 per cent of care home residents were short-stay residents. These short-stay residents were predominantly funded by local authorities, and an estimated 62 per cent of them were placed in local authority homes. Of local authority funded short-stay residents, 81 per cent were placed in local authority managed homes.

Admission and length of stay

13. Figures 22 and 23 show sources of admission by home type, type of resident and type of funding. The permanent residents in local authority homes were more likely to have been admitted from multi-occupancy households: 19 per cent, compared to 13 per cent in independent homes. The picture was similar for short-stay residents. Publicly-funded permanent residents were also less likely to have been admitted from single-person households and more likely to have been admitted from hospital than those who were privately funded. As might be

expected, a higher proportion of people in nursing homes were admitted from hospital and a lower number from single-person households.

Figure 22: Source of admission, by home type (%)

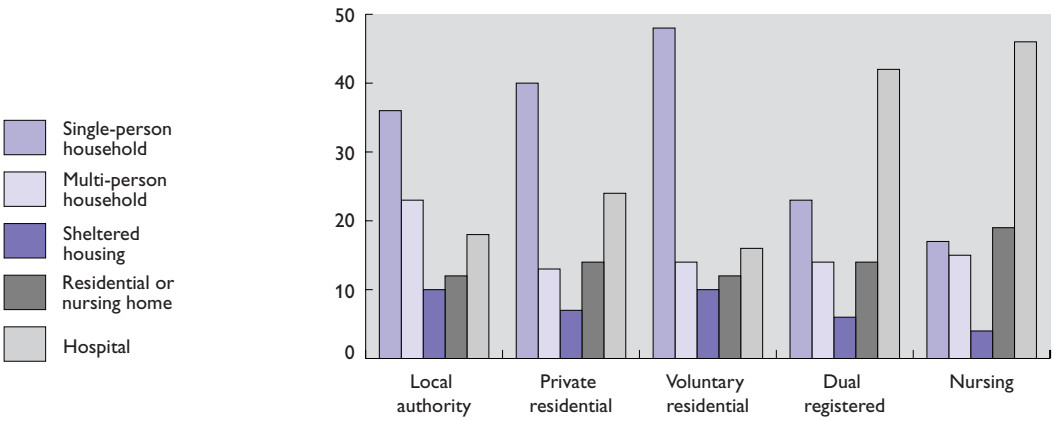
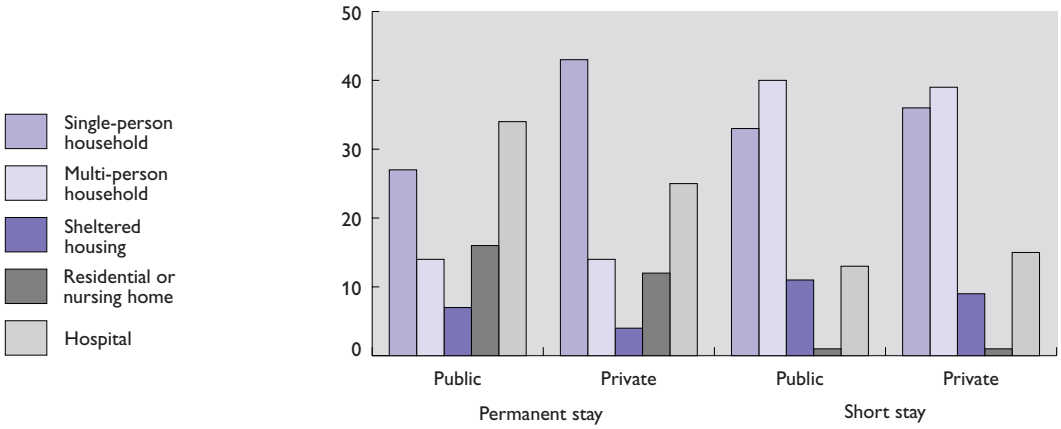


Figure 23: Source of admission, by type of resident and funding source (%)



14. Figures 24 and 25 show permanent residents' length of stay by home type, and the planned length of stay of short-stay residents by funding source. On average, publicly-funded permanent residents had been living in homes for 37 months, four months longer than those who were privately funded. However, the proportions of residents who had been in homes for less than a year were virtually identical in both funding categories. This was due to the higher proportion of publicly-funded individuals who had been in homes for longer periods of time. The most usual period of time for short-term stays was 14 days.

Figure 24: Length of stay of permanent residents, by home type (%)

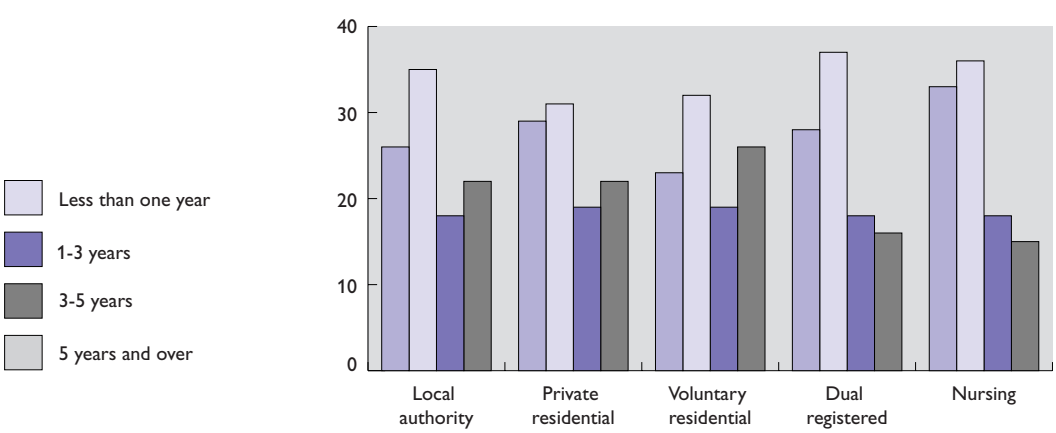
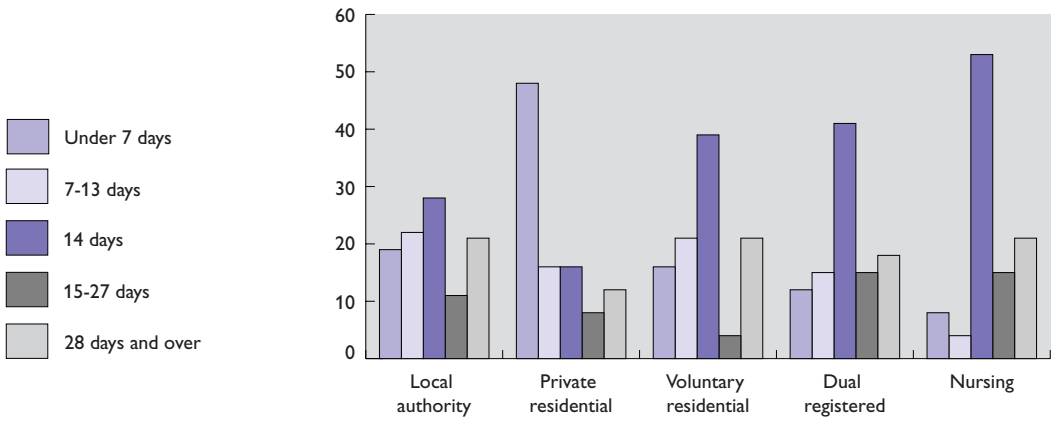


Figure 25: Planned length of stay of short-stay residents, by funding source (%)



15. Expected completed length of stay can only be estimated accurately on the basis of longitudinal data. The accompanying longitudinal study found that the median length of stay for publicly-funded admissions was 20 months, with average length of stay predicted to lie between 28.9 and 30.7 months. Median length of stay for those originally admitted to nursing homes was one year, and for those admitted to residential homes it was 27 months (Bebbington et al., 2001).

16. Cross-sectional information about uncompleted length of stay of current residents will be affected by a number of factors, including past rates of admission, local authority policies regarding the use of their own provision and the independent sector, and levels of funding available over time. The national average uncompleted length of stay for permanent residents was 36 months. As would be expected, this period was significantly shorter for those in nursing homes: 30 months. Although still longer than the predicted length of stay at admission, median length of stay was shorter — 24 months overall, and 21 months in nursing homes. People in voluntary sector residential homes had been there for longer — an average of nearly four years (median 31 months) — compared with just over three years in private and local authority accommodation (median 25 and 24 months respectively).

17. Just under 30 per cent of residents nationally had been in homes for a year or less, although this varied by home type. Nursing homes had a higher proportion of recent admissions, and voluntary residential homes a lower proportion. But this was not entirely due to the more rapid turnover in nursing homes. There were wide variations in the proportion who had been residents for long periods, defined as five years or more. This ranged from 15 per cent in nursing homes to 26 per cent in voluntary residential homes. One-fifth of all residents nationally had been in homes for over five years. Among residents aged 65 or over at the time of the survey, the maximum length of stay was 48 years. Excluding people who had been admitted aged under 65 reduced this figure to 22 years.

18. Publicly-funded residents were also more likely to be short-stay visitors than those who were privately funded. Among the former, 69 per cent of short-term placements were for 14 days or less; 29 per cent were for two weeks. But on average more of the private payers were planning to stay longer — 27 per cent of them for more than four weeks.

19. The majority of short-stay residents (74 per cent) were regular users of short-term care, and 55 per cent of them had previously visited the homes where they were staying. Nineteen per cent were on their first visit, but intended to become regular users. Publicly-funded residents were more likely to be short-stay visitors than those who were privately funded. Even so, 65 per cent of the latter planned to be regular users. However, in 24 per cent of cases home managers did not know whether their short-stay residents were regular visitors or not.

Age and gender

20. Nearly 80 per cent of all permanent residents were female, although the proportion of female short-stay residents was lower: about 70 per cent. Local-authority run residential and nursing homes had larger numbers of males than private residential homes.

21. The national average age, among those aged 65 and over, was 85 years. But the admissions survey found that people admitted to nursing homes were slightly younger that those admitted to residential care, and this was reflected in the population of the homes. Publicly-funded residents had an average age of 84; for privately-funded residents it was 86.

22. Younger people, usually those with physical disabilities, formed a small proportion of residents in the homes. They were often there because more suitable accommodation could not be found for them. Most of these younger residents — 2 per cent of them were under 40 — were found in either voluntary residential homes or in the private sector. Few were in local authority accommodation.

Figure 26: Age of residents, by home type (%)

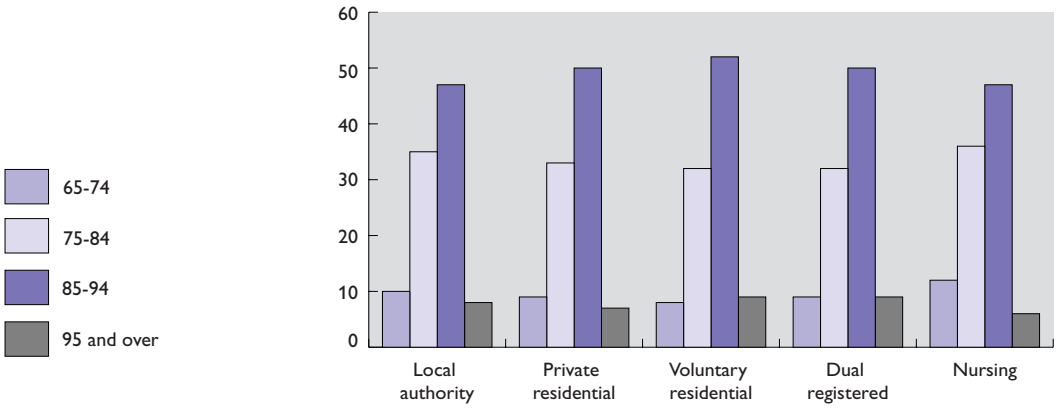


Figure 27: Gender of residents, by home type (%)

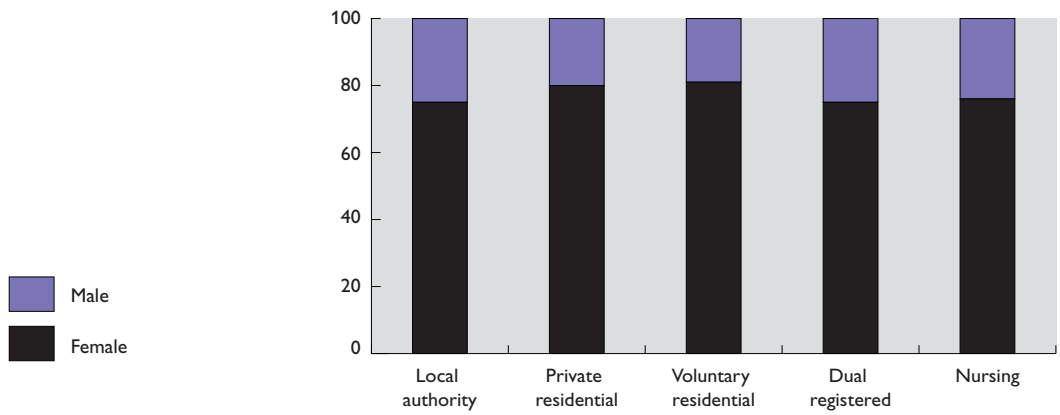


Figure 28: Age, by type of resident and funding source (%)

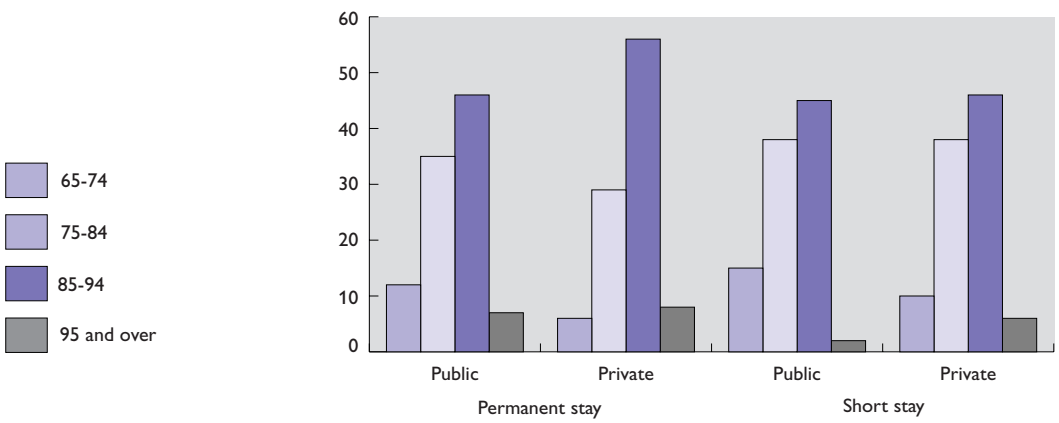
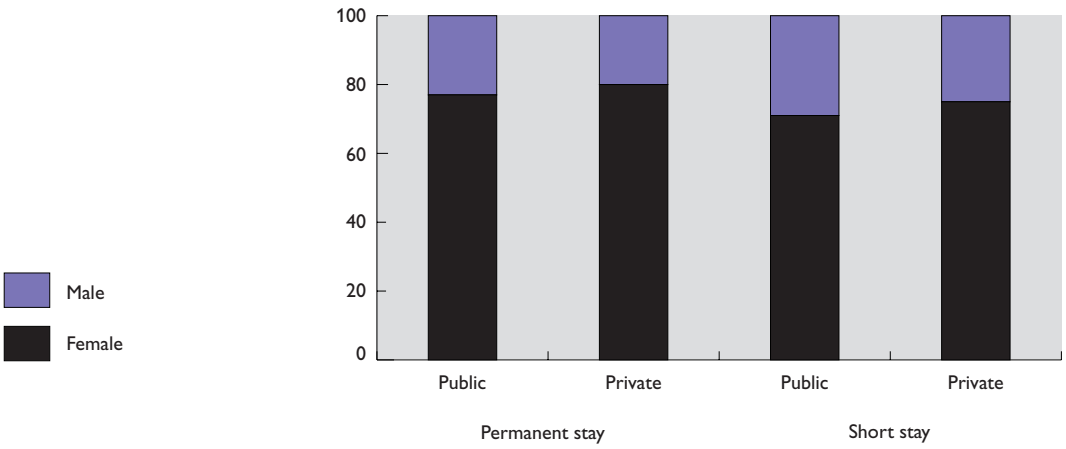


Figure 29: Gender, by type of resident and funding source (%)



Levels of dependency

23. A number of different approaches were used to measure dependency. These included the Barthel Index of Activities of Daily Living (Royal College of Physicians and British Geriatrics Society, 1992) and the DHSS 4-category measure used in previous surveys of residential care (Davies and Knapp, 1978; Darton et al., 1989). Cognitive impairment and challenging behaviour were identified by using items from the Minimum Data Set (MDS), a structured approach to assessment and problem identification (Morris et al., 1990; Carpenter et al., 1997). A seven-point scale, the Minimum Data Set Cognitive Performance Scale (MDS CPS) was compiled from this: see Box 4. Using these hierarchical categories provided an overview of problems in the areas of memory, functioning and communication. An additional question taken from the MDS concerned the frequency of problem behaviour, such as wandering, physical or verbal abuse and antisocial acts. Behavioural symptoms of depression were excluded.

Box 4: THE MINIMUM DATA SET COGNITIVE PERFORMANCE SCALE (MDS CPS)

0	Intact (no problems in any aspect of memory, decision making or functioning)
1	Borderline intact
2	Mild impairment
3	Moderate impairment
4	Moderately severe impairment
5	Severe impairment
6	Very severe impairment

Source: Morris et al. (1994)

24. Levels of dependency and cognitive impairment had significantly increased since previous surveys. This was most noticeable in the voluntary sector, and in nursing homes (see below). Figures 30 and 31 show dependency levels by home type, and by type of resident and funding type. While previous surveys had found little difference between publicly- and privately-funded residents, this survey found that people supported by public funds were on average more dependent than those who were privately funded.

Figure 30: Dependency of residents, by home type (%)

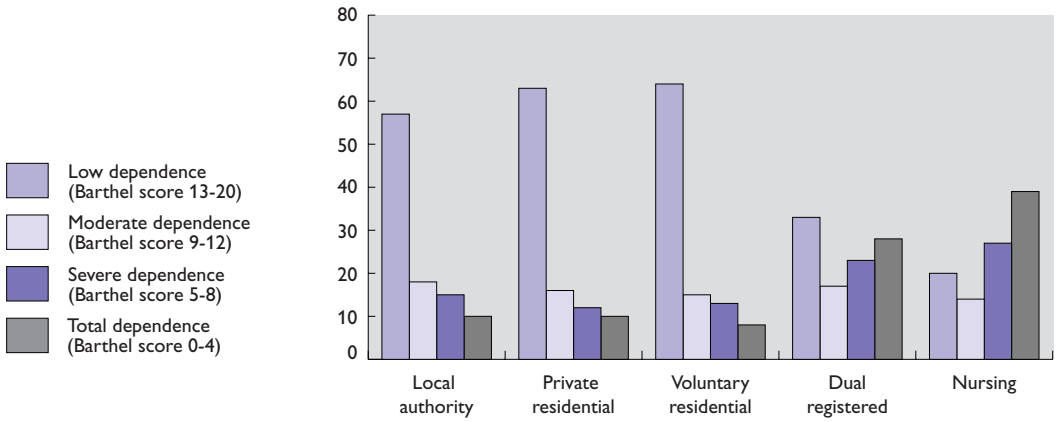
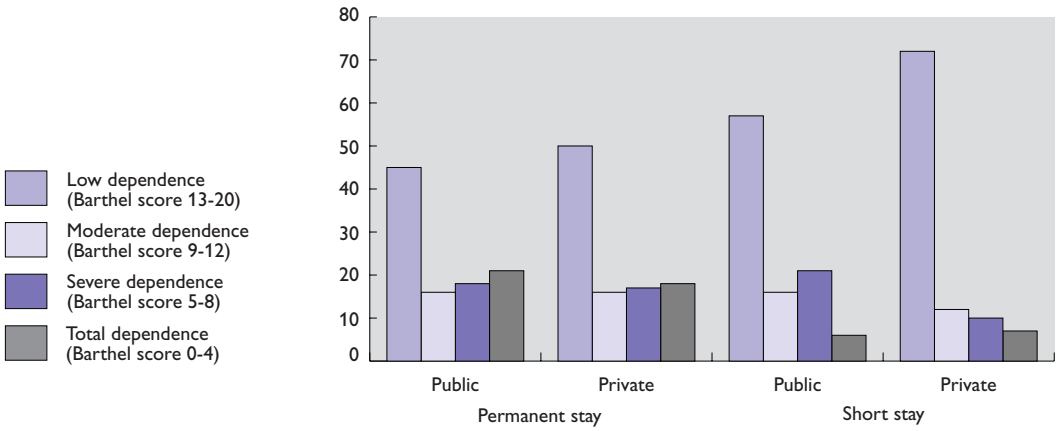


Figure 31: Dependency, by type of resident and funding source (%)



25. As might be expected, residents in nursing homes were more dependent than people in residential care. A higher percentage of them needed help with basic self-care tasks, and nearly 40 per cent were in the most dependent Barthel category, compared with 10 per cent of those in residential care.

26. Nationally, one-fifth of all residents were estimated to be in the most dependent group, but while both types of independent residential care had a similar dependency profile, people in local authority homes were found to have slightly lower Barthel scores, that is, higher levels of dependency. The majority of the latter were publicly funded, and would have been assessed before admission. Also, compared with other residential accommodation, fewer residents in local authority homes were found in the least dependent group.

27. However there were still significant numbers of older people with quite low dependency levels in long-term care. Nearly one-fifth of all residents scored 17 or more on Barthel and, according to the MDS CPS, were also mentally alert. Among the publicly-funded residents admitted during the previous year, the proportion was slightly lower, at 17 per cent. It is possible that there may have been unmeasured reasons for these individuals to be placed in long-term care; alternatively, they may have recovered after admission. When people admitted by local authorities were compared with existing residents, 42 per cent of the latter were in the least dependent group compared with 34 per cent of new admissions (Netten et al., 1997). The longitudinal survey of publicly-funded admissions found that 21 per cent of survivors had become more independent six months after admission (Darton and Brown, 1997).

28. Nationally, privately-funded permanent residents were significantly less dependent than their publicly-funded counterparts. Although this difference was not large, it is likely to be increasing. Out of admissions in the 12 months before the survey, 53 per cent of privately-funded residents and 42 per cent of publicly-funded residents were in the least dependent group.

29. In private residential homes, funding sources did not reveal any significant links with dependency levels. While local authority-funded residents in nursing homes were more dependent than their counterparts elsewhere in the system, there was no difference in dependency levels between voluntary, private and local authority residential care (Netten et al., 1997).

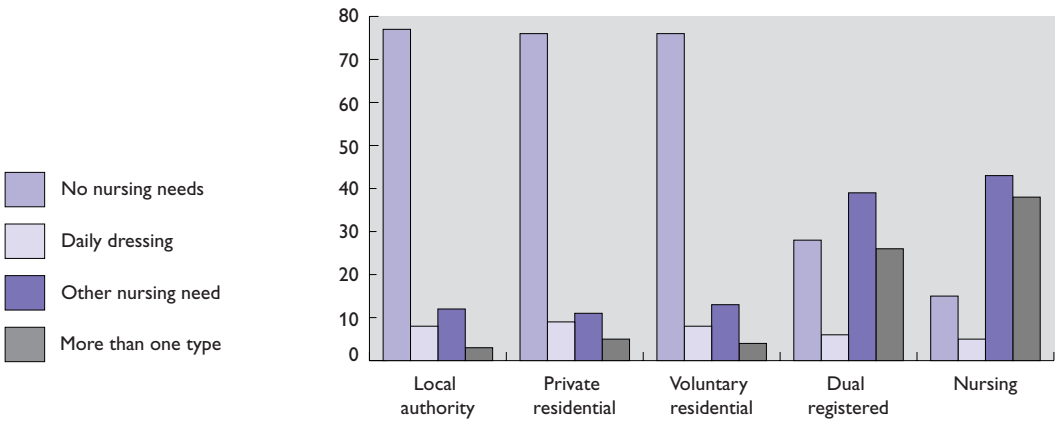
30. Spend-down cases — those who had been admitted as privately funded and run out of assets — had, on average, been living in the homes longer than other residents: 49 months, compared with 34 months for publicly-funded residents. The difference in dependency levels between them and other residents was small.

31. Apart from those funded by the NHS, short-stay residents were significantly less dependent than permanent residents on all counts.

32. In all homes, people admitted from single-person households were less dependent than those coming from shared households. People admitted from hospital were the most dependent of all. But finance was only associated with dependency in admissions from single-person households. Privately-funded people from this group were less dependent than people who were publicly funded.

33. Nearly half of all the people living in all types of residential homes needed some form of nursing care. Figure 32 shows nursing care needs by home type. As might be expected, people in nursing homes needed more care; only 15 per cent of them did not have an identified nursing need. Relatively little use was made of district nursing services: less than 4 per cent of residents were visited. Short-stay residents were less likely to need nursing care, but were more likely to receive visits from district nurses than permanent residents.

Figure 32: Nursing care needs, by home type (%)



34. Indicators of mental state revealed a similar pattern to the findings on physical dependency. People being admitted to homes at the time of the survey showed higher levels of cognitive impairment than the resident population. Figures 33 to 36 show mental state by home type, and by type of resident and type of funding. Local authority residential homes contained more people with cognitive impairment and disturbed behaviour; voluntary homes were more likely to be caring for people who displayed frequent antisocial behaviour. Nursing homes had the highest levels of residents with both types of problem. Far fewer of the privately-funded residents, permanent or short-stay, had any kind of cognitive impairment or exhibited behavioural problems than those who were publicly funded.

Comparisons with previous surveys

35. This study was designed to facilitate comparisons with the data from previous surveys conducted in 1981, 1986 and 1988 (See Box 1, Chapter 1). Levels of dependency and mental disability were found to be significantly higher than before. Figure 37 shows a comparison between 1986 and 1996 (Darton et al., 2000), based on the Katz Index of ADL (Katz et al., 1963).

Figure 33: Cognitive impairment of residents, by home type (%)

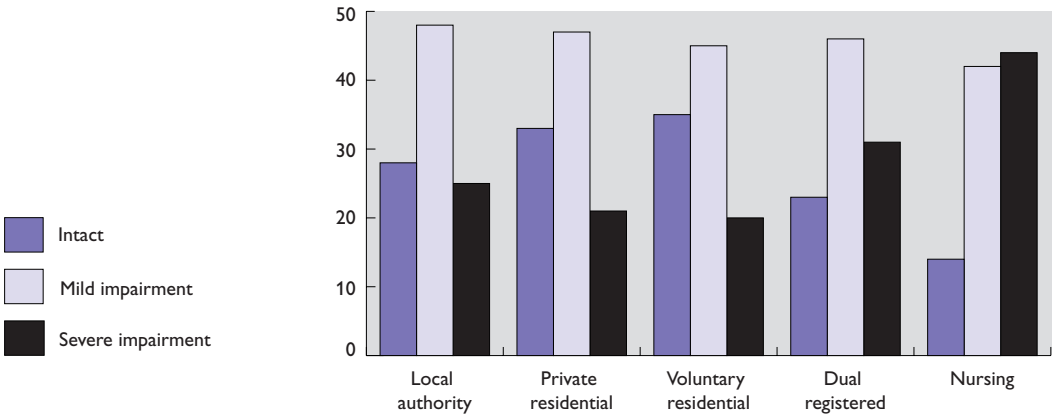


Figure 34: Antisocial behaviour of residents, by home type (%)

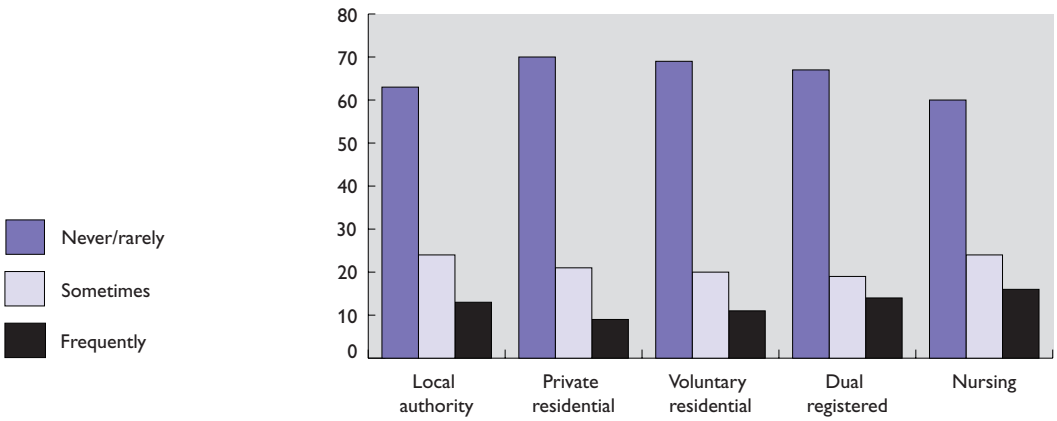


Figure 35: Cognitive impairment, by type of resident and funding source (%)

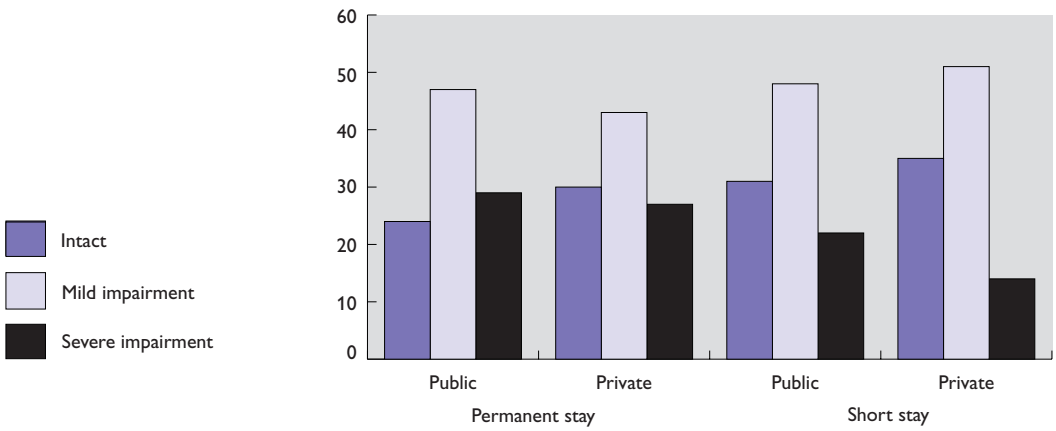


Figure 36: Antisocial behaviour, by type of resident and funding source (%)

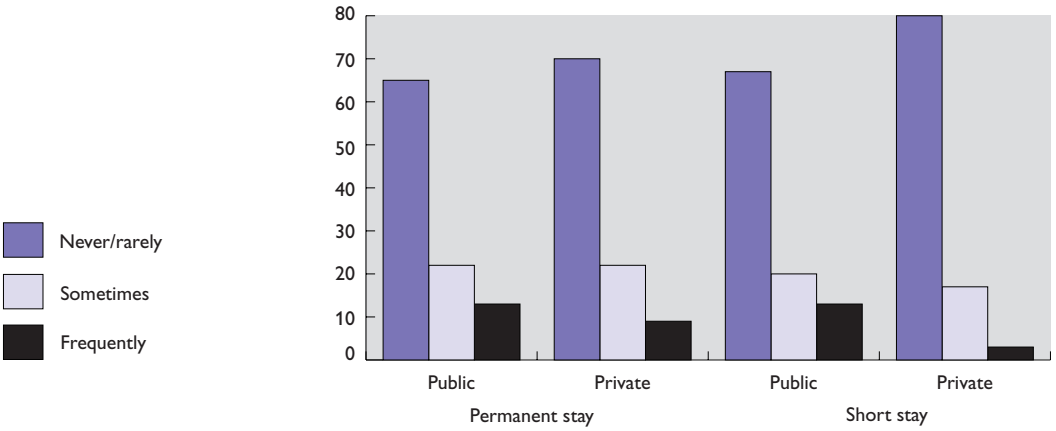
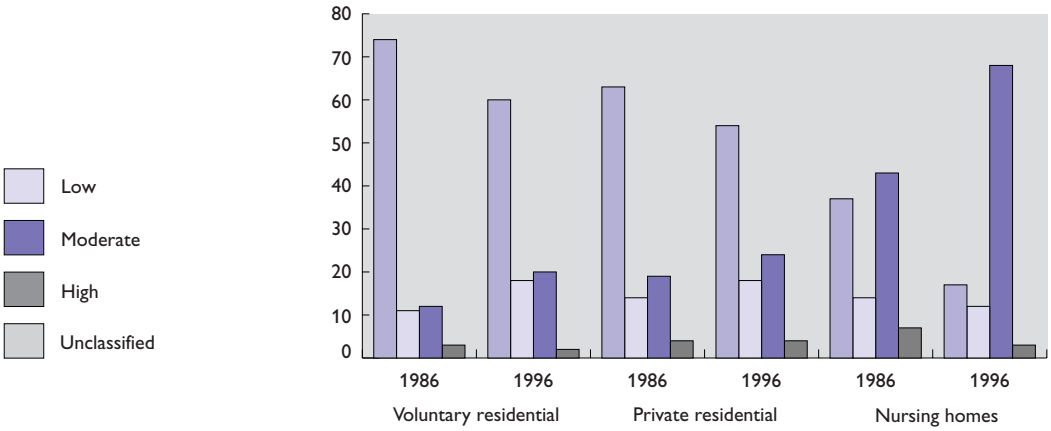


Figure 37: Dependency (Katz Index of ADL) of residents, 1986-96, by home type (%)



36. The proportions of female residents in residential homes in 1996 were similar to those in 1986 and 1988, but there were fewer women in nursing homes in 1996. In 1981, there were fewer women in voluntary sector residential homes and fewer men in private residential homes than subsequently. The mean ages of residents were slightly higher than before and, in spite of small variations, appeared to be continuing an overall upward trend.

37. With the exception of private residential homes, where in 1996 uncompleted length of stay had increased, length of stay had remained more or less the same. Voluntary residential homes still had the highest proportion of residents who had been living there for five years or more; private nursing homes had the highest rates of turnover. The mean length of stay for existing long-stay residents was approximately 40 months in residential homes and 30 months in a nursing homes, although there were wide variations.

38. In voluntary residential homes and in nursing homes, more people than previously had been admitted directly from hospital. Fewer people than in the earlier surveys had gone from hospital to either local authority or private residential homes. Residents in the latter were also more likely to have been living alone before admission than previously. The number of people admitted from sheltered housing had also increased.

39. Problems of physical functioning, mental confusion and levels of antisocial behaviour had increased between 1986/88 and 1996, but changes were more marked in voluntary residential homes and nursing homes than in local authority and private residential homes. In voluntary residential homes, the proportion of residents classified as heavily dependent had increased from 20 to 32 per cent between 1986 and 1996; in nursing homes, it had risen from 54 to 76 per cent. In 1996, mobility levels, the need for help with self-care tasks and levels of continence were quite similar in all types of residential home. Changes had also taken place in the reported levels of depression and anxiety, although these could be a reflection of changes in staff perception and awareness. But even taking this possibility into account, depression and anxiety were again reported to have increased most in nursing homes and in voluntary residential homes.

Conclusion

40. The study provided us with a national picture of the characteristics of residents including source of funding, age, gender and dependency levels. There appeared to be a higher level of dependency among publicly funded residents compared with self-funded residents suggesting that some of these people may be being admitted to care who might be able to be maintained in their own homes. However, the most significant finding was the considerable increase in levels of dependency in all settings, although most marked in nursing and voluntary homes. Such changes in the population being cared for has implications for costs and prices and it is to these that we turn in the next chapter.

3 What Influences Costs and Pricing

Background

1. Whatever the outcome of current policy debates, issues surrounding the quality and costs of long-term care will remain on the welfare agenda. In addition to having information about the nature of providers, both national policy makers and local commissioners of long-term care will need to be aware of what influences provider behaviour so that they can shape and develop the care home market effectively.

2. This chapter outlines the results of an analysis of costs and pricing in the independent sector and of unit costs in local authority homes. The independent sector analysis investigates why prices vary between providers, and seeks to identify some indicators of the important determinants of pricing. The local authority analysis looks at the factors influencing revenue spending and asks whether changes in unit costs are linked with residents' dependency.

The independent sector: costs and prices

3. Market prices are, in general, determined by supply and demand. However in an imperfectly competitive market like long-term care provision, they will depend on the demand faced by each provider as it interacts with their cost structure. Organisations providing nursing home and residential care are constrained in their pricing policies by the demand for their services, with the number of units sold being inversely related to the price charged, after factors such as location, type of client and competitors' pricing have been taken into account.

4. Given a home's fixed costs, the cost structure will reflect the level of variable costs related to the number of filled beds. An organisation will set its prices according to particular objectives (such as making a profit), and the level of demand it expects to attract, which in turn impacts on costs. This can be expressed in the equation: *price* = *cost* + *mark-up*.

5. The gross weekly charges for permanent and short-stay residents, averaged for each type of home, are shown in Table 1. While nursing homes, as might be expected, charged more than residential homes — approximately £100 per week — their short-term residents were paying slightly lower prices than those who were there permanently.

Table 1: Weekly charges in independent homes, by care type (£)

	Nursing		Residential		All	
	Mean	No.	Mean	No.	Mean	No.
Permanent residents						
Private	334	146	238	111	294	282
Voluntary	328	5	235	111	249	128
All	334	152	237	222	280	410
Short-stay residents	323	38	251	44	284	88

Note: The 'All' homes category includes dual registered homes.

6. Dual registered homes were excluded from this analysis. There were too few of them in the study, and they could not appropriately be combined with either of the other sectors. However they are a rapidly growing sector of the market. On average, they charged £318 a week.

7. Table 2 shows average prices by type of care and type of authority. Homes in London were more expensive, across all care types. Explanations offered for this included the high costs and low supply of care in London, different funding levels and different patterns of demand by London authorities as well as the types of client located in London.

Table 2: Average gross weekly prices for independent sector homes, by care type (£)

	Nursing		Residential		All	
	Mean	No.	Mean	No.	Mean	No.
London boroughs	413	23	295	29	353	56
Metropolitan districts	312	40	223	56	263	106
Counties	324	89	230	137	270	248
All	334	152	237	222	280	410

Notes: These data exclude 44 nursing homes and 81 residential homes included elsewhere in the study, as information about their weekly charges was not available. The 'All' homes category includes dual registered homes.

8. But in comparing the costs of residential and nursing care, it is important to understand that like is not being compared with like. The cost of nursing is included in most nursing home prices, but in residential homes nursing costs are borne by the NHS in the form of community nursing services. However, on average community nursing only added £5 per week per resident to the cost of residential care.

9. While approximately 25 per cent of the residents in both public and private residential homes required nursing care, they were more likely to be receiving such care in voluntary or local authority homes. In terms of the types of care identified, there appears to be no clear reason for this.

10. For a longer term consideration of the costs of care, it is useful to know what factors affect the price of care charged to the local authority. As mentioned above, prices are determined by the interaction of demand (mark-up) and cost, and in the context of residential care, demand and costs are influenced by factors that can be grouped into four categories; see Box 5. The 'empirical proxies' represent measures of these factors.

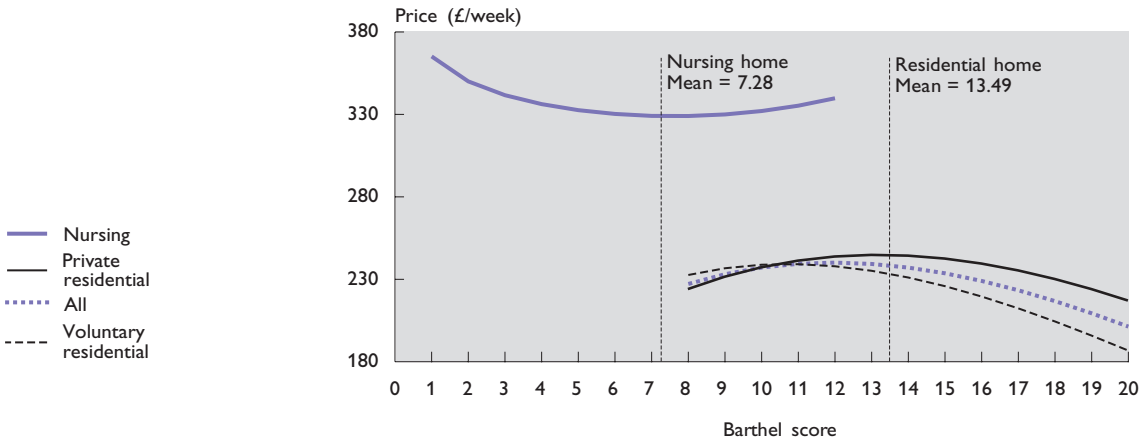
Box 5: FACTORS AFFECTING DEMAND FOR AND COSTS OF HOMES

Demand and cost factors	Empirical proxy
Client characteristics:	
Physical dependency/need	Barthel scores
Mental dependency/need	MDS CPS scores
Product characteristics:	
Places sold	Number of residents
Physical fabric of home	Single room proportions
	Purpose built
Organisational arrangements	Single home organisation
	Started from scratch
	On local authority preferred list
Types of care/clients	Terminal care provided
	Mental health care provided
	Primarily privately-funded residents
	Primarily LA funded residents
Home environment	Provision of entertainment
Ownership	Private or voluntary
Home size	Number of beds
Local authority characteristics:	
Local area labour costs	LA wage rate (female manual)
Competition/market structure	Nursing places per LA
	per LA population
Market size/type	Local GDP
	LA population
Commissioning/purchasing characteristics:	
Pricing arrangements/ reimbursement structure	LA has fixed/non-contingent pricing
	Variable per client (price) contract
	Home level, independent of client (price) contract
Purchaser type	Per cent of people privately funded
	Per cent of people LA funded

11. But if the demand and cost factors set out in Box 5 are considered in isolation the impact on price-setting is likely to be misleading. Therefore multi-variate analysis techniques were used to examine the differences in each factor as they related to particular homes, the prices charged and the costs generated, enabling patterns of association to be identified.

12. Physical and mental dependency was measured by the Barthel Index of Activities of Daily Living and by the MDS Cognitive Performance Scale, respectively (see Chapter 2). The large price differential between nursing and residential care, dominated the relationships between costs, price and levels of dependency. Figure 38 shows that in each type of home, small changes in the dependency levels of people in the mid dependency range had little effect on care costs in terms of staff resources. The relationship between dependency and price was most marked in voluntary residential homes. But for those people who were borderline between residential and nursing care a small change in dependency could result in a move which had major implications for both costs and price.

Figure 38: How price varies with dependency



13. Physical fabric, organisational arrangements, client type, home ownership and home size were all found to have effects on price. Higher prices were associated with purpose-built homes, while organisations with more than one home had slightly lower prices than single homes. Nursing homes with beds for people with mental health problems were associated with lower prices than general nursing homes; private residential homes charged more than voluntary sector homes. Size also had implications for economies of scale, although the finding that small residential homes (those with fewer than 15 places) had lower prices than homes of all other sizes could be a reflection of lower demand for them.

14. Both residential and nursing care are labour intensive, therefore the most important element of the cost of care is the cost of staff. The basic wage (i.e. as paid to unqualified, inexperienced care staff) was slightly higher in residential care homes than in nursing homes. The majority of nursing homes and private residential homes paid basic wages below £4 per hour (89 per cent and 92 per cent respectively). In contrast, a very high proportion of local authority homes had a basic wage between £4 and £5 per hour.

15. Privately-financed clients tended to pay higher charges than the others in both residential and nursing homes. This may be explained by the buyer power of local authorities, enabling them to keep prices low.

16. Local authority commissioning arrangements were also expected to affect prices and demand. Prices set at home level, independently of individual client dependency (so-called 'non-contingent' prices) may lead to deliberate selection of lower cost residents and therefore mean higher prices relative to a home's costs. In contrast, prices set on a per-client basis ('contingent' prices) tend to reduce provider risk and could therefore result in lower prices being offered in return.

17. The residential care sample produced a positive relationship between contingent pricing and price, but in nursing homes the reverse was true. Because of the large dislocation between residential and nursing care prices, it might be argued that the former could be too low and the latter too high. This could be due to historical factors, such as DSS limits for each type of care or, more recently, to inappropriate local authority behaviour in terms of price-setting and regulation.

18. The findings of the costs and prices analysis in the independent sector are summarised in Box 6.

Box 6: SUMMARY OF FINDINGS ON COSTS AND PRICES: INDEPENDENT SECTOR

- Relatively modest mark-up rates of price over cost, at around 10 per cent.
- A significant relationship between price and Barthel score as a measure of dependency, but the effects were very small.
- Larger effects of dependency on cost, which may be due to price-setting behaviour of local authorities.
- A large dislocation between nursing and residential care prices dominated the relationship between dependency and both prices and costs.
- Voluntary sector residential prices were more sensitive to dependency variations, and lower.
- Prices were very sensitive to variations in labour costs (local market wage rate).
- Competition lowered prices, but the market already appeared to be pretty competitive.
- Privately-financed residents were charged more for a similar service.
- Local authority pricing policies do have significant effects. The data suggest fixed prices are high in nursing care and low in residential care, although other factors are certainly relevant and the result should be treated with caution.

Local authority homes: costs

19. The unit costs of local authority residential care have always been higher than the price of independently provided care (Netten, 1994). Together with financial incentives in funding, this has led many authorities to reduce or even eliminate their local provision. In this survey, two authorities had no homes at all, and one had only one facility. This reduction has itself been associated with dramatically rising revenue costs in the mid 1990s (Netten and Dennett, 1996).

20. Cost information was available for 161 homes. Table 3 shows the range of unit costs by type of authority. The average was £300 per week, 18 per cent less than the national average of £366. Homes in London were 46 per cent more costly than those in the rest of the country and 39 per cent more costly than the overall average. (In 1995/96 the latter figure had been 32 per cent.)

Table 3: Unit costs per resident week, by local authority type (£)

	Unit costs per resident week			
	Average	Highest	Lowest	Number of homes
London boroughs	412	629	315	19
Metropolitan districts	282	577	184	44
Counties	281	498	162	98
All homes	297	629	162	161

21. Box 7 lists potential influences on the costs of local authority homes. Many of the factors discussed at the beginning of this chapter, in the context of the independent sector, are not relevant to locally managed homes.

Box 7: INFLUENCES ON LOCAL AUTHORITY HOME COSTS

Cost of inputs
- Basic wage rates

Resident characteristics
- Physical impairment
- Cognitive impairment
- Nursing needs

Home characteristics
- Size of home
- Design of home (group living or semi-group living)
- Occupancy, turnover of residents
- What the home provides for non-residents (e.g. day care, multi-purpose use of homes)
- What the home provides for residents (e.g. short-term care, specialisms, physiotherapy)
- Quality of care (e.g. proportion of single rooms, level of activities, degree to which independence is encouraged)
- Staff characteristics (e.g. qualifications, ongoing training)
- Use of volunteers

Regional variations
- Type of authority
- Local wage rates

22. Homes in the sample had an average of 37 beds, and the average occupancy level was 91 per cent. Increasing the number of places led to a reduction in costs for every additional bed. Costs were also very sensitive to levels of occupancy.

23. The costs of day care for non-residents also needed to be taken into consideration. Where day care levels were low, they had no discernable effects on the unit costs for residents. When more than 35 sessions were provided per week, these costs were higher.

24. Similarly, the impact of short-term care was not evident until provision reached a certain level. When the proportion of short-term residents was less than 17 per cent — in a 30 place home, five or less — there was no significant effect on average costs. However 19 per cent of the sample had a higher proportion than this, and costs rose as the number of short-term residents increased. In an average home, one short-stay resident was predicted to cost 5 per cent or £14 more than a permanent resident (£313 a week, compared to £299).

25. In theory, the quality of care is also associated with costs. The only factors found to have a significant association with quality were two SCES indicators of social climate (see Chapter 1, Box 3). An environment that fostered Independence was associated with higher costs; higher levels of Organization were associated with a cost reduction. Both these indicators were significantly higher in privately run residential care, where costs were considerably lower.

26. A summary of findings on the costs of local authority provision is shown in Box 8. Although the nature of provision has changed in the intervening period, comparison with similar data collected in 1981 (Darton and Knapp, 1986) suggests that current costs are 12 per cent higher than might be expected.

Box 8: COSTS OF LOCAL AUTHORITY PROVISION: SUMMARY OF THE ANALYSIS

- Strong relationship between the proportion of severely cognitively impaired residents and cost.
- Costs were very sensitive to level of occupancy.
- Costs were minimised in 60-bedded homes.
- Where day care was included, it only had a significant impact on the estimated costs of caring for residents when more than 35 sessions per week were provided.
- The impact of short-term care on costs was observable once the proportion rose above 17 per cent (the equivalent of more than five residents in a 30-bedded home). In an average size home short-term residents cost 5 per cent more than permanent residents.
- Two indicators of social climate were found to be significantly associated with the costs of care. The more the environment fostered Independence, the higher the cost; the higher the level of Organization, the lower the cost.
- The differential between unit costs in local authority homes in London and outside was far higher than in the independent sector (46 per cent), and remained so after allowing for resident and home characteristics.
- Adjusting for price differentials and changes in dependency accounted for most of the difference in unit costs in local authority care between 1981 and 1996. The remaining 12 per cent could in part be due the increased provision of short-term care and perhaps to unmeasured changes in dependency.

Conclusion

27. The study provided an opportunity to investigate the relationship between factors associated with demand for, and costs of care and prices, and factors associated with the costs of local authority managed care. From the analyses it would appear that the considerable increase in levels of dependency reported in the previous chapter and the improvements in facilities reported in Chapter 1 would have a relatively limited effect on costs. Both costs and prices were dominated by variations in factors beyond the control of homes: in particular local wage rates. This raises the issue of the degree to which homes are able to provide sufficient quality provision in those areas where external pressures on costs and prices are high. It is to this issue of supply that we turn our attention in the next chapter.

4 Prices and Supply

Background

1. Since the funding changes introduced by the 1990 NHS and Community Care Act, one of the most important issues regarding public sector residential and nursing home care concerns the price levels required to generate enough quality provision to match levels of need. The wide variations in supply in different areas are one aspect of this. Some urban areas appear to have a severe shortage of care home places, leading to 'bed-blocking' in hospitals. Elsewhere, inadequate profit margins and lack of demand have put homes out of business. This chapter argues that present funding and pricing mechanisms may be responsible for this uneven supply.

2. Chapter 3 provided an explanatory model of demand/supply factors which showed that price does appear to be sensitive to the supply characteristics of local markets. The question posed in this chapter is, by contrast, normative: what variation in local authorities' prices ought there to be in order to produce a pattern of supply that matches the level of demand, thus offering equal access to a local care home place to those with equal need?

3. This question does assume a market in which pricing changes will have a direct impact on suppliers' behaviour, and also one in which the purchasers (local authorities) possess a degree of monopsonistic power in relation to the providers (cf. Forder et al., 1999). Local authorities budget a price that they are willing to pay for this type of care based on their own assessment of the level of need, and on their own assumptions about the providers' supply response.

4. At present, there are few incentives to set prices in order to achieve a balance across different localities between need and supply. There are currently no national standards for provision or prices set by central government, and none agreed by the authorities' own associations, although common standards of provision will be established under the 2000 Care Standards Act. In the early 1990s, authorities were influenced by the national price rules previously set by the Department of Social Security when they paid for a large proportion of private care. Hence there is some history of uniformity of pricing, but not of sensitivity to local circumstances.

5. The question set out above is a particularly difficult one to answer empirically. But this chapter argues that the evidence points to the driving force behind local cost variations being the price of labour. But local price variations actually need to vary more than might be expected from a comparison of average local wage rates, in order to match supply to need. In consequence, existing cost variations can be perceived as a genuine response to the problem of matching supply to need, and not simply a symptom of inefficiency. Indeed, if anything, there might have to be greater variability than at present in order to achieve a true balance between local need and supply.

The London problem

6. The gap between need and supply, and the problem of high prices, is most evident in London, and much of the following analysis focuses on London. This chapter will say very little about need. Plausible measures of need have been developed elsewhere from the PSSRU surveys (Bebbington et al., 2001). These show that elderly people in inner London have above average levels of need for care at levels comparable with what care homes offer.

7. Table 4 shows measures of the levels of provision in London and elsewhere which illustrate the problem of supply. While the level of NHS and local authority residential provision is higher than in the rest of England (cf. Tomlinson, 1992), this does not compensate for the enormous shortfall in private nursing and residential care places. To some extent the level of community-based services is higher, but these in turn are almost certainly offset by a shortage of informal support for those people who could be cared for at home.

Table 4: Service levels for elderly people in London and England, 1985 and 1993

	Inner London		Outer London		Rest of England		England	
	1985	1993	1985	1993	1985	1993	1985	1993
1. Persons aged 75+ (000s)	163.6	151.6	284.4	294.9	2603.9	2964.0	3051.9	3410.5
2. Available beds on wards for elderly patients	18.5	15.4	15.6	11.5	18.3	11.6	18.1	11.7
3. Occupied beds by patients 75+	-	18.3	-	15.1	-	15.7	-	15.8
4. Beds for the elderly in registered nursing homes	6.5	13.6	7.9	18.7	11.8	46.5	11.1	42.5
5. Places in local authority residential homes	44.6	28.2	32.9	18.5	37.5	22.2	37.4	22.1
6. Places in registered voluntary homes	15.3	14.7	15.8	14.4	9.4	10.3	10.3	10.9
7. Places in registered private homes	6.1	7.5	13.0	21.4	28.8	51.9	26.1	47.3
8. Whole time equivalent district nurses	-	5.4	-	4.6	-	4.6	5.0	4.6
9. Whole time equivalent home helps	25.6	23.9	16.1	16.6	16.1	15.4	16.6	15.9

Source: Bebbington and Darton (1995). Based on DH, DHSS and OPCS statistics.

8. These variations cannot be explained by differences in need. The situation in London was exacerbated by the huge fall in local authority residential provision following the 1990 Act; local authorities had previously been major providers. Although Table 4 relates to the situation shortly after the Act, more recent evidence (London Research Centre, 1999; DH, 2000a) indicates that these differences persist.

Standard Spending Assessments

9. If there is one important determinant of what local authorities will pay for places in care homes, it is what they themselves can raise through local taxes and government grant: the Revenue Support Grant in particular. The standard spending assessments (SSAs) — the basis for setting the Revenue Support Grant — include an assessment of each local authority's spending need for residential and nursing home care, in terms of both the level of need and the unit cost of a place. The grant is a composite of the whole range of local government services, and the assessments for individual services are not hypothecated. Local authorities are not obliged to provide that level of service, or to match that unit cost. Indeed, they are exhorted to find alternative methods of care wherever possible. But the method of assessment does provide some basis for judging spending need, and places some parameters on what might be appropriate to spend. Many local authorities do use these assessments for planning their services.

10. The unit cost relativities within the SSA are based on the Area Cost Adjustment (ACA): the element in the calculation which allows for local variations in input prices. SSAs are intended to compensate authorities for unavoidable differences in the cost of providing services at a level which corresponds to their rated level of need, and the ACA is the means of computing this. The key element of the ACA is the labour cost adjustment, designed to allow for local differences in labour markets.

11. The original rationale for the labour cost adjustment was that it should reflect evidence about local variations in the price of labour: 'The central assumption ... is well founded: the amount you need to pay in each authority to attract staff of the right calibre and qualifications can be inferred from the wages that private sector employers in the area find it necessary to pay' (Elliott et al., 1996). The assumption behind this rationale was that in the private sector, market forces would ensure that wages represented the current 'equilibrium' state of the underlying markets for inputs: the price that would produce the required supply of labour to meet local demand. In the public sector, it was assumed that employers might not have the same incentives for the keen wage bargaining that could match supply and demand with similar accuracy.

12. Geographical variations in labour prices for the ACA are calculated using evidence from the annual New Earnings Survey (NES) on average earnings within regions. The method involves standardising actual average earnings within each region on the basis of about eight occupational groups that are broadly representative of the labour force used in local government. Public sector employees are now included in the NES earnings calculations. Regional averages are used mainly because the NES is not large enough to provide highly accurate measures at the local authority level.

13. The regions used are: City of London, Inner London, Outer London, South East Inner Fringe, South East Outer Fringe, Other South East, Rest of England. Some smoothing is done between the three SE regions to ensure progressively higher adjustments moving towards central London. The rest of England is grouped together because regional analyses have not found consistent and significant earnings differences.

14. However, two reasons have been proposed for making the ACA slightly different from the labour force adjustments calculated from average earnings. First, a 1996 review proposed adjusting the differentials in average earnings to allow for the actual quality of people in the local labour market. Elliott et al. (1996) argued that: 'workers in the City may be highly paid because there is a concentration of very highly qualified workers in the City ... The fact that you need high pay to attract highly qualified people to the City does not imply that you need high pay to persuade less qualified people to work as teachers in the area.' For this reason, a regression-based adjustment was proposed to compensate for such differences.

15. The second difference is an allowance for costs unrelated to labour. Like most local authority services, residential care is predominantly labour intensive. Nevertheless there are some costs, such as those for goods, which do not vary greatly regionally; others, particularly the capital cost of the premises, differ in a different way. So the ACA for residential care does not allow for the full variation of the labour cost adjustment and, based on average rateable values, a small additional adjustment is made to allow for high property values in the South East.

Actual variations and the ACA

16. Even with the amendments proposed by the review, the evidence from both residential and nursing care is that the actual variations in costs considerably exceed the ACA variations. Table 5 shows the comparison of the London boroughs in our study with the rest of England, based on official statistics for supported residents published by the Department of Health. As a considerable proportion of people funded by London boroughs were in fact placed outside London, the actual differential in unit costs for places inside and outside London was probably higher than that shown in column 1. This is probably why there is even greater variation in local authority homes costs (column 2), as almost all of these were situated locally.

Table 5: Average weekly unit cost of local authority homes and the Area Cost Adjustment, 1995/96

	Average unit cost of all local authority funded residential and nursing care £	Average unit cost in local authority homes £	Average PSS Area Cost Adjustment	Average ACA for PSS recommended by the 1996 review
London boroughs	363	413	1.1471	1.2683
Other areas	268	277	1.0102	1.0895
London as % of other areas	135	149	114	117

Note: From administrative statistics 1995/96, for the 21 local authorities in the study only. Both columns 3 and 4 are population weighted.
Sources: Columns 1 and 2 are from RO3B, 1995/96, RA/95 and RA/96 (for full details of calculation, see Bebbington, 1997). Column 3 is for 1995/96. Column 4 is from Elliott et al., 1996, table 6.1.

17. Chapter 3 showed that the actual variation in prices between London and elsewhere can be entirely explained by a model which includes a range of supply factors. So it does appear that the actual variation in average unit costs is not only greater than the ACA, but can be accounted for in terms of factors outside local authority control. This on its own is not entirely conclusive, for the model used in Chapter 3 is essentially correlational. Some of the indicators of supply may in practice be proxies with other things. For example, the labour cost measure serves to identify London authorities and it is possible that other aspects of the link between London and high prices are captured by this factor. In order to consider this further, it will help to examine what exactly is causing the high price variations.

What causes price variations?

18. To examine this, first let us consider the various components that make up price. We do so using the following decomposition of the cost equation:

$$\text{Price} = \text{unit cost} + \text{mark-up}$$

$$\text{Gross costs} = \text{employee costs} + \text{running costs}$$

and so :

$$\text{Average unit cost} = \frac{\text{employee costs}}{\text{number of staff}} \times \frac{\text{number of staff}}{\text{residents}} + \frac{\text{running costs}}{\text{places}} \times \frac{\text{places}}{\text{residents}}$$

$$= \frac{\text{unit labour cost}}{\text{staff productivity}} + \frac{\text{running cost per place}}{\text{occupancy rate}}$$

Here, price is the gross charge to all who pay it: often a combination of local authority and client. If we assume that marginal and average unit costs are closely related, then high prices may be due to any of five factors. Of these, the 1996 survey found comparatively small local variations in: *staff productivity,* which averaged 1.4 residents per staff member in residential and 1.0 in nursing homes, both in London and elsewhere; and *occupancy rates*, which averaged 89 per cent overall, but were 95 per cent in residential homes in London.

19. Evidence about the other factors was only available from the survey for local authority homes, for which the mark-up is nil (i.e. costs = prices), and so invariant. However, the other two factors varied considerably between London and elsewhere: *employee costs* averaged £400 per week in London and £300 elsewhere and *running costs* (per place per week) averaged £68 in London and £50 elsewhere.

20. It can be seen that, with regard to both employee and running costs in local authority homes, the cost is one-third more in London than outside. The similarity of the differential does suggest that much of what was included in running costs is not goods but labour-intensive services whose price is directly affected by labour costs. This has been confirmed by detailed examination of the accounts of a few local authority homes.

21. Whether the high cost in London was due to wage levels *per se* or to differences in the calibre of staff, or other reasons, is a subsidiary question. But the following points may be noted:

- Home sizes were the same in London as elsewhere.
- Staffing ratios were also very similar, if allowance was made for the lower proportion of part-time workers and the higher vacancy levels in London.
- A higher proportion of London staff were full-time.
- The proportion of staff with nursing qualifications was the same in London as elsewhere (around 15 per cent of all care staff).
- Bottom-grade care staff wages (as reported by heads of homes) were 25 per cent higher in London for both local authority and independent residential homes. This differential is greater than London weighting for the appropriate public sector pay scale.
- Vacancy rates were higher in London. The average proportion of vacancies for care staff was 5 per cent in London, and 3 per cent elsewhere.
- Agency staff were far more likely to be used in London (nearly one half of homes used them, compared with one quarter of homes elsewhere). Agency staff were particularly expensive, and were often a response to lack of flexibility in the ability to provide sickness or holiday cover.

22. These points suggest several causes of high employee costs in London: higher base wages; use of agency staff; less use of part-time staff. Although this survey did not investigate 'grade drift', Bebbington (1995) found that social workers with equivalent levels of experience and qualifications tended to be appointed on slightly higher pay scales in London, and the same was likely to be true for other professional grades. Despite the advantages of higher pay, it appeared to be harder to maintain full staffing in London.

Matching demand to supply

23. So far it has been argued that variations in care home prices exceeded the apparent differences in average local costs measured by the ACA, mainly for reasons connected with the cost of labour. Given the available evidence, the question of which price variations would achieve a balance between need and supply across different localities cannot be answered with total confidence. However, the greatest supply shortfalls continue to manifest themselves in precisely those areas where prices are highest. For this reason, it does appear that the existing price variations are not only more indicative of the likely equilibrium prices than the ACA, but that the price differential necessary to promote the required match might actually be greater still.

24. This section examines some ancillary evidence that appears to point to a similar conclusion. This shows that: first, variations in prices in the private sector are at least as great as those in the public sector; second, that residential care cost differentials have been persistently higher than the ACA for many years; third, that turnover is highest in those areas where wages seem to be highest in relation to the ACA. If the ACA is indeed a true indicator of price differentials, this goes against the conventional wisdom about labour markets.

Comparing prices in the private sector

25. The ACA methodology presumes that what is happening in the private sector, where market forces are assumed to operate with relative freedom, will be indicative of the true equilibrium wage rate at which the supply and demand of labour will balance. This opens up a broader possibility. We can look at how price is responding in the private sector as an indicator of how the balance between demand and supply of care homes as a whole is achieved. Therefore the experience of residents who are wholly self-funded should be more truly indicative of the behaviour of a free market.

26. As a result of the privatisation that followed the community care reforms, residential and nursing care was the first example of a service included as a major component within the SSA methodology to develop a private sector on a scale which started to approach that of the public sector. By March 1996, one-quarter of all recent admissions to care homes were of wholly self-funding people. One in five of the independent homes in the survey had a majority of wholly self-funding residents. Chapter 2 shows that self-funders tended on average to be a little less dependent, but overall the private and public sectors for residential and nursing care were only slightly differentiated in their product.

27. Hence it is possible to make comparisons between private and public sectors that were sufficiently equivalent to provide a test of the central tenet of the ACA methodology. Moreover, such comparisons could include productivity and other relevant factors as well as labour costs.

28. The logic of the argument closely follows the ACA's rationale for labour costs, described above. In the mixed economy created by the community care reforms, it is expected that the balance of demand and supply would determine price, rather than input costs, which had done so when the local authorities had managed the service. Moreover, if the market was operating freely, independent providers would compete against one another on price, until the price of care reaches the level at which they could provide the required service standards with an acceptable return on their investment. This price would therefore be closely related to what providers would have to pay to obtain labour and capital to operate their service in that area.

29. In practice, the private market is unlikely to behave so ideally. First, the market as a whole is still dominated by the local authorities, who purchase three-quarters of all care. Many of the newly independent homes have devolved from local authority ownership, but still retain a close working relationship with their original owners. Second, in recent years concerns about levels of regulation and profitability have created short-term barriers to market entry. These barriers produce supply problems, and led to variations that are not related to input costs. Third, the characteristics of care services often mean that individual self-purchasers are far from the sovereign consumers envisioned in an ideal market.

30. What happens in the private market may not be directly analogous with what should be happening in the public sector. Public sector services are generally planned in relation to predetermined assumptions about need levels, not as a response to price *per se*. The price at which demand and supply equalise in the private sector is not necessarily the same as the price required to ensure sufficient supply to meet a given level of need.

31. In general, prices must be raised in order to increase supply, but as the price increases in the private sector, demand declines. By contrast, the level of need for public sector provision remains the same, unless acceptable substitutes can be found. It may actually increase, as demand spills over from the private sector. High prices may mean that more people are unable to fund their own care. The implication is that the geographical variations in the equilibrium price levels required to match comparable levels of need are likely to be greater than the apparent price differences in a free market economy.

32. The survey found that actual prices for self-funders did not differ that much, on average, from what is charged to local authorities. Table 6 shows that the area variations between London and elsewhere for self-funders, and for homes that mostly take private patients, were very similar to those in the public sector (Table 5, column 1). This at least suggests that actual variations in charges hold up in the private sector, even if it does not indicate pressure for widening the variation.

Table 6: Average weekly unit cost of local authority homes and charges to self-funders, 1996

	Average unit cost in local authority homes £	Average charge for self-funders in residential homes £	Average charge in residential homes with a majority of self-funders £	Average charge for self-funders in nursing homes £
London boroughs	399	300	314	443
Other areas	272	234	232	332
London as % of other areas	147	128	135	133

Source: PSSRU 1996 survey. Columns 1, 2 and 4 are summarised from Table 6.1. These are the averages per resident (hence the small difference with Table 5.14).

Variations in the past

33. The variations in costs have been very persistent. Table 7 shows that similar variations between London and elsewhere were present in 1981. However the ACA was less then, because the variation in average labour costs was less. For 1981, Darton and Knapp (1986) showed what was confirmed in Chapter 3 as also true in 1996: that it was impossible to explain these differences by the care needs of residents or by the characteristics of homes.

Table 7: Average weekly unit cost of local authority homes and the Area Cost Adjustment, 1981

	Average unit cost in local authority homes £	Average PSS Area Cost Adjustment
London boroughs	92	1.0655
Other areas	75	1.0028
London as % of other areas	123	106

Source: Column 1 from Bebbington & Darton (1983, Table 3.3.4), and is based on 235 homes in the 1981 PSSRU survey. Column 2 is for 1980/81 (70% of the labour cost index).

34. When the SSA method was originally introduced in 1980, the high unit costs in London were widely attributed to the previous methodology for distributing grant to local authorities. This was believed to have favoured London, allowing it to provide a more costly service. The persistence of these differences through the 1980s was next blamed on the rates system, and on alleged management weakness in controlling wage demands and lack of incentives to act efficiently. At the time, it was easy to raise money through increased rates, and the system was such that in many areas of London the rates burden did not (by and large) fall on voters.

35. However, the high-spending authorities' ability to raise rates was brought under control by a variety of means while the management of social services became much more cost-aware, revolutionised by the 1990 NHS and Community Care Act. Yet the differences in actual unit costs persist; indeed, they have grown just as variations in the ACA have increased. The implication would seem to be that the underlying cause of these differences is less ephemeral than previous explanations imply.

Labour cost variations

36. It largely remains matter of conjecture whether equilibrium wage differentials in the public sector are really approximated by actual average wage differences across the private sector, even when adjusted for staff quality. We have already offered a theoretical reason why wage differentials in the public sector may have tended to be greater. There has also been some empirical support for this view. In the case of the main employee groups in labour markets — teachers, police and firefighters — the 1996 ACA review conceded that the actual differential in earnings did not seem to be straining towards the earnings differential in the private sector (Elliot et al., 1996). If it were, one would expect to see high turnover in those areas where pay was lowest in relation to ACA, and vice versa. Yet the study found that vacancy rates were actually highest in London, where pay was highest in relation to ACA. In 1990, Bebbington (1995) showed that turnover rates among social workers were not highest where their pay was lowest in relation to average earnings, but the reverse: they were higher in those areas where the labour market was most buoyant.

Should care homes be local?

37. The argument about matching local supply to local levels of need is based on the assumption that care in a care home ought to be provided locally. Residential and nursing home care is, however, different from the majority of social care services. It is practicable for an older person to move in search of care in a care home should they wish to do so. London boroughs place 30 per cent of their supported residents outside their own areas (DH, 1997b, Table L22.) This response is almost certainly a consequence of the shortage of supply in London. For other authorities, the figure is 5 per cent.

38. Why cannot individuals and public agencies simply purchase the most economical service available nationally, making local price differences irrelevant? The probability is that many residents prefer to be located close to their original home, in reach of former social contacts. But very little is known, either about residents' preferences, or about the circumstances in which London boroughs use homes outside their areas. Many people do move in old age in search of help as a result of increasing disability, and it is possible that people without strong local ties might prefer to live in a home able to offer better facilities for the price than in one in a high cost area.

39. This is an emotive issue. In the 1970s, it was claimed that some local authorities were 'bussing-out' older people to inferior private homes in depressed seaside resorts. There are practical problems too, as negotiations for admission require sensitivity between social worker, client and home, often at short notice; a transaction not so easily managed at a distance. But properly managed this approach might not seem inconsistent, not just with improving efficiency, but also with widening the options available to clients.

Conclusion

40. This chapter has argued that supply is unevenly distributed in relation to demand. This supply shortfall appears to be a response to the high price of providing care homes in certain areas, notably London. The price for a care home bed is correlated to regional differences in the cost of labour and other inputs; it would appear that the required price variations for the service exceed the variations in the general price of labour, as measured by a standard index.

41. There would appear to be two 'solutions' to this problem. If supply is to match demand on a local basis, then public authorities must offer greater variation in prices than at present (or possibly financial incentives in other forms to encourage supply). It seems unlikely that this can come about purely as a result of local planning, but will need central direction and funding through, for example SSAs. The alternative is to acknowledge supply shortfalls in certain areas, and adopt a policy that provides incentives to encourage people to move to lower cost areas.

5 The Policy Implications

Background

1. This survey provides a rich source of data about the population in residential and nursing home care in 1996, and about the homes themselves. The results presented in this report focused on the primary objectives for which the research was commissioned: the relationship between dependency and costs; a baseline description of the residents cared for; and the characteristics of the homes. In addition, the survey points the way to other potentially valuable areas of research.

Box 9: AREAS OF POLICY CONCERN

- The impact of the reforms on the use of publicly-funded residential and nursing home care
- The cost implications of rising dependency levels
- The use and costs of local authority homes
- Regulating residential care and nursing homes: a single system?
- The use of homes by self-funded residents
- Equality of access to care *
- The impact of local authority purchasing policies, strategies and procedures on local markets
- Variations in the supply of care, and its implications for the distribution of central government funding
- Standards of care

** Note: This important policy issue is addressed more fully in the companion study on admissions to care homes (Bebbington et al., 2001).*

The impact of the 1990 NHS and Community Care Act

2. The findings set out in this report and in the report of the associated longitudinal survey (Bebbington et al., 2001) suggest that the reforms introduced by the 1990 Act have had profound effects in three areas: the admission process; the types of residents cared for; and the structure of the residential and nursing home market.

3. Compared with previous surveys, a marked increase in dependency was found among residents in all types of home. This was most noticeable in nursing homes and in voluntary sector residential homes. In the nursing homes, it could partly be attributed to the impact of the withdrawal of the NHS from its role as a provider of continuing care. The increased dependency found in voluntary residential homes was probably partly due to the inclusion of homes previously managed by local authorities in this category — about one-fifth of the total.

4. Overall, publicly-funded residents were found to be more dependent than those who were self funded. This difference was most marked among recent admissions. Again, this was a development which had not been recorded in previous surveys.

5. There were still a substantial number of residents — about one-fifth of the total — whose dependency levels were relatively low. This could have been the result of inappropriate admissions. Individuals who were self-funding may have been unaware of, or lacked access to, alternative services. It is also possible that some people may recover to some extent after admission. Both hypotheses suggest that the new investment in intermediate care services (Cm 4818-I, 2000) may be successful in enabling individuals to stay on in their own homes.

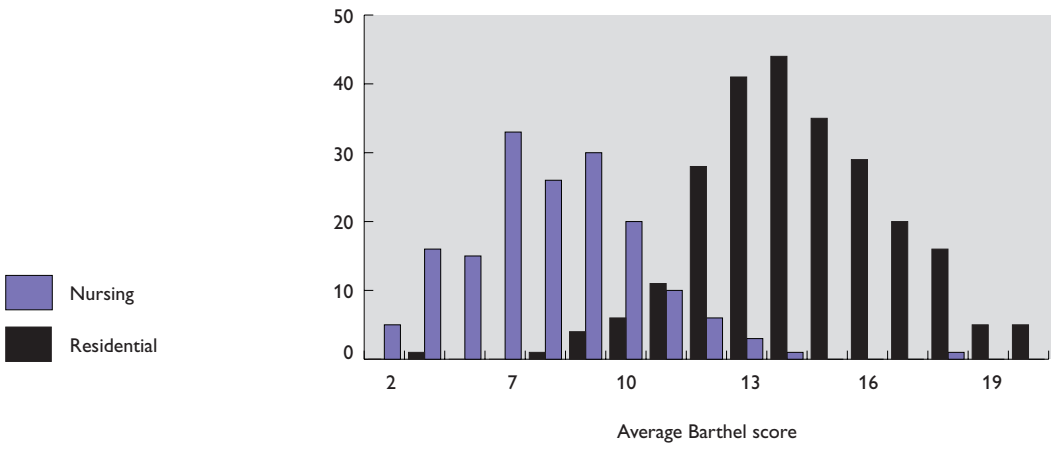
The cost implications of rising dependency levels

6. The most important factor that affected the relationship between individual needs and the costs of care was the residential and nursing home divide. Other influences included: differential pricing practices based on the source of funding; conditions in the local market; and local authority purchasing policies.

7. Together, the different regulatory requirements for nursing and residential homes and the pricing policies employed by homes and by local authorities combine to make the major cost difference the decision whether to place an individual in — or to move them between — residential or nursing care. Any estimate of the financial implications of rising dependency levels will need to take these factors into account.

8. Where there is an overlap of dependency levels between the residential and nursing sectors — within the range of Barthel scores identified — dependency has very little effect on either price or cost. About 13 per cent of residential homes had approximately the same average Barthel scores as some nursing homes, while 20 per cent of nursing homes shared average scores with a residential home. This pattern is shown in Figure 39. The overall average Barthel score was 7 in nursing homes and 14 in residential homes.

Figure 39: The distribution of average Barthel scores, by home type (number of homes)



9. Any predictions regarding cost differences will depend on how new regulatory arrangements are introduced. But it is possible to consider some of the implications of the increase in dependency that has occurred since previous surveys.

10. Chapter 2 shows that dependency levels had increased dramatically over the previous decade, especially in nursing homes and in voluntary residential homes. In nursing homes, the proportion of severely dependent people had risen by 37 per cent. In voluntary residential care, it had grown by 27 per cent. Prices in nursing homes had risen more slowly than in residential care, even though the former had experienced a greater rise in levels of dependency. When adjusted for earnings inflation using the Earnings Index or the Personal Social Services Pay Index, prices in residential homes rose by about 3 per cent between 1988 and 1997. In nursing homes they actually fell (based on data in Laing & Buisson, 1997).

11. Chapter 3 reveals the relatively flat relationship between costs and dependency in all care sectors. Assuming that no substantial changes in productivity had taken place over this period, this implies a rather modest increase in the costs of care for this more dependent population. One interpretation, however, is that local authority pricing policies have resulted in prices being kept below the level that might have been expected if costs had been passed on to the consumer.

12. The admissions survey found wide variations in the proportion of publicly-funded residents placed in nursing home care. This could largely be explained by the characteristics of the individuals concerned, suggesting that local authorities are reasonably consistent in their judgements of the need for nursing home care. The variation was probably due to differences in policies and practice in caring for people in private households. Those authorities that maintained people to a higher level of dependency in private households would be likely to place a higher proportion of people admitted to residential care in nursing homes.

13. So far, taking into account how people were placed, the analysis has allowed an estimation of the rate at which costs changed in relation to dependency levels. Further work is needed in order to translate this into a range of likely cost values and, given the way in which dependency was measured, to make a direct cost-dependency connection.

14. The cost of community nursing should be included, to ensure that all public spending costs are taken into account. As discussed in Chapter 1, the requirement that nursing homes should have certain levels of suitably qualified staff is a major reason for the cost differential between them and the residential sector.

Local authority homes: use and costs

15. The analysis of homes managed by local authorities suggests that wage and price inflation, together with rising dependency levels, explained most of the dramatic rise in unit costs in the period between 1981 and 1996. The remaining 'unexplained' 12 per cent rise may partly have been due to the increased use of these homes to provide a high number of short-term places, and also to unmeasured effects of dependency.

16. However, the fact that local authority homes remain more costly than independent provision continues to provoke debate as to whether this difference is justified. It has been argued that public sector homes offer care for those that the private sector may be reluctant to provide for: people with dementia or behavioural problems, as well as individuals needing short-term care.

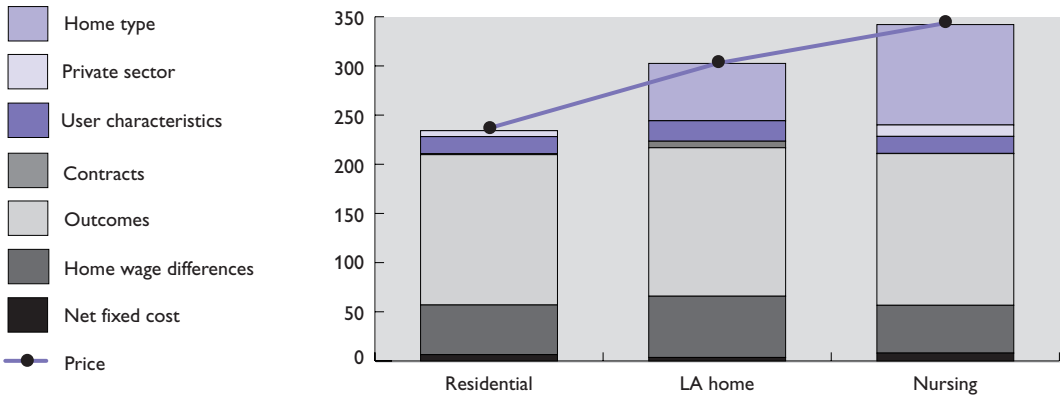
17. It is true that most short-term care was provided by local authority homes, and that dementia and behavioural problems were more prevalent there than in the other sectors. Local authority home costs have been linked with high proportions of short-term care and also to the numbers of residents with severe dementia. But the costs analysed were only revenue costs. Once capital costs were included, the costs of local authority care were found to be higher than those of nursing home care (Netten and Dennett, 1997). But Chapter 2 shows that nursing home residents were considerably more dependent than those in the care of local authorities. Moreover, the most severely demented residents were found in nursing homes rather than in local authority residential homes.

18. Indicators of the quality of care suggest that while the social climate of homes clearly differed between the different sectors, there were few grounds for claiming that higher quality was the reason for higher costs in local authority homes. While the ratios of care staff to residents were higher in local authority homes than in private residential homes, this difference disappeared when the input from independent sector proprietors was taken into account. Also, the staffing levels in nursing homes were even higher than those in local authority homes.

19. In the local authority sector, the social climate factors related to costs were Independence and Organization (see Chapter 2). Independence, which is associated with higher costs, was higher in the private sector; Organization, associated with lower costs, was also higher in independent sector homes. However, it should be noted that the Organization measure referred to clarity of procedures and to residents 'knowing where they stand'. This could be associated either with more organisational efficiency, or with more rigid regimes which may be less costly to administer.

20. Therefore, the cost difference seems unlikely to be justified in terms of case-mix or care quality. But Chapter 3 did demonstrate that wages were clearly much lower in the private sector. It is possible that the introduction of the minimum wage may reduce some of the existing cost differences. However, a subsequent combined sample reduced-form price analysis found that local authority homes were £58 per cent more expensive than residential care homes even after accounting for case-mix, quality (SCES), wage differences and contract types — see Figure 40. It has also been suggested that the transaction costs of local authority in-house provision are lower than for the private sector market. This cost saving would to some extent offset the apparent higher production costs in the public sector.

Figure 40: Private residential, local authority and nursing home costs per week: a comparison (£)



Regulating residential and nursing homes

21. Apart from the issue of the dependency overlap between nursing and residential homes (referred to above), there is a clear distinction between nursing and residential care. Nursing homes have higher average levels of dependency (see Chapters 2 and 3), and the reasons for placing people in them are associated with their need for nursing care and with medical conditions such as malignancy (Netten et al., 2001).

22. The regulatory requirements for nursing homes demand higher staffing levels and higher levels of qualification. These factors are the major influence on care costs, and it is unlikely that introducing a single regulatory system would bring about change in the short-term. Residential homes, on the other hand, can draw on a wider pool for extra staff, and demand might rise if they were able to provide care for more dependent people at lower prices. This situation could produce short-term inflation in care costs.

23. Analysis of point-of-placement prices suggested that prices set in advance at the home level were lower than those agreed either at the local authority or the individual client level. Higher prices in residential care were associated with individual client-related price setting; in nursing homes, this practice was linked with lower prices. Authorities may wish to take notice of these findings when pricing arrangements are negotiated under a single regulatory framework. On the basis of the previous arrangements, the costs analysis allowed hypotheses to be made about what the realistic costs might be for different levels of dependency.

24. One frequently-raised issue concerns the adequacy of nursing care provided in residential and nursing homes. The survey suggests that there may be a lower take-up of community nursing services in private residential care than in either local authority or voluntary homes, although the levels of need were similar in all those settings (Chapter 2). This issue would need to be addressed in the regulation and standard-setting arrangements for single care homes.

Self-funding residents

25. Valuable information emerged concerning the nature of self-funding residents. The evidence suggested that some people in residential care could have been cared for in the community, as their levels of cognitive impairment and physical disability were relatively low. Such individuals were more likely to have come from single-person households and they tended to be older than other, more dependent residents. When expert advice was not available, it may have seemed necessary for an individual to move into residential care just because they were old, frail and lived alone. Alternatively, some older people may themselves have wished to go into residential homes when they were less dependent. Residential care provides company; also, they may have wanted to be admitted before a crisis.

26. The cost analyses found that self-funding residents were paying more for what appeared to be the same care. It is likely, therefore, that they were subsidising the publicly-funded residents.

27. Any policies which diverted those people who could be cared for at home away from residential and nursing home care would raise the average dependency levels in homes. This, in turn, would have knock-on effects on the costs of residential and nursing home care. Such effects would be compounded by the cross-subsidisation of publicly-funded residents. Possibly as a result of the reforms, more of the recently-admitted residents were self-funding than was previously the case.

28. If local authorities continue to exert downward pressure on prices, the gap between the costs to private payers and the fees paid for individuals funded by the public sector may grow even wider. If authorities were to exercise their financial muscle on behalf of the self-funders, a point could be reached where quality will suffer and/or homes will go out of business. Some argue that this is already happening.

29. The proportion of residents that will fall into the category of being publicly funded at least in part will widen considerably in the future as a result of the Government's response to the Royal Commission. From April 2001, the value of an individual's home will be disregarded in means-testing for the first three months after admission to care in a residential setting. Moreover, from October 2001, free nursing care will mean that the nursing component of the fees that residents in nursing homes currently pay will be met by the state. Such changes are likely to increase the influence of local authorities on prices even further.

Equality of access to care

30. Equity and social exclusion are important policy issues which are addressed more fully in the companion longitudinal study (Bebbington et al., 2001). However, the survey data provide empirical evidence about the role played by nursing and residential homes in providing social care. Inequalities in access to health care have frequently been documented and, although there is less available evidence, it is likely that there are similar problems with access to social care.

31. Concerns have frequently focused on the 'disadvantaged' social groups, but there are other issues which could be explored. While the value of an individual's home will be disregarded in means-testing for the first three months after admission to care in a residential setting from April 2001, there are continuing concerns about the effects of the capital limits on eligibility for state support.

32. Research on equity has already offered information about the types of people who seek statutory assistance. These data could be interrogated further in order to explore local factors, such as the effect of rurality on service use. On a wider scale, it would be possible to link the surveys with, for example, the General Household Survey, in order to analyse the efficiency and equity between residential and nursing home care in terms of gender, income and capital, and housing tenure.

Local authority purchasing policies, strategies and procedures

33. Chapter 3 highlighted the considerable influence on prices exercised by local authority purchasing policies, strategies and procedures. In particular, the way in which homes were reimbursed was linked with a sizable difference in the prices charged. Adopting flexible arrangements, where prices varied on a per-case basis — rather than imposing single predetermined prices — corresponded with higher prices in residential care homes and lower prices in nursing homes. This finding took labour costs and client dependency into account.

34. In addition, the choice of arrangements for reimbursement appeared to affect the margins within which homes operated and the business risks faced by providers, thus having an impact on provider stability. Other work funded by the Department of Health (the Mixed Economy of Care programme from the Nuffield Institute for Health, University of Leeds, and the PSSRU at the London School of Economics) suggests that reimbursement mechanisms and commissioning arrangements also affected the targeting of appropriate services.

35. As these local authority procedures have such an important impact — and as they could be adapted with relative ease — purchaser commissioning warrants urgent policy attention.

36. For authorities managing the current market, the survey findings imply that competition policy should play a relatively minor role. The analysis found that the presence of competition had little significant association with provider prices. But even for those 'facing low competition', overall competition is high. If competition was less strong, local authorities would be less effective at holding prices down.

Variations in the supply of care

37. Chapter 4 argued that local variations in the equilibrium price rate for residential and nursing care — the price at which sufficient local supply will be generated to match a standard measure of the level of need — may not be appropriately indicated by the variations in average local costs for labour and capital, as measured by the Area Cost Adjustment (ACA). In particular, it is likely that London faces higher relative prices than might be inferred by comparing average local costs.

38. The main evidence for this is:

- The explanatory model in Chapter 3 appeared to show that price variations between London and elsewhere could be explained by a range of factors that were mostly, if not entirely, outside local authority control.
- Although the relative price paid for care has been higher than that implied by the ACA for 15 years or more, there is still a shortfall of this type of care in London.
- Although higher wages are paid in London, staff turnover and vacancy rates also tend to be higher, implying that the higher wages are not sufficiently compensatory.
- Price differences for self-funding residents in the emerging private sector, which might be assumed to reflect market forces, mirror actual current cost differences in the public sector rather than the ACA variations.

39. These price differentials have long outlived the earlier causal explanations that often ascribed them to various forms of inefficiency. The present study found little evidence that in other respects services were provided less efficiently in London than elsewhere: in terms of size of homes, staffing ratios, staff calibre and occupancy rates.

40. This conclusion has important implications for the calculation of Revenue Support Grant paid to local authorities, to help them provide a service matched to needs, and to reduce social inequity. It is also important for personal planning. But if a less local service became acceptable, perhaps as a result of changing attitudes to the desirability of remaining locally, and also by facilitating individual access to services at a greater distance, then local supply and hence price variations would matter less.

Standards of care

41. Concerns about the standards of care provided by residential and nursing homes have led to the production of a number of policy documents over the years. In 1984, the Code of Practice for Residential Care (Centre for Policy on Ageing, 1984) listed a total of 218 recommendations covering social care, physical features, specific issues relating to individual client groups, staffing and the responsibilities of registration authorities. Similarly, the Social Services Inspectorate produced comprehensive guidance on standards for residential care for elderly people in 1990 (DH SSI, 1990). However, most of the recent concern about standards has related to those with immediate financial consequences: bedroom size and the provision of en suite facilities (DH, 1999).

42. Chapter 1 outlined the new national standards on room sizes and other facilities that were announced in 2000, and which will be introduced between 2002 and 2007. The new standards will apply to all homes and be overseen by the National Care Standards Commission, established by the Care Standards Act. The standards required for floor sizes and single bedroom provision will broadly be those specified in the 1973 DHSS Building Note for residential accommodation for elderly people (DHSS, 1973), although some flexibility in room sizes will be allowed (Cm 4818-I, 2000).

43. Comparisons between the 1996 survey and earlier surveys have indicated that standards of provision in residential and nursing home care have improved over time, and these findings are reinforced by those of Laing & Buisson (1997, 2000). Despite this, however, less than one-third of the private residential homes, dual registered and nursing homes in the survey met the standards to be required for the number of single and double bedrooms. Since the survey, the standards of provision have improved, and Laing & Buisson (2000) report that in March 2000 the proportion of homes with more than the required proportion of shared rooms (20 per cent) was 47.2 per cent.

44. These changes have been attributed to consumer pressure and the demands of purchasers and inspecting authorities. However, as nearly half of all homes do not meet the requirement, Laing & Buisson note that the rate of home closure is likely to increase. Although the deadline for compliance to the standards on occupancy of shared rooms has been extended from 2002 to 2007, it is unlikely that the closure of homes will be avoided. This will affect smaller homes first (Laing & Buisson, 2000). These will tend to be homes run by individual proprietors, rather than larger providers.

45. Most of the preceding discussion about care standards has concerned room sizes and the sharing of rooms. However, care standards will also be extended to other aspects of care such as staffing, training and care practice. The survey can provide information on these aspects, which are less likely to have changed over time since there has been less consumer and policy pressure in these areas.

Conclusion

46. The study has provided us with an extensive picture of the characteristics of homes and their residents, and the opportunity to explore factors associated with costs, prices and supply of homes under the current arrangements. Clearly the reforms introduced by the 1990 NHS and Community Care Act on the care homes sector generally and on the type of residents being cared for. The findings also cast light on current policy issues and provide a valuable baseline from which to identify the implications of initiatives such as the introduction of care standards and changes in regulatory requirements of homes.

Appendix

Sample selection, response rates and weighting

Selection of local authorities

The sample for this cross-sectional survey was based on a sample of local authorities drawn for the longitudinal survey of admissions (Bebbington et al., 2000). For the admissions survey, an initial sample of 20 local authorities, stratified by type of authority (London borough, metropolitan district, and county), was selected and approached to discuss participation in the survey. Within authority type, local authorities were subdivided by a further geographical stratification and then classified according to the following additional factors: socio-economic group, population sparsity and migration rate.

Uncertainties about agreement to participate and some delays by authorities in advising of their withdrawal resulted in a final group of 18 local authorities for the admissions survey, including 14 of the original 20 selected and four of five approached as replacements. The final group included five London boroughs, eight metropolitan districts and five counties. Comparisons of the final sample of authorities for the admissions survey with national socio-demographic indicators and statistics of residential provision suggested that the selected authorities were not atypical, either as a whole or within authority type. However, the final sample was rather unbalanced in terms of the proportion of older residents supported by local authorities in care homes in each authority type.

For the cross-sectional survey, all the local authorities in the admissions survey were approached, together with seven additional local authorities, selected to reflect the under-represented authority types: London boroughs and counties. In particular, London boroughs tend to have small numbers of homes, so a larger sample of London boroughs was desirable. Four of the seven additional authorities approached agreed to participate in the cross-sectional survey, in addition to 17 of the 18 authorities included in the admissions survey. Of the 21 authorities in the final sample, there were seven London boroughs, eight metropolitan districts and six counties.

Selection of homes

The survey included residential homes for elderly people managed by local authority social services departments, and registered residential homes for elderly people, registered nursing homes for elderly people and dual registered homes for elderly people run by voluntary and private organisations. Small homes, that is, those with fewer than four places were not included in the survey. The A-Z Care Homes Data-on-Disk database was used for selecting the sample of independent sector homes. Dual registered homes were combined with residential care homes for the purpose of selecting the sample, and three separate sampling frames were constructed to select private residential and dual registered homes, voluntary residential and dual registered homes, and private and voluntary nursing homes.

In order to achieve the objective of a sample size of at least 600 homes, an allowance was made for non response, and 822 homes were approached. Homes were selected within home type (local authority residential, private residential, voluntary residential and nursing home) with probability proportional to size, size being defined as the number of places recorded on the sampling lists. In order to ensure that an adequate number of homes in London were included in the final sample, double the number of private residential homes and independent nursing homes were selected in London.

Selection of residents

For homes with no more than 20 residents, information about individual residents was requested for all residents, while for homes with more than 20 residents, corresponding information was requested for a sample of 20 residents, selected using a systematic sampling procedure administered by the interviewer. Samples of permanent and short-stay residents were selected separately, up to a maximum of 20 individuals in each case, short-stay residents being defined as those with a planned date of discharge.

In cases where there were more than 20 permanent or more than 20 short-stay residents, interviewers were instructed to employ a systematic sampling procedure for selecting a sample of residents, using lists of residents obtained from the manager of the home. Using a random starting point corresponding to the last digit of the home's telephone number, residents were selected systematically using a predesigned procedure.

Response rates

Some information was available about 673 homes: 82 per cent of the original sample. A complete response, including information on residents, was obtained for 617 of these homes (75 per cent of the original sample). Information was obtained for 11,882 of the 20,209 residents in the 617 homes. 7,474 members of staff provided completed staff questionnaires.

Table A1 shows the response rates for different types of home, based on complete responses. As anticipated during the planning of the survey, the overall response rate for voluntary residential and dual registered homes was higher than for private homes, 80 per cent compared with 64 per cent, although a larger proportion of private than voluntary dual registered homes responded. For nursing homes the response rate was 70 per cent, which was similar to that obtained in the 1986 survey (see above), whereas the response rate for independent residential and dual registered homes was lower than in the previous survey.

Residents in local authority and private residential homes were relatively over-represented in the sample, whereas residents in nursing homes were relatively under-represented. These differences reflect the relative sizes of the different types of home and their clientele, and the sampling procedure employed. In a number of cases, the type of home reported by the respondent differed from the type of home recorded on the sampling lists, principally due to an increase in dual registration, as shown in national statistics (Department of Health, 1997a).

Weighting

For the purpose of this report, both the home-level and the resident-level data have been weighted to ensure representativeness by type of authority and to adjust for varying selection probabilities and response rates. During this process, the type of home was reclassified to correspond to that stated by the respondent before weighting the data to correspond to the national distributions of provision by each type of home. Finally, since different sampling fractions were used for the

different types of home, overall estimates across homes have been obtained by weighting the data in proportion to the number of homes of each type in England.

For the analysis of the resident data, the sample residents were weighted to represent the total number of residents in the homes which responded with complete information, following weighting for unequal probabilities of selection of homes and to adjust for representativeness at the level of the type of authority. As in the analyses of the home-level data, overall estimates across homes were obtained by weighting the data to correspond to the estimated national distribution of different types of home.

In this report, the number of individuals shown for each category is the weighted number of individuals for whom the relevant information was obtained, and the overall total number of individuals is the sum of the numbers in each category. For the purpose of statistical tests, the weighted total should be rescaled to correspond to the achieved sample size in order to avoid overestimating the number of statistically significant differences.

Table A1: Response to the survey, by type of home

	Number of homes in sample	Number of complete responses[1]	Response rate	Complete responses			
				Number of residents in sample		Total number of residents in sampled homes	
	No.	No.	%	No.	%	No.	%
Residential homes							
Local authority	175	160	91	3542	30	5476	27
Voluntary	153	127	83	2424	20	4112	20
Private	200	122	61	1969	17	2433	12
Dual registered homes							
Voluntary	20	12	60	246	2	513	3
Private	36	29	81	554	5	1067	5
Nursing homes	238	167	70	3147	26	6608	33
Total	**822**	**617**	**75**	**11882**	**100**	**20209**	**100**

1 This excludes one home for which full information was obtained but a majority of residents were aged less than 65.

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