

# JOHN KENNEDY'S CARE HOME INQUIRY



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## FOREWORD

Reports are regularly published about the state of the care sector, the prospects for residential care, and the ways they are financed and inspected. This report offers something rather different. Written by John Kennedy, the Director of Care Services at JRF and JRHT, it is a personal inquiry into the care homes sector which houses and cares for 400,000 older people in our country, and in which John has worked for more than three decades.

Drawing on testimony from residents, care workers and their families, this inquiry is an important corrective to a narrative that too often offers blame and criticism, instead of hope and encouragement.

The care home of the future needs to be one in which all are valued and cared for, placed in the hubs of their communities. Yet while we want care that is based on relationships and respect, provided with kindness and compassion, we seem unprepared to follow the logic of our demands.

The challenge John formulates is aimed at all of us. There is no one agency or policy that can improve the situation on its own. It will require a collective effort. The voices and aspirations of residents which shine through this report are a reminder of the potential prize. I am proud to have commissioned this report and commend it to you.

**Julia Unwin**

Chief Executive, JRHT/JRF

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# ABOUT THE INQUIRY

From May 2013 to May 2014, JRHT's Director of Care Services, John Kennedy, carried out his own personal inquiry to discover how to address the crisis in UK care homes for older people.

The aim was to build on JRF's programme of work on Relationships and Risks – looking at a relationship-centred approach to care that is not just risk-reactive. John wanted to see where relationships and risks are managed well and uncover what needs to change to make services for care home residents better.

To see if he could get right to the heart of what people really think about the care home sector, John took a fresh approach, using social media to broaden the range of views and seek an honest and immediate response from those closest to care homes – people with experience of the care sector, those working in, being cared for and shaping the delivery of services in the sector, including residents, relatives, friends, care staff, managers, cleaners and volunteers.

The report also draws on findings from existing JRF research related to care of older people and newly commissioned research into some of the potential barriers to improving care homes, focusing on issues such as excessive paperwork and low pay. It also looks at relevant learning from the delivery of care in other sectors and from one local authority developing relationship-centred care that is seeing results in improving the way services are commissioned and delivered.

John used blogs, Twitter and Facebook to connect with a whole range of people involved in, or with experience of, the care home sector. This social media activity prompted many new connections and sparked numerous conversations with key people and organisations. Responses and comments were recorded and collated and then grouped by common themes identified. John was also interviewed by an external researcher to record his reflections from conversations with people and organisations.

A summary of the social media used and range of contacts is detailed in the Appendix.

The four pieces of new research are:

1. Pay, conditions and care quality in residential nursing and domiciliary services.
2. Is excessive paperwork in care homes undermining care for older people?
3. Learning for care homes from alternative residential care settings.
4. Commissioning relationship-centred care in Essex: an evaluation by Essex County Council.

The key findings of each of these reports are discussed in the overall analysis that follows. The full reports can be found on the JRF website [www.jrf.org.uk/careinquiry](http://www.jrf.org.uk/careinquiry).

In his analysis of the mix of current research and new thoughts, John identified six common themes. This report sets out John's reflections on those themes as he discusses the various outcomes of new research and current thinking.

The report ends with a set of principles and recommendations for those involved in the care sector.

This report is aimed at the various organisations and groups that have a part to play in improving care homes, including care homes themselves.

## The broader context of the inquiry

This personal inquiry forms part of JRF's wider Care Homes: Risk and Relationships programme. Its approach is based on the assumptions that:

- A care home is better if it supports: good relationships between people who live and work there; good relationships with the wider community; staff at all levels to spend time with each other to reflect on their practice.

- A care home is better if its approach to risk is: relationship-centred, co-produced, and comes from the understanding that we are human and different.

All our work in this area is underpinned by five principles:

- **Relationships** – relationship-centred care is key to enable a good quality of life for those who live and work in care homes.
- **Co-production** – involving people who live and work in care homes, and whose lives and work impact on care homes, to design better solutions.
- **Appreciative inquiry** – drawing from what care homes do well, and recognising they have a place – without ignoring what they do badly.
- **Solutions-focused** – wanting to make a practical difference.
- **Cost-aware** – money matters and overlooking this undermines impact.

Through this personal inquiry and the related portfolio of work, JRF/JRHT seek to achieve:

- an open and evidence-informed debate around how to improve life in care homes for older people.
- sensible, streamlined and co-produced approaches to paperwork in care homes.
- principles and recommendations for regulators, commissioners and providers so that care homes are good places for people to live and work in.



# INTRODUCTION: MY YEAR-LONG JOURNEY

“Perhaps the sentiments contained in the following pages, are not YET sufficiently fashionable to procure them general favour; a long habit of not thinking a thing WRONG, gives it a superficial appearance of being RIGHT, and raises at first a formidable outcry in defence of custom. But the tumult soon subsides. Time makes more converts than reason.”

Thomas Paine, *Common Sense*, 1776

One day I may end up in a care home. Does it scare me? Does the idea fill me with dread? Does it you? The issues affecting care homes never seem to change. Why not?

These are questions I have been asking everyone I’ve met over the last year. The answers I have received are very concerning because many of us have these fears – not just members of the public, but people working in the care home sector too! Why is this so? Well, those not working in the sector are frightened by the constant negative portrayal of care homes in the media and the political sphere. This is understandable. But more worrying is that those close to care homes, working in them, managing them, see the structural faults, the faulty engineering. They see a system that is almost set up to fail.

In a sense we keep concentrating on the ‘architecture’. What do I mean by this? Well, say we compare our care homes to a bridge – our system concentrates on the architecture: does it look nice; is it painted; are the white lines on the road clear; is the speed camera in place?; has it got lights on the top to warn aeroplanes?; do we walk across it every now and then to make sure all is OK; have we kept a record to demonstrate we are paying attention? So, it seems to me this bridge looks OK.



The bridge, it seems to me, should work. However, this bridge is fundamentally unsound – its ‘engineering’ is inadequate and deeply flawed. The stone pillars that support it are set in sand, not concrete. There are not enough pillars to support its weight. The frame is made from the wrong kind of steel, and the cables are too thin. A high wind or a rising river will twist and distort it until it fails. It isn’t sound.

I have worked in the care sector all my working life. Beginning in the mid 80s, I’ve been a care assistant, handyman, cook, administrator, registered manager, general manager and a director of care services. I’ve worked in both the private ‘for profit’ sector and now in the ‘not for profit’ sector. Over these last 30 years, it feels to me that we have stumbled from crisis to crisis, from one Panorama programme to the next, from inquiry report to inquiry report.

Care homes can be good places. They can be safe, secure and stimulating places to live and work, capable of fostering good relationships between people living and working in them and wider communities. I’ve seen many and spoken to many highly committed people, truly outstanding people, driven by vocation and a deep desire to make people’s lives as good as they can; people who are genuinely connected to and passionate about giving kind, compassionate care, despite the challenges. They are certainly not doing it for the money or prestige!

**“Over these last 30 years, it feels to me that we have stumbled from crisis to crisis.”**

Managers and care staff deal with the deeply personal every day. They feel it too. They give of themselves personally. Working in a care home is not like working in a hotel or a supermarket. The care home as a community has to deal daily with loss, pain, anxiety and death. Do we recognise this?

I’ve also known many hundreds of older people whose care I have been responsible for. I have had thousands of conversations

**CURRENTLY  
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OF FRONTLINE  
CARE STAFF  
EARN AN  
AVERAGE  
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PER HOUR**

with residents and their families, warm enriching conversations. I've also had some deeply affecting conversations, sometimes because the service I'm responsible for has not been good enough, but sometimes because I have been negotiating the very personal emotions of guilt and family conflict.

We know that good relationships really matter to people living and working in care homes, but what are we doing to nurture them? Why have our attempts to improve quality and prevent scandals seemingly failed? Why does the fear and animosity towards care homes persist so deeply?

Is it all terrible? Is it all abusive? No, of course it isn't. The majority of times it is good (now I am not saying as good as it could be, but good) and the majority of care homes are trying as hard as they can to do the best they can.

That is why I don't dread living in a care home per se. I do view the prospect of frailty, loss of function and dependency with some trepidation, but then who wouldn't? I do dread being badly cared for! I do worry about being at the mercy of stressed staff without the time to care, alienated by poor pay and a negative, defensive culture, treating me as a commodity to feed, dress, med and bed. What I want is kind, confident, compassionate, skilled people looking after me. I want to have a human relationship with them. I want to feel safe. I want to feel valued and I want to have a bit of banter as well. I want something of them and their time and I want them to feel they can give it. I would also like to be able to give of myself too. I don't think this is possible unless the people who are caring for me are treated humanely too. There are care homes that are like this, but they struggle. They succeed against the odds, in spite of the system.

The care home is a significant part of the UK social care infrastructure and is likely to remain so for the foreseeable future. Around 400,000 older people in the UK live in care homes, cared for by over a million care workers, 24 hours a day, seven days a week. With an ever-increasing population of older people, getting care homes 'right' is crucial to ensure a 'good life' for ALL of us – our parents and grandparents, aunties and uncles, friends and neighbours and, not least, ourselves! This IS personal, because,

if I am fortunate enough to live to a good age, I want to be cared for in a nice place by valued and compassionate people – people who treat me kindly and have the time to care.

To investigate the key issues and to try and find out how to address the crisis in UK care, I was asked to lead this personal inquiry into care homes for older people between May 2013 and May 2014. The personal inquiry approach seeks to take an honest, human approach to the issues, provide a proper honest discussion and hopefully propose realistic actions to improve things.

I've been looking at how things could be done in a way that promotes real relationship-centred care and moves away from risk-obsessed, blame-petrified and task-focused care. I looked at what we already know from existing research, and examined new personal research of the 'unspoken' truths, using conversations and social media. I also commissioned new research to see what is good and why, and uncover any new issues and solutions.

During the inquiry I concentrated specifically on care homes for older people. I have, however, drawn from evidence in other kinds of residential setting – for example, children, and learning disability services – to see what alternative approaches may be helpful.

So do we need another report? Only in the last few months we've had Francis, Cavendish, Kingsmill, Demos – and many more before them too. All saying that things need to change and setting out very convincingly what needs to be done. So do we really need a Kennedy too? Well, it feels to me that there are some fundamentals that need emphasis. Care homes don't and cannot work in isolation: they are in a system. Doing more to them from above won't improve care – it hasn't up to now. Likewise, the inspection system can't, on its own, improve care; it can only tell us what it is measuring. In order to improve the status, consistency and quality of care, we need to make sure that the system supports care homes as well as holding them to account.

In order to make change, we have to address the underlying causes of our malaise, the disconnect between our societal expectations and our societal actions. So how do we make sure that this happens? We are forever ignoring the obvious, reaching

instead for systems, frameworks, charters that in some way will create 'quality' like an alchemist tries to make gold from lead. We should address the underlying problems within the care sector. If we at least start to face up to and admit the challenges, we have some chance of getting to some solutions.

**“I wanted to understand what was wrong with the ‘engineering’ of the care home that continues to resist the ‘architectural’ initiatives of government and regulation.”**

I wanted to get under the skin of care homes in the UK and discover what people really think, what has to change, what is good and why. I wanted to take every opportunity I could to talk to people with real experience – residents, relatives, friends, care staff, managers, cleaners, volunteers. I wanted to visit people and places known for excellent relationships to understand how this has been achieved. I also wanted to visit and speak to people in places that are not succeeding. I wanted to hear why and what gets in the way. I wanted to encourage people with experience and knowledge to talk about what they think is really the problem. There is plenty of ‘unspoken’ truth just waiting to be heard. I wanted to understand what was wrong with the ‘engineering’ of the care home that continues to resist the ‘architectural’ initiatives of government and regulation.

Social media was a useful tool for connecting with a range of people and organisations. I was contacted by chief executives of care home companies who said, “I would like to talk to you... I’m really worried about the future. We try really hard, but we feel the pressures are now so much, it is very difficult for us to provide the level of care and support we think is needed...” I have been contacted by care staff who have said, “Why don’t you come to my care home, I will talk to my manager.” I have also had relatives of people coming forward and giving me their stories of their mother or father. Some of the stories were not so good, but

some people took the time to come and say, “My mother was in a really good care home and this is why I think it was a good care home”.

I used various social media to share themes and issues, and I admit, sometimes to be a little provocative to get people’s reactions. For example, I put together my own ‘Top 10 most important attributes of a good care home’ to encourage comments and add to the debate.

Why a ‘personal inquiry’ and not the usual kind of report or commission? Well, how we care for ourselves in old age is deeply personal; this is not about ‘them’ – it is about ‘us’. We hope that the personal nature of the inquiry – my voice as someone who knows by experience the flaws in the current system – may have more power to make change, be able to make us stop and think, reflect and to make the change we need actually happen.

The approach of a personal inquiry makes it different from an academic report and allows us to say things we might be more reticent to say in a more theoretical way. Don’t expect a long, deeply academic critique; they are not in short supply. This is a personal reflection, based on personal experience and the experiences and reflections of those living, working and visiting care homes.

### **John Kennedy**

Director of Care Services, JRHT/JRF



# RECOMMENDATIONS

Distilling all the research and feedback, I have come up with a set of recommendations divided between care homes, government and the system. By 'the system' I mean regulators, commissioners and the NHS. Some are very practical things; others are more philosophical, requiring a change in attitudes. I don't apologise for this. Care homes are not DIY stores, supermarkets or car factories – they are much more complex. It is much more difficult to judge quality; it's a messy human business and we need to accept that.

I am very conscious of many previous reports and inquiries over recent years, carried out by far more eminent persons than myself, and so I apologise if I have appropriated recommendations also made by others.

We should declare the social care sector as a sector of 'primary national strategic importance'. After all, old age is not about 'them', it's about US!

## Recommendations to improve the state of the care home sector

Consider the following principles:

1. Be appreciative of the million and a half people who work in our social care sector. They are your friends, relatives and neighbours. They care for us and our own. Judge them by the reality of humanity not by an idealised, unattainable expectation.
2. Be proportionate about risk. Share the risks, don't just try and pass it on.



## Supporting the right attitudes, values and culture

For care homes:

- Providing care is not the same as making widgets: it comes with a wider social responsibility of national importance. If your business model is driven solely by profit, you shouldn't be in the business. The vision, values and attitudes required to run a care home start in the board room and proprietor's office. Your business has a significant social and community impact. Take responsibility.
- Be active in your representative organisations. It is time to step up and help create a vision for the 21st century care home. Stop being passive. Care homes will only get better if you are part of creating the solutions.
- Be open, honest and transparent. Be candid about your strengths and your failings. Resist defensiveness.

For government:

- Declare the care sector a 'sector of primary national strategic importance' for the country, the economy and ourselves.
- Recognise that social care on the cheap is very expensive. The opportunity cost of low investment in our social care system is simply pushing higher cost onto the NHS. It is also inhibiting our national economic potential by failing to effectively support a modern labour force.
- Regulate the market, don't just inspect. We need to take a 'whole system' approach. We need proper regulation of the market as a whole. Regulation should encompass pay and working conditions; staffing levels, commissioning practices and transparent tariffs. These are the factors that directly impact on quality of care. Only with firm foundations can the care sector deliver. Regulate the market to compete on quality. Regulate for success not failure.

- Care managers need a professional body. Managers should be registered and have a licence to practise. The body should set professional standards, have disciplinary powers and provide a voice at a national policy level.
- To give assurance and to raise the status of the profession, care workers should be registered and have a licence to practise.
- Introduce a single assessment instrument to provide real data on quality indicators, dependency profile and resource needs. Understand the care home sector. This would give valuable data in measuring quality. It would also provide a national statistical database to inform strategic planning for health and social care.

For the system: regulators, local authorities, the NHS:

- Ensure that your requirements support the ‘mission’ of the care home. Be mindful that whatever extra you ask them to do takes time away from relationships and people. Find out about your local social care providers. Engage with the care sector in partnership.
- Rationalise the ‘paperwork’ burden on care. Work together to ensure a proportionate bureaucracy that supports ‘people time’ not ‘office time’. It is people who make the difference in the end, not paper.
- Share what is good. You need to be more ‘in the game’ – don’t just point out what is wrong; engage in finding solutions too. Listen. Share your experience.
- Be collaborative and involve the care sector at the inception stage of new requirements and initiatives – not just a consultation at the end of the process. Care homes have a lot of experience to share.
- Ensure there is someone on your boards with direct experience of working in and running care homes.



# WHAT MAKES FOR GOOD CARE IN CARE HOMES?

There are excellent care homes out there, and there are poor care homes: what is different about them? What makes the good 'good' and the poor 'poor'? How do we change the system – whether regulation, market, funding, structures – to maximise the potential for 'good' and 'excellent' to prevail?

Over the past year, I have been gathering new thoughts on how to revolutionise improvements in the care sector. I have been fortunate not to be confronted with a standing start – the existing research through JRF's Better Life programme has proved a solid ground – starting with what we already know is working in the care sector and what barriers are preventing best practice. The new research I commissioned helped to fill in some gaps, and my engagement with those interested in the care community using social media helped to introduce some fresh ideas on what we should be examining in greater detail.

From JRF's Better Life programme (Katz et al, 2011), we already know that older people with high support needs want a quality of life that includes relationships, living somewhere pleasant and accessible, having input into decisions and the opportunity to mix with other people.

Other JRF research (Bowers, 2009b) highlighted the following aspects of a 'good life':

1. People knowing and caring about you.
2. The importance of belonging, relationships and links with your local or chosen communities.
3. Being able to contribute (to family, social, community and communal life) and being valued for what you do.
4. Being treated as an equal and as an adult.

5. Respect for your routines and commitments.
6. Being able to choose how to spend your time – pursuing interests, dreams and goals – and who you spend it with.
7. Having and retaining your own sense of self and personal identity – including being able to express your views and feelings.
8. Feeling good about your surroundings, both shared and private.
9. Getting out and about.

Our current research (Bowers, Katz, Owen, 2014) showed us that there are several challenges that must be overcome for older people to enjoy a good quality of life now and in the future. These include:

- Overcoming negative stereotypes and ageist assumptions.
- Ensuring that support is founded in rewarding and positive relationships.
- Treating care home residents as equal stakeholders, not only as passive recipients of care.
- Empowering older people by giving them a voice, and then listening to them.
- Breaking through the barrier of unnecessary paperwork which reduces the capacity to respond to residents' needs.
- Dealing with the substantial organisational, policy and social responses needed to produce the change needed.
- Having clarity on what can be expected of publicly-funded services.

What the research tells us is that we need to be open to radical and innovative approaches, changes that can improve lives. With this in mind, I looked at the existing and new research, my social media engagement and the conversations I've had with people over the past year. Naturally, there were common themes that emerged. I mapped those themes and narrowed down the focus to six areas which I think capture some of the most basic needs and most blatant shortcomings in the care sector.

What follows is a discussion around the combined findings, summarised under these themes:

1. It's all about people and relationships.
2. The workforce who give care are people too.
3. People who feel involved feel happier.
4. Emotions and attitudes create empathy and are hard to measure but they are really important.
5. Top-down, outside-in regulation is not working.
6. The dysfunctional care market comes with huge opportunity costs.

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## 1. It's all about people and relationships

What I want to know is that you are interested in me, that you know... that I am a football pundit... and that I married the girl of my dreams. [[Damian via Facebook](#)]

What people say they want is good quality relationships. This message is not only one that I would agree with, but in the course of this inquiry, it became clear that it is a message that everyone agrees with too.

But what do we mean by good quality relationships? Well, I would argue that relationships mean different things to different people. Some people want a very informal, chatty, personal relationship with care staff, others a more formal, even slightly distant relationship. Some people are on their own, never visited, others have huge extended networks of family and friends visiting them and supporting them.

So, the relationship an older person has with the care home is different in each person's case. Isn't that what we would expect? Some like to take part in activities, others would prefer to just have one-to-one time for a chat or, indeed, be left alone. In my experience, care staff try to do this, but it is not easy.

When I prompted with a question on Facebook, "What would I want coming to live in a home?" the responses highlighted some

of the current concerns with care homes and also how things could be better. One person's response highlighted the importance of relationships and getting to know people as individuals:

What would be on my agenda would not be getting the right meds or having my bed made or some food – I trust you to give me that and look after me physically – I'm not bothered whether you write that down in detail, as you do... what I want to know is that you are interested in me, that you know I like to get on my soap box and rant... that I am a singer of the highest order and will give you a Pavarotti or a Neil Diamond on demand; that I relish any opportunity to speak Spanish and tell of my time in Latin America; that I am a football pundit and love to bet on the footy (so I'll need wi-fi and a laptop); and that I married the girl of my dreams.

If I receive the message I am an inconvenience, if the only conversation I get revolves around 'open wide, sit down, stand up', then I will seek to go 'home', I may be labelled as 'challenging' as I try to leave. If I get the message that I am welcome amongst peers, that I have the opportunity to have an impact on the world around me, that people here are interested in me, then I will stay, happy that I am in a place where I feel I can belong. [\[Damian via Facebook\]](#)

A key element of person- and relationship-centred care is the need for residents to be treated with respect, dignity, kindness and compassion. One comment I received from an assessor of local authority care homes stated how a lack of person-centred care was the result of "the continuation of task-based medical dominated practice".

One former care worker, who is now trying to improve the way care is delivered through advocacy, stated how they were "successfully improving the quality of life for residents by listening, engaging and making sure their wishes are known and respected." [\[Charmaine via Facebook\]](#)

The existing research shows us that relationship-centred care is at the heart of many examples of best practice. Our new research,

looking at alternative residential care settings, confirmed that there are indeed some good examples already out there. We found that relationship-based care was a feature where there was a positive culture. This also encouraged staff to use activities to build relationships and engage more openly and freely with residents.

**“Relationship-centred care means residents are treated with respect, dignity, kindness and compassion.”**

We have an increasingly diverse and individualised society, but our care home system is a ‘Henry Ford’ model; an undifferentiated production line. If we are to provide individual relationship centred, responsive care for all our citizens, care that respects our individuality, our ethnicity, religion, sexuality, all in fact that makes us who we are, we need to ensure that those who care for us have the skills and confidence required. If care staff are to be able to prioritise relationships they need the time, space, confidence and encouragement to invest in them. The system needs to provide this environment for the right culture to prevail.

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## 2. The workforce who give care are people too


We pay dog walkers and babysitters more than we pay care workers. [\[Thea via Twitter\]](#)

One of the key factors in the care crisis is not just our societal indifference to the needs of our frail older citizens, but also the incredibly low value we put on the work done by the more than one million people who work in social care. It seems utter common sense to me but how can we expect our care workers to value and respect us if we show such little regard for them? Average wage rates suggest that supermarket assistants are paid more than care assistants – evidence of how much we value this skilled role.






Social media has been a vital part of our research

 **John Kennedy**  
@JohnnyCosmos Following

For people to care they need to be cared for!  
Pretty obvious really [jrf.org.uk/blog/2014/04/why-social-care-workers-undervalued...](http://jrf.org.uk/blog/2014/04/why-social-care-workers-undervalued...)


⏪ ↻ ⭐ ...

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RETWEETS **3** 

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3:13pm - 17 Apr 2014

 **John Kennedy**  
@JohnnyCosmos Following

National care home open day #NCHOD2014  
Great idea but shouldn't care homes be part of your community every day?

⏪ ↻ ⭐ ...

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RETWEETS **4** FAVOURITES **4** 

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9:19pm - 17 Jun 2014

Staffing and related issues was a dominant theme throughout the inquiry. Many comments highlighted the low pay afforded to care home staff and how this, combined with poor working conditions, can affect quality of care as well as staff morale.

And, while much of the focus was on the care workers' role in caring for residents, it was also clear from my conversations that residents care about staff too. I've talked to hundreds of care home residents over the years. This personal experience, backed up by the Better Lives research, tells us that what really, really matters to residents is those individuals who look after them. They are interested in care staff as people and are concerned with their wellbeing. In fact, whenever residents have come to me to voice concerns or suggestions, they are often saying it because they are anxious about the impact on staff and their workload.

For me, one of the surprising findings of the inquiry was the strength of feeling among care home staff, positive in terms of the enthusiasm and commitment about the work that they do, but also the anger, disappointment and frustration about how they are perceived, treated and the lack of understanding about what the role involves.

The care home sector employs hundreds of thousands of low-pay workers, mainly women. Care workers are the lowest paid, lowest status workforce in the economy. Every extra pound on their wages reduces the call on the benefits system and increases the tax and National Insurance yield. Care workers' pay packets don't go to offshore bank accounts, they get spent in local economies on goods and services which provide opportunities for others. A decent pay also empowers and validates the status of care. We know our economy is far too weighted towards a significant low-pay, low-status labour market. Remember we are talking about over a million workers. This is fettering our potential and the potential of our citizens.

Wages were just one factor in the more complex business of retaining and motivating staff to do their job well. There are other things besides pay that can help staff to feel valued. Important areas included having the right working conditions that help staff to do their job well, opportunity for progression,

learning and skills progression, more contact time with residents and supportive management and organisational culture.

Our round-up of existing JRF research (Carr, 2014) highlighted the physically and emotionally demanding nature of care work and looked at what motivates care workers to deliver quality care and examined the relationship between pay and conditions for care workers and the quality of care experienced by people using the service.

## “There are other things besides pay that can help staff to feel valued.”

The ‘culture’ in which care staff work is also significant in creating the right environment for good care, for the building of good relationships. Of course the culture in a care home is an internal responsibility, but it is also a shared responsibility, and is massively shaped by the external system. How they are perceived and how they are treated by the external system has a fundamental impact on the internal culture of a care home. When we looked at examples from alternative residential care settings (Burtney et al, 2014) we found that a care home with a positive organisational culture has the potential to have a beneficial impact on the lives of residents, families and staff. Features of a positive culture are complex and depend on a number of factors, including organisational structures, management arrangements, the physical environment, the relationship between staff and residents, and skilled staff and teamwork. The ability of a care home to get these factors right is enhanced or fettered by the system in which the care home operates. A negative, critical, accusatory external system crushes good human relationships, making staff, providers and regulators defensive and disempowered.

It seems ‘in plain sight’ to me but if we want care workers to provide the kind of compassionate care we say we want, then we have to care for them too. We need to recognise and acknowledge their skills and qualities, through appropriate pay and also through how we value them as professionals and as really important people in our lives.

**IF WHAT WE  
SAY WE WANT  
FROM CARE  
IS TRUE, IT  
NEEDS TO BE  
REGARDED  
AS A HIGHLY  
SKILLED  
PROFESSION**

People felt that care work was demanding and challenging work, requiring real skill and core human qualities: “It’s skilled work requiring honesty, emotional intelligence, respect, humour and vigilance of the client’s needs.” [\[Heather via blog\]](#)

Care work is not a low-skill occupation. Care work, in fact, requires incredible levels of skill and personal abilities. High levels of emotional intelligence are needed, combined with negotiating skills, resilience and kindness and compassion in spades. Care workers have to be able to deal with giving the most exquisitely personal care to the most vulnerable people at the end of their lives. They have to deal with all the emotions surrounding pain, anxiety and death. If what we say we want from care is true, it needs to be regarded as a highly skilled profession.

Comments received highlighted the need for greater recognition of this and the work of care workers: “There are amazing carers within care homes who have remarkable inner qualities and they do one of the most important jobs that exists in our world, caring for those who are living through aging, and dying. The carers’ ability to draw on those inner qualities within themselves is stymied by the risk-averse, regulation-driven, paper-drowning, media negativity and public prejudice that make care homes so hesitant to set sail into the 21st century...Time for transformation.” [\[Georgeanne via blog\]](#)

### **“More contact time would enable staff to develop a more meaningful relationship with residents.”**

For residents to feel valued and have their individual needs met, many comments referred to the need for staff to have more contact time with residents. This would also enable staff to develop a more meaningful relationship with those they care for. However, the task-focused approach, heavy workload and low staffing level means that, for many, this is not possible.

If a provider is short-staffed, then the care workers on shift simply don't have time to sit and talk to residents, and owners put pressure on staff and management to be 'busy' – doing physical tasks like laundry or cleaning, not 'sitting around chatting'. [\[Alice via blog\]](#)

One comment suggested the idea of having a minimum amount of contact time and identified the knock-on effects of this for staff:

If there was a requirement for a minimum amount of 'contact' time and activity aimed at individual's wellbeing, and if this was measured... as part of the standards of the home, maybe staff would feel that they had permission to ignore the beds for a while and sit and spend time with people. The knock-on [effect] might be that the staff enjoy their roles more and get more job satisfaction and the standards would quite naturally improve as would the residents' experience. [\[Dementia forward via Facebook\]](#)

## **“Inadequate staffing levels in many care homes often mean staff are overstretched.”**

It was clear from comments that working conditions included support from a suitably sized team. Inadequate staffing levels in many care homes often mean staff are overstretched. The pressure and potential stress caused by these demands can be damaging to the wellbeing of staff and leaves little time or energy to focus on nurturing relationships with residents:

I work in a big home with 60 residents; all with diverse care needs... I work nights with a ratio of four carers and one run. It is hell for the first five hours trying to get everyone into bed and settle ones already there with two twos as most clients are double-handlers. This is surely not providing

the proper care aspect as time is not there to listen and reassure and be in three places at once, causing tension for the residents wanting to be in bed and the carers trying their hardest to achieve it. [[Lea via Facebook](#)]

If they are over-stretched because their employer has cut down on staff, if they are working for less than the living wage and have a zero hours contract, if they are given a series of tasks to complete rather than encouraged to work on their own personal initiative, then you will not have a working environment that generates kindness. [[Via Facebook Unison Retired Members](#)]

Staff stress and burnout are real concerns for residential care settings, often caused by increased workload and unsupportive environments. A focus on relationships and relationship-building was felt to be central to training for care staff, although it was recognised that there is a need for a more realistic view of human relationships. There is a need to acknowledge that it is easy for anyone to react negatively to the emotional pressure created by stressful working conditions and poor support mechanisms:

Relationships should be at the heart of training and development, and care staff who feel listened to and valued and who have positive and productive working relationships with their trainers, will... learn how to relate well to their residents... We all learn these qualities through our own experience of being cared for and cared about. [[Jim via blog](#)]

Often we see staffing levels as simply the sole responsibility of the provider. In my view, this is nonsense. We have no adequate way of linking residents' needs to staff skills mix and numbers. There is no functional linkage between care home fees and needs. The way we fund care has resulted in 'bare bones' staffing levels and appalling pay. The sector is structured to fail.

Poor or inadequate support systems for staff, including poor management, can lead to staff feeling 'de-humanised' which

can affect their ability to empathise and care for those they work with. Comments identified other ways in that staff could be better supported, including the provision of counselling and, not surprisingly, good support from management.

### **“The manager of a care home is the key player in nurturing the quality of relationships.”**

For me, the absolute primary mission of the care home is to maximise the quality and value of the relationships within and without the care home setting. They can do this by nurturing the relationship between resident, family and care home. If the relationship between these agents is good, then the care home will be good for that person. Who is the key to this? In my view, it is the manager of a care home who is the key ‘nourisher’, the key player. Yes the ‘tasks’ still need to be done, but without the quality of the relationships, it won’t be a ‘good life’. It will be, at best, a safe and fairly joyless life. In my discussions with care providers and regulators, everyone agrees that the key ‘must have’ for quality in a care establishment is the manager but they can’t do it single-handed. The system needs to support them. Our research (Burtney et al, 2014) also reinforced that strong leadership and good recruitment processes can also help to prevent abuse and reduce the risk of harm to vulnerable adults in care.

Our evaluation of the work of Essex County Council (Granville et al, 2014) demonstrates that taking an ‘appreciative’ approach to care homes and working in partnership with them has significant positive outcomes for the confidence and effectiveness of care managers and staff. The Essex My Home Life example highlights how systemic change requires strong leadership. And their leadership development programme has had an important impact on care home managers. The research said that leaders with the right skills, attributes and credibility are needed to create and push forward the local vision. These leaders need to be trusted and supported by senior and operational managers, and have



a clear values base to help them stay focused on the outcomes to be achieved in the longer as well as short and medium term.

However, the evidence from My Home Life and from my conversations during this inquiry, say that good managers are increasing leaving the sector – many saying that the job has become a poisoned chalice, they have burned out. The CQC are so concerned about the number of care homes without a registered manager that they have begun issuing fixed penalty notices.

The role of a manager is a highly skilled, intensive and very personally demanding role. People who possess these skills can choose between a number of roles in the labour market, get paid more, respected more and don't have to live with the relentless pressure of managing an emotionally intensive 24-hour-a-day, seven-days-a-week operation. They also occupy a statutory legal role as Registered Manager with all the 'go to gaol' cards that go with it. But they have no voice as a profession; they are not represented at any level. And care home managers are also underpaid compared to their equivalents in the NHS and undervalued as well.

A number of social media comments referred to the role of managers and how the approach, skills and style of manager can have a huge impact on the care staff and care home in general. There was a strong sense that a good manager was a 'central ingredient' of a good care home and that bad management had a serious impact on staff and the care of residents:

Bad management creates anger, bitterness and resentment – causing staff to carry out their duties when they are stressed and feeling undervalued. Good staff leave. Good management means staff feel comfortable communicating issues with their management and know that, when something needs to be done, it will be done. [\[Paige via Facebook\]](#)

Management style and approach impacts on how staff feel and how they, in turn, approach their work. One respondent stated: "I have known staff to be resentful of visitors because they are institutionalised themselves; this is down to those running the home." [\[Margaret via Facebook\]](#)



I don't know about you, but personally, I would want the people who care for me to be those who really 'care', who have a heart and a gift for the job and who connect with and use ideas from the people they work with. So, for care homes to really provide the relationship-centred care we all want, they need to be able to recruit from the widest possible pool of the labour market. Recruiting the right people with the right attitudes and values is essential, but is a challenge when you can earn more stacking shelves in a supermarket! Care homes simply can't compete in the labour market effectively. And many people highlighted the need to pay care staff more in order to recruit from a much wider pool of the labour market. The recent Demos report stated that "78% of frontline care staff earn an average of £6.45 per hour. This is just 14p more than the minimum wage (based on 2013 figures)". Paying care workers a Living Wage would be a good starting point. If your recognition doesn't even include a wage you can reasonably live on then it doesn't bode well for nurturing a culture of compassion and kindness.

### **“Recruiting the right people is a challenge when you can earn more stacking shelves in a supermarket!”**

While we saw that pay is not the prime motivator, it is the prime demotivator. JRF's research into pay and conditions in residential nursing and domiciliary care (Carr, 2014) showed that organisations need to understand the personal motivation of care workers, many of whom are driven by a primary commitment to residents. If an employer is unable to provide staff with the conditions to focus on what residents want, then some staff may be more likely to move to another social care provider.

The vast majority of care workers have a strong vocational motivation for the work they do, but unfortunately, this is not true for all. In speaking with providers, I can see that they struggle daily to recruit the right people; some admit that they might

have to take people who do not ideally suit this kind of work. Not everyone has the personal qualities to be a good care worker, and we need to make sure that the care home is able to exercise as wide a choice as possible to get the right people.

In the social media feedback, one manager stated how recruiting and supporting the right staff was central to person-centred care. It was also suggested that seeking staff with compassion, or with the potential to be compassionate, should be an essential part the recruitment process. Comments we received suggested that this was a natural instinct or quality and not something that could be taught, however, there was a strong sense that it can be modelled by leaders, managers and peers, who could inspire the same in their staff and colleagues:

If we want staff to be compassionate, we must be compassionate towards staff. [\[Elin via Twitter\]](#)

We haven't a hope in hell of improving the quality of care unless we fundamentally address the glaringly obvious needs of the care workforce. For care workers to be able to really deliver high quality relationship-centred care they need our support to do it, not our neglect and disdain.

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### 3. People who feel involved feel happier

Policy across all four UK nations has emphasised the need for older people to have voice, choice and control over their lives. Yet there remains a lack of real understanding as to how to make this happen in care homes. [\[Owen, 2012\]](#)

From our existing evidence about the experiences and aspirations of older people living in care homes, we can be certain that people have a great desire to influence the decisions made about them. The Essex County Council My Home Life example (Owen, 2012) also suggests that a relationship-centred approach to care that creates community, maintains identity and involves residents

can help older people in care homes have a greater say and control over their lives.

Personalisation of services is a core aspect of health and social care policy, but tensions can arise where individual choices conflict with organisational policy. Factors that can help relieve these tensions include good communication, a positive culture, creation of a defensible trail of decision-making, good relationships, participation and a strong and skilled workforce. Promoting independence is also a key aspect of personalisation.

Evidence from other residential care settings – such as for children, people with learning disabilities and hospice care – supports reablement to improve physical capacity, quality of life, emotional functioning and mobility in people receiving care (Burtney et al, 2014). This investigation also shows how greater involvement of people who use services and their families, positive organisational cultures and increased relationship-based care can improve the quality of care offered. It presents promising ideas that could improve the culture of care homes for older people and experiences of care and support for staff.

**“Task-driven essentials mean there is not enough slack to ensure the meaningful things in life are always the priority.”**

We know from existing research (Bowers, 2009) that having activities to do to contribute to family, social and community life, help us feel valued. A number of comments expressed the need for people in care homes to be kept active and for a range of activity options, based on the needs and interests of residents. There was a sense that activities should be integrated into the daily life in care homes and focused on improving quality of life.

One comment expressed how activities could allow residents to “try new hobbies or maintain old ones”, thereby helping them maintain their sense of self. Some see this element of care to be as important as the provision of food and medical care: “I think

activities, enrichment, purpose...should be seen as important as sustenance and medication.” [Sandra via Facebook]

Other comments highlighted how residents themselves could have a role in designing and delivering and choosing activities around their needs and passions: “residents...could enjoy sharing their expertise and enthusiasms with their neighbours... [they] can be ‘activity organisers/facilitators.’” [Susan by email]

In addition to activities provided within the care home setting, it was recognised that opportunities for residents to get out of the care home environment for normal everyday activities were just as important: “It is essential to enjoy life outside the home – when was the last time people were able to go shopping?” [anon]

Social media comments also highlighted how feeling valued can have a positive impact on mental health and reduce some of the challenges associated with this (this applies to staff as much as residents):

If the elderly had a sense of purpose and felt valued that would eradicate the incidents of depression in our care homes and certainly reduce aggression... It is the fundamental basis of Maslow’s hierarchy of needs... and just basic common sense! [Niamh via Facebook]

Many care homes try and create opportunities for activities and engagement but this is often subordinated to the ‘task’ driven essentials. There is simply not enough slack to ensure that relationships and the meaningful things in life are always the priority.

During the course of the Inquiry one thought kept coming back. When did care homes become absolutely totally responsible for the complete physical, mental and emotional wellbeing of those in their care. When did everyone else opt out?

**“It is indicative of our attitude to care that, so far, the digital revolution has passed the sector by.”**

**GREATER  
INVOLVEMENT  
OF PEOPLE  
WHO USE  
SERVICES  
CAN IMPROVE  
THE QUALITY  
OF CARE  
OFFERED**

There has been talk for years in the care home world about ‘telecare’, ‘assistive technology’ but, in reality, the digital revolution has simply bypassed care homes. They are distinctly 19th century in terms of paperwork and wholly ‘analogue’ in managing information. I have seen some examples of ‘electronic care records’ but, in all honesty, they are more often than not simply transferring paper to a spreadsheet or database (stuff is still printed out too, often creating two parallel systems). Other applications are aimed at risk and control, tracking staff and residents or managing confinement, and are almost exclusively deficit focused. There are some examples of more positive initiatives but, again, these are isolated examples.

**“Care homes have the potential to be a major central ‘hub’ of our neighbourhoods and communities.”**

There is an opportunity to use modern tablet devices (increasingly popular with older people), wifi, cloud storage, and so on, to improve the connectivity and power of residents. There is potential to remove paperwork by ‘real time’ information-gathering, freeing up staff energy for personal interactions.

The potential for collecting residents’ and relatives’ feedback and choices continually could be immensely powerful in increasing the care homes’ self-awareness and responsiveness.

Opportunities for engaging with the arts, politics and civic society could be enhanced, not just for older people themselves, but for society in general as older people are supported to take part and contribute too. We have so much to gain.

The care home resident in the 21st century will simply not be satisfied with Freeview and the odd Skype call. The possibilities are as yet hardly mapped. But, looking how the digital world has revolutionised how we communicate, shop, participate, complain and say who we are, it is indicative of our societal attitude to care that, so far, all this revolution has simply passed the sector by.



The role of community, family and friends was also seen as important. We can't get away from the fact that a care home does become a sort of strange extended family. You live with other people and you are living with them when you are vulnerable. The staff are there all the time and it does become a community.

A number of comments we received related to care homes as communities with each 'member' – whether staff, residents, relatives, or the wider community – playing their role.

Care Homes as communities – this is how they should be seen and run...strong teamwork between staff, people living in the CH, relatives and friends is key to good care and community spirit. [\[Blogger via Facebook\]](#)

Other comments indicated that there should be more opportunities for relatives to be involved in the running of care homes. There was also need for greater recognition that relatives also have support needs which the care home and wider community could help to meet.

We need more help, information, guidance, support preparing and training for families to support elderly too. [\[Via Twitter Specodi @Specodi\]](#)

There was an emphasis in the comments on people feeling that the community had a role in caring for its older generation.

Taking care of the very old and frail is hard. Families often care for years on end but then need help. [\[Via Twitter R&RA @relresuk\]](#)

It was felt that a shift in attitudes and diminished sense of responsibility had led to people seeing it as the 'job' of the care home to do the caring. There was a call for people in the wider community to take back this responsibility and have a role in improving care for the older generation;

For things to change, we as a society need to change ...we need to take care away from profit-making organisations and give them to our local communities. We need to value our elders more and instil these values in our national curricula...we as a community should also be more involved. We should start caring for our elderly neighbours more before they need care. [\[Angela via Facebook\]](#)

It shouldn't all be a 'job' leaving only professionals and the government responsible but it's all OUR responsibility...as neighbours, friends and families, to improve the care of our loved ones!! [\[No via Facebook\]](#)

A potential barrier to increased community involvement in care homes was the lack of accessibility. Care homes are often viewed as 'closed' places, where visitors need to sign in and be 'cleared'. This could be reducing the opportunities for people to interact informally with their wider community. The need for safety checks and controlling access to care homes is grounded in reducing risk, but this can have a counteractive effect on care homes. This all means you can't just wander in after work to visit someone, have a cup of tea or read them a book. You have to have a volunteer's policy and a CRB check. You have to ring the doorbell and sign in at reception. This could be contributing to the fact that care homes can often be closed and empty places, and that is not good for the residents or the staff. Ironically I can, as I do, pop in anytime I like to my elderly, frail, vulnerable neighbour without anyone's permission at all!

As we all know, positive relationships are a two-way street. And we cannot expect positive relationships between individuals and groups if there isn't a culture to support appreciative relationships. Staff, residents, relatives and the wider community need to feel empowered to engage on a human level. Whilst they feel 'suspect', unwelcome or unappreciated they can't build good relationships.

Care homes have the potential to be a major central 'hub' of our neighbourhoods and communities; a place where people

come together, where relationships can flourish and where networks of support can be created for everyone.

A flourishing volunteering movement supporting care homes would be great. It exists in hospices, why not care homes? What is it that makes care homes so off limits, so outside of our communities and neighbourhoods?

As well as the basic elements of how care is delivered, I wanted to use the inquiry to really get under the skin of some of the more difficult areas of our dealings with care homes. Do we have an attitude problem with care in general? Is this part of the problem?

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#### **4. Emotions and attitudes create empathy and are hard to measure but they are really important**

It is so important that we discuss the realities of home care.

[Yasmin via the blog]

*How and where* care is delivered are obvious targets for discussion, and I did not find it difficult to encourage ideas on these aspects of care. However, more difficult to pinpoint are the often unspoken aspects of care homes – the side that we are perhaps scared of talking about and the side that is less easy to regulate and legislate – our emotions, attitudes and assumptions.

**“A deeply ingrained feeling of guilt is behind much of our struggle around care homes.”**

One thing that has kept coming back to me over the last year has been the realisation that our care sector is affected by stubborn cultural prejudices which permeate the landscape. Guilt – I believe that we have a deeply ingrained feeling of guilt that is behind much of our struggle around care homes. We feel a shame in not looking after our older citizens ‘like we used to’. We do need to come to terms with this.



Our society is fundamentally and irreversibly different from how it was 50 years ago. The proportion of older people, particularly the very old, is greater than it has ever been. Isn't that great? We are all living longer! But we are also having fewer children. We are far more mobile in our working careers than we ever were. Once, an extended family may have lived within a few miles of each other and an abundant younger generation could support the few who made it to old age. Now a smaller group of younger, widely dispersed relatives faces the challenges of caring for many grandmas, uncles and parents. We no longer have the societal structure we used to so 'professional care' is our solution. The guilt of knowing that we have handed over our responsibilities to someone else is a significant barrier in allowing us to be appreciative in our relationships with care homes. We need to grow up and get over it – or take grandma home and care for her ourselves. What we must stop doing is projecting our guilt on to care homes to make ourselves feel better.

**“Ageism and sexism are pervading attitudes.  
This has got to change.”**

Why have we got into this state? Why, if care for our most vulnerable and frail is so important, so fundamental to our sense of righteousness, do we treat those who provide the care so badly? I think it is because ageism and sexism are pervading attitudes.

The care sector is highly feminised. I would estimate that 95 per cent of care workers are female. Approximately two-thirds of residents are also female, although this is slowly changing. There remains a deeply ingrained prejudice that care work is 'women's work', domestic and expected, combined with a stereotype of 'little old ladies' who just need a hand with their washing and someone to play draughts with. I would suggest that the fact that care work is the lowest paid sector in the legitimate labour market is strongly linked to the historical value placed on care work, which in turn is linked to sexist attitudes to perceived 'low-skill' female roles. This has got to change.

The pressures in care homes are becoming more and more intolerable. We have a low-paid, stressed workforce, rushing from one person to the next with minimal time to wash, dress and engage with frail, vulnerable and often very lonely people. In fact, if we sit back and look, it would be hard to design a system less able to prevent neglect and abuse than the one we have. In this inquiry I have concentrated mainly on care homes but the situation in homecare is arguably worse. The system itself is a safeguarding alert.

The Panorama programme never asks how long the care worker had been on duty, how many people they had to help to bed, how many call bells were ringing, how many staff had rung in sick this shift (and the next shift which still needs covering), how much paperwork was left to do, how painful the scratches on their arm were, how anxious they were to get done because another resident was wandering the corridors, confused and aggressive and trying to get out. Nor indeed how much they are worrying about their own personal circumstances, such as debt and how they'll pay the bills. This is not to excuse abuse, but it is to try and understand why it happens so we can do all we can to minimise it.

**“The Panorama programme never asks how long the care worker had been on duty or how many call bells were ringing.”**

In the words of Billy Bragg, “Virtue never tested is no virtue at all”. Yet there are lots of people imposing their virtue on care staff, which has never been tested through having to experience the reality of working in a care home.

A care home environment where staff do not feel valued and supported can lead to increased risks. If staff feel defensive, have financial worries, they will be more wary of ‘rocking the boat’ and losing their job. Therefore, whistleblowing incidences may be less likely, making the care home a more risky and unsafe environment.

Do our default human settings have something to do with the safeguarding issue in care homes too? Why do people do bad things? How can we stop them? I have spoken a lot about the pressures on care homes and the workforce. I keep reviewing what I've written to make sure I am not overstating – saying good things about care workers and defending care homes almost feels taboo, makes me feel like a guilty apologist. I am not an apologist for poor care or abuse, but we do need to understand more about why abuse happens if we are serious about tackling it effectively.

**“We need to understand more about why abuse happens to tackle it effectively.”**

We need to be much clearer about whether we believe we can eradicate all abuse and neglect from care homes. The standard ‘lessons learned, it shall never happen again’ hasn’t stopped it happening again and again. I don’t think we can, but our societal rhetoric appears to suggest that we can and we should. I think we should be more honest and realistic. Will there never be another bent copper, bad doctor or dishonest politician? Of course there will. I would argue that we need to ensure that the fundamental ‘engineering’ of care minimises to the greatest degree possible the likelihood of abuse occurring. At the same time, it should strengthen the circumstances that will foster, nourish and embed good attitudes, values and relationships.

The best way to safeguard the frail and vulnerable is to create and nurture a strong culture of good care in just the same way as a bad culture allows for abuse and neglect to flourish. Psychological experiments on humans have shown time and time again that we are ALL capable of neglect at least, if not active abuse, if we are put in a ‘bad culture’. Psychologists call it ‘situational attribution’ – the assumption that a person’s behaviour is influenced by an external influence from the environment or culture.

It is all too easy for us to take the comforting view that we (the system) have no responsibility for the culture and that abuse and neglect are purely 'dispositional' (the flipside of the psychologists' coin) simply down to individuals. Emotions and attitudes create empathy and are hard to measure but they are really important. We ignore them at our peril and need to face up to the realities of human factors.

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## 5. Top-down, outside-in regulation is not working

Staff and managers feel tied by red tape and procedure which disempowers them from really doing the job they're there to do and that they really want to do, which is to care! [\[Malcolm via blog\]](#)

Our attitude problem applies to regulation too. We are stuck in a mindset where this traditionally happens from the outside in, rather than from inside the sector looking out.

In the 30 years I have been involved, care homes have changed immeasurably. The complexity of people's needs have increased dramatically, length of stay has fallen from years to months, and the number of people whose needs include multiple complex conditions has increased. The complexity of the working environment has also become more transactional, confounded and confusing. Each new round of legislation, regulations and standards places another responsibility on the care home. And it always goes in that direction – never, in my time in the sector, has any new initiative substantially supported care homes.

The expression 'skin in the game' was explained to me in relation to the airline industry. In aviation, everyone's 'skin is in the game' – passengers, pilots, crew, executives and regulators – no one wants a plane to fall from the sky. Consequently, not just one aspect of the industry is 'regulated' but the whole system is. The culture is also open and as 'blame-free' as possible. This encourages sensible analysis of risk/benefit. If something goes wrong, the first question is 'what went wrong with the system?' not 'who can



we find to blame?’ As a consequence, aeroplanes very rarely fall out of the sky.

So, what about the care sector? What of the current regulatory, safeguarding, commissioning environment? In my view, all the agencies surrounding the care home, although doing what they are *asked* to do, aren’t doing what they *need* to do. The transactions are all one way. They don’t have ‘their skin in the game’. They don’t share the risks or support the mission. What they do is stand on the sidelines and demand assurance without accepting some of the collective ‘systemic’ responsibility. We end up not getting better over time but being part of an endless circular firing squad.

I would argue that the care home sector isn’t in fact *regulated* – not in the usual sense – rather, it is *inspected*. The factors that really have an impact on quality – such as culture, managers, workforce, staffing levels, pay, clear mission, funding – are out of the ‘regulatory’ scope. You will find all these areas are mentioned in the care standards but all framed in terms of ‘the care home must ensure’; never, ‘commissioners must ensure that fee levels allow providers to meet the standards’, for example. There is no regulation of pay and conditions, commissioning standards or adequate funding.

## “Do regulators and commissioners have their skin in the game?”

Each bit of the assurance map is separately overseen by a variety of agencies (often overlapping) whether that is the CQC, Health and Safety Executive, Local Authority and health commissioners. All need their own assurance in their own format. They are all, just like the care home, trying to do their job for all the right reasons, but the reality is counterproductive.

It all feels driven by fear – a fear of making a mistake and getting it wrong. This is not just felt by the staff and managers but by the ‘regulators’ too. It is also contributing to another barrier to delivering good care.

**ARE CARE  
HOMES  
PUTTING  
RED TAPE  
BEFORE  
RESIDENTS?**

Over the years, the expectations on care staff and managers to understand and manage complex legislation and protocols has continually ratcheted up. There are safeguarding protocols, assessment of capacity and consent to treatment, assessing and managing complex risks. Again, in the absence of a system-wide approach to these issues, care homes are required to develop more paperwork, further driving a wedge between the carer and resident as people who have a relationship and towards a more anodyne transactional interaction.

A military friend of mine made a very interesting observation, when we were discussing complexity in the care home world. He reflected that the top brass in the military spend a huge amount of effort and time in translating complexity into simplicity to support the soldier in the field. To ensure the soldier is very clear and confident in their duties and responsibilities and that they have the training and equipment to do their job. His reflection was that in the world of care the opposite happens. The fairly straightforward concepts of kindness, respect, individuality are translated onto the floor of the care home in a maelstrom of conflicting directives around personalisation, capacity, risk, consent making the job of the care worker confused and conflicted. Never really knowing if they are doing right.

In my experience, care homes are very passive – they never say no to any request for another form, another assessment or another policy. Of course we need paperwork, but should it really take up so much time and energy? As I see it, paper is used as proxy measure of good care. Paper might tell you what was supposed to have been done, it can never really tell you what was actually done or indeed crucially, how it was done.

Are care homes putting red tape before residents? To examine this, I commissioned new primary research: *Is excessive paperwork in care homes undermining care for older people?* This study (Warmington, 2014) examined the practical impact of paperwork and explores whether it makes care homes better places to live, or reduces the amount of time staff have to devote to caring.

Here is what we found: paperwork – a lot of it. We identified more than 100 separate items of paperwork that must be

completed regularly in care homes. There's a lot of duplication and, some staff felt that paperwork was inefficiently designed or implemented. About half of the paperwork produced was used infrequently.

A most startling finding for me is the perception that it is the quality of a care home's paperwork which drives judgement and values, rather than the care it provides. Staff feel they're valued – and often promoted – on their ability to produce paperwork rather than ability to deliver quality care. This reduces residents to a 'bundle of paper and risk' and staff to defensive office dwellers. And some care home managers report spending 20 per cent of their time (a whole day a week!) on paperwork rather than on leadership activities that could improve the quality of relationships for residents.

Echoing these findings, many of the social media comments we received indicated that paperwork was excessive, time consuming, not focused on residents' quality of life and should be streamlined to avoid duplication.

Too much time spent on paperwork means less time for building relationships and improving quality of care. There was also a recognition that more paperwork did not mean that care was necessarily high quality and that "writing it down does not mean it is done well". [\[Geoffrey via Facebook\]](#)

The quality of care has to come first and, unfortunately, being in a lounge filling in paperwork is not the same as being in a lounge communicating with residents.

[\[Cognition Systems via Facebook\]](#)

Some comments highlighted the necessary role for appropriate and proportionate paperwork. They also indicated that involving residents in paperwork processes can lead to mutual benefits. One care home manager reflected on how involving residents in care planning paperwork can be mutually beneficial: "Care planning is often done amongst the residents, including them, and can be quite engaging." [\[Care home manager via Facebook\]](#)

I do also feel that paperwork where appropriate has its place. Good care planning is critical, provided that the staff are party to it, and it is alive to persons changing needs/wellbeing. We have a separate daily report at which one care plan is reviewed daily. All staff need to know what the care plan says, that it is right, that we are doing what it says, or need to change something. I often find that the original care plan has got some things wrong. The care staff know the person better, and this combination approach means that the care is better planned, communicated, driven and amended. [\[Care home owner via Facebook\]](#)

There was a sense from the comments that paperwork is currently trying to appease too many different requirements and needed to be streamlined to avoid duplication and save time and money. One care home owner states: “Personally I would like to scrap the endless forms, charts and scripts that exist, but to do so would mean condemnation from CQC and other healthcare professionals...we seem to have no choice but resort to disciplining staff for not completing care plans properly, risk assessments and/or recording what happened in the course of care.” [\[Care Home Owner\]](#)

This is, of course, a really difficult area because much of the current ‘system’ has come about through iteration, slowly building on itself over the years. When you look at things in isolation, they often make sense; you can see why it might be a good idea, but the composite is a behemoth.

**“Ironically, despite all the forms, we have almost no actual statistical or objective quality data on care homes.”**

While the care sector is drowning in paperwork, it is ironic that, nationally, we have almost no objective statistical data on who are currently living in care homes, or what their needs are. We have no useful measure of case mix, age profile, prevalence

of conditions, complexity, length of stay. Without this basic information, it is impossible to strategically plan the workforce, type of and location of future provision.

Many countries at least have an annual census or, in the case of the US, rolling case-mix data. We could consider using a standardised assessment model to understand the fundamental basics of care (such as nutrition, drug use, pressure sores, falls, depression and so on). This could give us some national information and quality indicators on the needs and dependencies of the current UK care home population, information which we have little of today. This approach may also be able to address the duplication issue – having one point of data collection, informing multiple regulatory needs with consistent, objective data.

It could provide reliable and useful data to regulators helping to target poor care and allow inspectors to concentrate on the people story when they inspect and not spend so much time in the manager's office.

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## 6. The care market comes with opportunity costs

I think the main problem is when 'caring' becomes a business... This brings along with it a whole new set of problems. [\[Rachel via Facebook\]](#)

How much does care cost? Residential care for £507 per week may sound like a lot (and it's much more than most local authorities will pay!) but it is only £3.02 per hour. I would be hard pressed to get bed and breakfast in most cities for less! And that would be without personal care, laundry, activities and emotional support, and so on.

We have, for over 30 years, had a predominantly for-profit care home sector, with a diverse mix of providers, mainly small and medium enterprises, and most in the private sector. Most are sole traders or small partnerships. The top five corporate providers only supply about 20 per cent of the care beds. The theory is that they will compete on quality; poor providers will exit the market and good ones succeed. Is this how it works?

# HOW MUCH DOES RESIDENTIAL CARE COST IN COMPARISON WITH A B&B STAY?



**Residential care** costs **£507 per week**  
which is only **£3.02 per hour**

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**B&B** average price per week based on  
three star availability for 7 nights



As a market, the care sector has some quite unique characteristics:

- The purchase is distressed and emotional, usually made in a time of crisis.
- Switching provider is a tough decision.
- Supply is geographically restricted, as people want to be near their neighbourhoods, friends and relations.
- Barriers to entry to the market are high.
- Some markets are monopsonistic (similar to a monopoly, but a large buyer; the Local Authority, controls much of the market, and drives prices down).

The finances of care homes are not complex, and it would be quite straightforward to identify financial benchmarks that would support a functional market, including a reasonable profit. We also need to do this to ensure that investment comes into the sector to replace the increasingly 'unfit for purpose' stock.

Private care homes can be excellent, but they need to operate in a functional market – one that is not just set up to compete on price; this is dangerous. If a care home is under financial pressure, there is a significant danger that corners will be cut and quality reduced.

The basics of the market need to be functional to promote competition based on quality. We need to be more open and honest about profit, about what is reasonable and set up the market to include minimum tariffs and functional commissioning practices to ensure that good care homes can be viable. We need to regulate the market in the true sense.

I think the main problem is when 'caring' becomes a business... This brings along with it a whole new set of problems, but I think that shared values and beliefs of what care is about is a good starting point for any care home/agency or service to look at closely and share with staff. [[Rachel via Facebook](#)]



I wondered before I started this inquiry how significant it was that the vast majority of care homes are ‘for profit’. I have to say that it hasn’t loomed large and people seem much more concerned with the quality of the care they experience. When this issue has come up, it has been in relation to poor care, where people connect poor quality with cost-cutting to preserve profits. If the quality is good, then the profit is much less of an issue.

## “The theory is that care homes will compete on quality.”

Some comments we received indicated there should be no profit in the care sector. Some people indicated that this factor, combined with a preference for the cheapest provider, was a key barrier to improving quality of care.

There was a sense that care homes should not be ‘too business like’ and that big providers are “delivering public services at minimum cost”. [David via Twitter]

Some felt profits were made only by “reduced care standards” and employing “poor staff”. [@womeninmind]

As long as local authorities only care about commissioning the cheapest provider then it will repeat. Local authorities enable abusive situations by driving down cost and not caring if a service can be provided for the amount they will pay. They are complicit – from commissioning onwards – in enabling the spiral of bad care to exist and then they sit back in safeguarding hearings and act as judge and jury... The local authorities who will only fund the cheapest solutions are complicit. [Sarah via Facebook]

In truth, competition usually only manifests itself in price and there is evidence that, where there is price competition, quality falls. Customers tend to have to purchase in crisis and often

geography is the main criteria. If you don't like the place, it is very difficult (and often dangerous) to move.

Care homes are not sandwich shops: they can't open and close in response to the market in a 'fleet-of-foot' way. Care homes are very financially fragile. The vast majority of cost is wages, accounting for about 55 per cent to 65 per cent of turnover (even with rock bottom wage levels). The breakeven level is high. Care homes often have no choice in the rates of pay they can offer, as even a small increase can raise the breakeven point higher and threaten viability. A small dip in occupancy levels of one or two beds can be the difference between viability and loss. When care homes have to compete on price, there isn't actually much scope for being 'efficient'.

This is the market we have created. It is not of the care homes' doing. For investment to come into the sector, for existing stock to be repaired and improved we must have a market that accepts the need for a 'return on capital'. We must be more honest about the true cost of providing good care and build that into our funding models. To not do so is dishonest and creates a financially fragile sector which has huge risks for quality.

## **“Location of care homes near to families and social networks is crucial.”**

It makes sense that, as well as being interested in *how* their care is delivered, care home residents will be most concerned about *where* their care is delivered. Also, to be successful community hubs, care homes need to be in suitable locations.

Sited near to families and social networks was felt to be crucial. Also, access for friends and relatives to visit freely and access to other “life” services (such as a hairdresser, vicar, newspapers, TV/entertainment, and so on) were also considered necessary. Access to outdoor space, fresh air and sunlight was also seen to be beneficial for the mental health of residents:

Outdoor easy access to fresh air and sunlight (vitamin D) and ideally the sight and sound of water (research shows mental health benefits for this), [\[Audrey by email\]](#)

The location of care homes is completely unmanaged. No assessment of need is done and no strategic planning of capacity is done. Consequently where care homes are is entirely at the discretion of care home operators. Consequently we have huge new institutions being built in wealthy parts of the country whilst almost no new provision in poorer communities. We are heading for a two tier care home market.

### **“There are significant ‘opportunity costs’ associated with a dysfunctional care market.”**

Employment costs in the care sector are already at rock bottom and this poses an inherent risk. Many care workers who spoke to me during the inquiry told of the relentless cost-saving pressures faced by them in their daily work. This manifests itself in low or erratic staffing levels, not covering shift shortages, rationing equipment, rationing incontinence pads, minimal basic training, and no time to reflect or invest in building relationships.

There are also some significant ‘opportunity costs’ associated with a dysfunctional social care sector. We often categorise care as a ‘cost’, a begrudged drain. I would argue that this attitude is actually costing us a great deal, not just in terms of the impact on people but on our national finances.

It is said that roughly 30 per cent of acute hospital beds are, at any one time, occupied by older people who don’t need nor want to be there. The cost to the NHS is crippling. We spend roughly 1.8 per cent (down from 2 per cent) of national expenditure on social care and 15.3 per cent on the NHS. This is not a satisfactory or sustainable situation. The care sector is inadequately resourced to step up to effectively supporting the NHS in an ageing society. It is a classic ‘ha’peth of tar’ situation.

The national expenditure on services  
in 2012/2013 was **£669.8 billion**



The amount spent  
on **NHS services**  
was **£102.6 billion**.  
As a percentage of  
spend this was **15.3%**



The amount spent  
on **adult social care**  
was **£12 billion**. As a  
percentage of spend,  
this was **1.8%**

There is much talk at present about integration of health and social care. This is essential but it requires a significant shift in resources, status and attitudes. Acute hospitals have no relationship with the care homes in their locality. They have a transactional collision every so often, when a resident is admitted to hospital or the discharge team wants to discharge, but it is not a functioning partnership. Amazing really when you would have thought that, given the challenges of an ageing population, care homes should be a primary strategic partner in any health economy.

### **“There is a business case for creating and managing functional care homes.”**

A GP visiting a single older person at 8pm on a Friday night has often no choice but to admit them to hospital for want of a bit of company and some help with eating and drinking. There is no relationship that would allow a respite admission to a local care home or indeed an immediately responsive homecare visit. This has enormous consequences for the individual and huge unnecessary cost. There is no functional connectivity between health and social care. If care homes were supported to be ‘hubs’ of connectivity in their health communities, massive benefit could accrue.

The ageing of our society is a good thing, but it brings with it challenges. The ‘dependency’ ratio in the economy is changing and more and more of us will have elderly friends and relatives who will need care. If we persist with a bottom-dollar social care system, we will drive significant cost and inefficiency into our economy. We have recognised for a long time that adequate child care is essential in allowing families, particularly women, to engage with the labour market. Without a functioning social care sector, one in which we have confidence, more and more economically active people will be excluded from work to provide caring responsibilities.

It is estimated that the current funding gap in social care is £2.8bn per year (approx. 0.178 per cent of GDP). Sounds a lot in

a time of austerity. But we are still a wealthy country. How we spend our money is a political decision, not a scientific definite. The sector simply needs significantly more investment, not just from the moral perspective of ensuring we are adequately caring for our older citizens, but because the opportunity cost of an impoverished care sector is huge for the NHS and the economy.

Funding for social care and care homes was highlighted as an issue by a number of respondents. Comments related to the view that funding goes to wrong places; that funding should be sustainable; that there should be no profit in care; and that there simply is not enough funding for the social care sector.

The impact of local authority funding is a critical factor ... councils [are] looking to the NHS for funding. We have been struggling ... to align and join up health and social care budgets and we must do this to ensure choice, quality and flexibility in caring for older people. Many older people who become ill would recover better if they had Hospital at Home in their care home, and the saving on hospital admission should be diverted to the care sector to pay for this. [\[Janet via Facebook\]](#)

I don't think we can be silent about the role of statutory agencies in this. They apply constant downward cost pressures on providers, they will insist on placing people in the cheapest facilities. [\[Sarah via Facebook\]](#)

Concerns were also expressed about the lack of sustainable funding for the care home sector and how achieving good quality care should be the key driver rather than an emphasis on profit:

Sustainable funding is also crucial. Private social care is a lot more common than private health care, as entrepreneurs realised it was a growing market. This is not necessarily a bad thing as long as the driver is care, not £££. [\[Age UK via Facebook\]](#)

It was also felt that there was a need for new systems and a change of approach to improve the sustainability of funding for care, given the increasing ageing population:

Our country cannot bear the ever-increasing costs of caring for an ever-increasing population that expects care to be free. We have to wise up to these facts. Care will never be a rewarding career financially, we as a society have to give more back for free to our elders. We need to have an insurance scheme we pay into if we want good care in our old age. [\[Angela via Facebook\]](#)

There was a suggestion that the government fails to acknowledge the true cost of care, and a call for increased public sector funding in line with the policies that will increase retirement age:

On the face of it, the professionals have to up their game, the government need to increase finances. Please do not forget that policy now is to increase the retirement age so where are all the volunteers going to come from? Unless it is as is happening now, that people out of work [will have to] go and work in care homes in order to receive job seekers allowance. This all spells disaster. [\[Angela via Facebook\]](#)

I worked out that for board, lodgings, food, water, care staff 24 hours, light, heat, laundry, activities... a home was being paid £2.20 an hour, that is what social services would pay! I would defy anyone to provide all those services for that price. [\[Sarah via Facebook\]](#)

There is a business case for creating and managing functional care homes. The market is one we have created but it doesn't work. The market should be managed to create what we want – good, viable care homes in the right places; crucially too, care homes with the skills and capacity to support our ageing communities and our NHS.

We need to regulate the care home market. We do it for trains, utilities, aeroplanes? *Why not care?*





# MAKING A BETTER FUTURE – CONCLUSIONS

If planes were falling from the sky, we would be getting right to the cause of the issue and solving it.

So why have we neglected our care home sector for far too long? It is dysfunctional and unfit for our 21st century society and in need of significant change. We can no longer rely on exceptions; we need to fundamentally strengthen the foundations of the sector to promote relationship-centred care of the highest quality, consistently and commonly.

Care homes continually attract criticism as being institutional, de-personalised and closed places. The never-ending series of scandals further exacerbates the sense of a permanent crisis. But what is our response? It seems to me that the response is a deficit response – more sanctions, more bureaucracy, more blame, more shame – more *doing to*. This is creating a culture of fear and insecurity, squeezing out the human. But it is the human that matters most.

From my experience of working in care homes, and from the evidence I have heard over the course of this inquiry, there is plainly a confused ‘ethical environment’. Giving care to another person is a human-level relationship, but the current system appears to fail to recognise or support this. The ‘mission’ should be the nurturing and nourishing of good personal relationships; that is what older people say they want, and it is indeed what motivates people working in care homes. It is what I would want too.

There are many great care homes but sadly not enough are good enough. From my personal experience, those that are really good have inspirational people working in them. We need to make sure that this is common and that poor care homes

are rare and short-lived. To do this, the system needs to allow the great to flourish.

The system is not supporting the mission – it is concentrated on blame and defence, not good quality care. The underlying problems are ignored, unrecognised. Real change is needed. But the power to enact change is scattered across the system. We need to come together to make our care homes better.

### **It's all about people and relationships**

People living in care homes – and one day, one of them might be me and you – are there because they need some help with everyday things: exquisitely personal, everyday living that we take for granted. It is vitally important not just that the help is given, but how it is given: with dignity, mindfulness and respect. Also, with personality, engagement, and the human touch. That bit of a chuckle, that sharing of life, gossip, is what makes a life – we mustn't squeeze it out. This is the mission, this is the purpose. Whatever we do must support the quality of relationships. Nothing we do should get in the way!

The system should fundamentally support relationships between care homes, relatives and residents. You can't tell people to be kind – you have to make the whole system kind.

### **The workforce who give care are people too**

It seems obvious, but we are not doing it: the best way to get the safest care for us all is to have the right people, with the right support, in the right culture.

If we want good relationships, kindness, compassion and empathy, the people who give us our care need to be cared for and supported themselves. If they are not, they won't be able to care for us well. We have to accept this and recognise it. We need to make sure that the people who care for us are paid properly, supported properly, respected and that they are given the space to allow their natural qualities to shine through.



The manager of a care home is the key component of quality. A huge amount is expected of them. The system needs to support them, not hinder them. They need to be recognised for their expertise. Without a better system, this key component of quality will be missing. Without the best managers, care homes can't succeed.

### **People who feel involved feel happier**

We have isolated our care homes, excluded them from our communities. In doing so, we have excluded those living in them too. We have also taken a huge potential asset out of our health and welfare system. Care homes need to be brought in from the cold. They must be part of our communities and be able to contribute to our communities. We must break down the barriers and allow them to be more open and confident. The 21st century care home resident won't want to be only surrounded by other residents and staff; they will want to be connected.

Think personal. If you were to need care, what do you want it to be like? Keep this in mind when you engage with care homes.

### **Emotions and attitudes create empathy and are hard to measure but they are really important**

We need to recognise that this is a human business with human frailty. We need to be more realistic about risk and how we engage with it. We must be able to understand better the difference between evil and a mistake. Our lives are risky, things go wrong. They go wrong in care homes sometimes too. Just because we cross the threshold of a care home doesn't mean we shouldn't still have some risk in our lives.

Our well-intended but misguided over-reaction to risk in care homes has created an 'everyone is guilty and under suspicion' culture. This is deeply damaging to our ability to promote good-quality relationships.

## **Top-down, outside-in regulation is not working**

I have been working in care homes long enough to have seen many approaches come and go aimed at ensuring quality of care. We've had at least four regulators, maybe more. The demands on care homes in terms of paper and bureaucracy has increased substantially. No one has ever approached me and said, "What could we do to help you improve the quality of care?" Each new regulatory framework recalibrates the sector, re-defining quality in terms of the criteria of the day. Each new framework has everyone running around trying to understand it, trying to get the right answers, create the right paperwork for the inspector. Far too little is done to ensure the fundamental conditions required to promote good care.

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

I can see the dilemma for regulators. Although most care homes respect and take heed of inspectors' advice, some resist all intervention, heading straight for the lawyers. This adversarial approach infects the whole system, leading to the endless cycle of more paper and more compliance.

## **The care market comes with opportunity costs**

The market is erratic, chaotic and unresponsive. It is not providing what we want it to provide. We need to look at it again. 'For-profit' care can work; I've seen it. There is good and terrible in all sectors of the market.

A functional, quality social care market could ensure the long-term viability of the NHS, significantly add value to the performance of the economy and, most important of all, give all of us the chance of receiving the compassionate care we desperately want when we need it, where we need it.

We need to understand much more about the needs of our care home population in order to be able to plan strategically for our ageing society. Where care homes are, what they do and how they fit into the wider health economy is vital.



## APPENDIX: SOCIAL MEDIA METHODOLOGY

The specific social media I used to engage with people included a Facebook page, my own Twitter account, and several blogs on the JRF website. The blogs attracted comments which were also shared on Twitter and Facebook, where feedback was captured.

I also wrote 11 blog posts related to the subject of the inquiry on the JRF website. The purpose of the blogs was to test thoughts, assertions and themes coming out of the inquiry.

### Blogs

We received 48 responses to the 11 blog posts – quite a high response for JRF blogs – the titles of which are listed below in Table 1. These blog posts prompted a number of email contacts and generated a total of 1,122 tweets (and many more re-tweets), 363 ‘likes’ on Facebook and 65 ‘shares’ via LinkedIn. The most popular blog described the “10 most important attributes of a good care home” (15 October 2013) which generated 334 tweets and 61 ‘likes’ on Facebook.

Social media was used as a means to get responses to whether people think what I am saying is absolute rubbish and I’ve got the wrong end of the stick, or whether they think, “Yes, actually that feels about right, we should do something about it.” I have to say that, in the vast majority of cases, the responses that came back were supportive of the assertions being made, that are being tested.

Blog title	Date posted
New year, new care sector?	5 January 2012
Time for a revolution in the UK care sector?	25 April 2012
The Big Care Home Conversation: have your say	22 May 2012
Why we’re committed to paying the Living Wage	5 November 2012

Blog title	Date posted
State of care in Britain today – we need a revolution	23 November 2012
We need a plan to care for our aging society	8 May 2013
Help me find out how to address the UK care crisis	21 May 2013
Can we really improve care while support staff are treated so poorly?	10 July 2013
The 10 most important attributes of a good care home	15 October 2013
Why care homes are putting red tape before residents	27 February 2014
Why are essential social care workers so undervalued?	17 April 2014
National Care Forum Blog – Bringing quality to life	21 May 2014

## Facebook and Twitter

The Facebook page attracted 155 ‘likes’ and a total of 90 posts by others during the inquiry. The blogs were also posted on the Facebook page, with some reaching upwards of 700 users. Responses came from staff and managers in care homes, residents and their relatives.

I used my own Twitter account, and tweeted throughout the period of the inquiry, particularly in response to events, new reports or documentaries (e.g. *Panorama*) and there were 116 tweets in response these. Over the period of the inquiry, I gained over 1,000 followers to my Twitter profile.

I noted a distinct difference between the audience that Facebook and Twitter helped me to engage with. Twitter tended to elicit responses from management level and policy professionals, whereas Facebook tended to attract comments from more frontline staff, residents and relatives.





## Conversations and visits

Often sparked by the social media contact, I also had a series of conversations with people in a range of roles (from regulatory bodies to residents and staff in care homes) to uncover what they really thought about care homes and the care home sector. I spoke to a number of individuals and organisations and a selection is detailed in the table below.

During the course of the year I also spoke with a great many people in the day-to-day course of my job as Director of Care services, including residents, staff and relatives but also local authority and health staff, other providers and when appropriate used the opportunity to test ideas and gain their views.

## A selection of the people and organisations visited

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2013

21 May	<b>Community Care Live Conference</b> The UK's biggest event for social work and social care professionals. This is where the inquiry was launched; post-cards were given out, professional stakeholders talked to.
7 June	<b>Helga Goutcher (Head of Clinical Practice at BUPA Care Services)</b> Visit to Bridge House in Leeds.
12 June	<b>Heather Wakefield (Head of Local Government at UNISON)</b> Visit to see Head of Local Government at Britain's biggest trade union, twitter contact.
4 July	<b>Visits to Sheffcare homes</b> Facebook contact – Visited Grange Crescent Residential home and Paddock Hill Residential Home. Met with staff and residents.

11 July	<p><b>Meeting with Paul Burstow and Claudia Wood</b> Paul Burstow (Former Care Services Minister – MP) and Claudia Wood (CEO of Demos) are heading the Commission on Residential Care hosted by Demos.</p>
24 July	<p><b>Care Home Inquiry visit at a care home in Malton</b> Member of staff emailed John and recommended he visit The Abbey at Old Malton. Met with residents and staff.</p>
16 September	<p><b>Care Quality Commission (CQC)</b> Meeting with David Behan, Chief Executive, CQC.</p>
23 September	<p><b>Meeting with a resident of Hartrigg Oaks, York</b> A resident got in touch with John via email. Now a resident at Hartrigg Oaks, he used to work in social care and wanted to share his views.</p>
10–11 October	<p><b>Residential Forum:</b> the forum was founded in 1994 on the initiative of Dame Gillian Wagner and with the support of the National Institute for Social Work. Its purpose is to promote the achievement of high standards of care for children and adults in nursing homes, residential homes and schools, and to contribute to improving the quality of service to the public. Members of the forum are people of standing and experience drawn from the public, private and voluntary sectors, as well as some who can speak for service users and carers. John shared the inquiry and the initial ideas with the Residential Forum over a two-day event – with Claudia Wood from Demos.</p>
17 October	<p><b>Beth Britton</b> Beth is one of UK’s leading campaigners on dementia with a large online presence through her blog and Twitter following. She was one of John’s Twitter contacts and visited Hartrigg Oaks.</p>
<b>2014</b>	
January	<p><b>Meeting with Spring Hill Care</b> John was invited via Twitter to visit Springhill care group in the north west.</p>

27 January	<p><b>Phone call with Nick Acland (Henry Smith Charity) re: Quality of life in care homes</b></p> <p>Director at Henry Smith Charity (large grant-making charity) which supplies grants to projects focusing on combatting social inequality or economic disadvantage.</p>
14 February	<p><b>Andrea Sutcliffe</b></p> <p>Visit to the Chief Inspector of Adult Social Care at CQC in London.</p>
20 February	<p><b>Roundtable on working conditions of care workers (House of Lords)</b></p> <p>Baroness Denise Kingsmill CBE is leading a review for the Labour Party to investigate poor working conditions (non-payment minimum wage, zero hours contracts, etc) in care sector and impact on the workforce and quality of care provided. Roundtable with policymakers and researchers to form recommendations to improve working conditions without reducing accessibility to care or increasing care costs.</p>
5 March	<p><b>Phone call with Oldham Council re: care homes research</b></p> <p>As a result of reading his “10 most important attributes of a good care home” blog post.</p>
20 March	<p><b>Care home visit:</b> to The Partnership in Care group, Bury St Edmunds. Care home visit met with the Directors, residents and staff.</p>
14–15 April	<p><b>Residential Forum</b></p> <p>Another Residential Forum was a chance to contribute research findings to discussions with other experts in residential care sector.</p>
May	Meeting with <b>Civil Aviation Authority</b>
May	Meeting with <b>Health and Safety Executive</b>

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## ABOUT JOHN KENNEDY



John gained a degree in Economics BA (Hons) Econ from the University of Manchester in 1987 and is now Director of Care Services at Joseph Rowntree Housing Trust (JRHT) and Joseph Rowntree Foundation (JRF).

John joined JRHT/JRF in 2001 as Deputy Director of Care Services and became Director of Care Services in 2004. He currently manages a mixed portfolio of care homes, retirement villages, supported living in York, Leeds, Scarborough and Hartlepool.

Before joining JRHT/JRF, John spent 15 years working for an independent care company in the East Riding of Yorkshire. His last role in the company was as General Manager. He also previously ran his own business delivering IT solutions to the care sector and newsagents.

John's other roles include: Board Director, National Care Forum (NCF), Trustee of the Wilberforce Trust – a charity providing accommodation and services to adults with learning disabilities, specifically those with a visual impairment; Foundation Governor and Chair of the Finance Committee at The Joseph Rowntree School, York; Commissioner – York Fairness Commission, sponsored by the Archbishop of York. (Final report published 2012); And Commissioner – North Yorkshire and York NHS Clinical Services Review chaired by Dr Hugo Mascie-Taylor (report published 2011).



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For more about John Kennedy's  
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