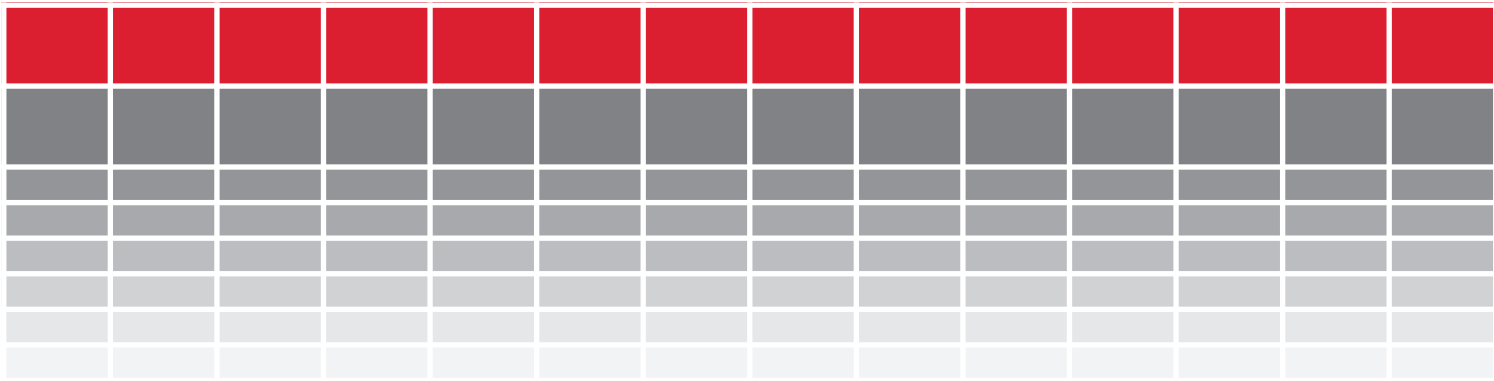


The Future of Adult Learning Disabilities Care Provision



REPORT
July 2008

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Foreword

The way we support and care for adults with a learning disability is changing. *Valuing People, Our Health, Our Care, Our Say, Putting People First* and *Valuing People Now* all contain consistent and clear messages; independence, personalisation and choice.

in Control pilot schemes have been successfully executed and over 120 councils have signed up for the national roll out. The Individualised Budgets pilot schemes are currently being evaluated. Those previously cared for in residential homes are now choosing how their care is delivered and supported living is being hailed as the future setting for all adults with a learning disability, including those of the highest dependency.

The purpose of this report is to examine the transition of this sector towards its future. We identify the drivers for change, the barriers and challenges to achieving Government targets and the feasibility of such wholesale changes.

This report debates if supported living is appropriate for all those currently in residential care and whether high quality residential care should remain as one of the portfolio of care options from which an individual can choose.

There are inherent difficulties for existing care home owners in transferring their businesses into supported living and these must be addressed. The Turnbull ruling

and unclear guidance on whether a former care home operator can deliver domiciliary care to their (now) tenants lead many providers to question the financial viability of supported living. Others question the sustainability of supported living when *Supporting People* money loses its ring-fencing next year.

With the CSCI being replaced by the Care Quality Commission in the coming months, there are opportunities to shape the future of registration and continuing regulation as opposed to reacting to it. It is time for providers and commissioners to look to the future policy of the incoming regulatory body with effective commissioning and developing good working relationships.

Whether you are reading this report from the perspective of a care provider, commissioner or interest group, I hope that you find it informative and insightful and I welcome any comments you may wish to make.



Robert Chamberlain

Editor in Chief

Care Management Matters

1 - Executive Summary

Introduction

Attitudes to people with learning disabilities have been transformed in the last decade. The Government's personalisation agenda has led many local authorities to favour placing their clients in a supported living environment in the community rather than in residential care. Some are now indicating they want all future placements to be in supported living. What impact will this have on the residential care market?

Current market

The number of people with learning disabilities is growing, as is the proportion with complex needs. At the moment 40,000 are living in residential care, 22,000 in supported living and 27,000 receive domiciliary support. Funding for supported living has risen sharply in recent years while the number of new placements in care homes has dropped.

Local authority spending on learning disabilities doubled in the last decade. At the same time councils are facing ever-greater financial constraints. Three quarters now only provide services for clients who have 'substantial' or 'critical' needs.

Trends in learning disability care

Councils are increasingly looking to place adults with learning disabilities in supported living rather than residential care, partly because it is a cheaper option for them since many of the costs are met from other funding sources.

The introduction of the *Supporting People* grant – designed to help individuals move into their own accommodation, rather than residential care, in the community – has had a big impact on the market. A number of care homes have deregistered and reconfigured as supported living in order to qualify for the grant.

Another factor has been personal budgets, which pull together all the income streams and give the user power to decide how to spend that money. This is leading to a very different relationship between the user and service provider. It could also have a big impact on councils' commissioning role.

Some now argue that all adults with learning disabilities – including those with profound disabilities and/or challenging behaviour - would be better served living in their own accommodation rather than residential care in the community. A Department of Health report by Professor Jim Mansell argues this is a human rights issue.

Future for care homes

Factors that could decrease demand:

- New costing model introduced by local authorities that seeks to standardise care home fees but also, it is believed, drive down costs. At the same time they are demanding ever-higher standards.
- The current credit squeeze could be the final straw in pushing many care home owners out of the market.
- Many feel that government policy now works on the basis that residential care is undesirable and has had its day.

Factors that could maintain demand:

- The number of people with learning disabilities continues to grow – as does the complexity of needs.
- More users are moving into the market – for instance, 3,000 patients are due to move out of NHS campus provision by 2010.
- Many believe care homes continue to provide the best and most cost effective environment for people with profound disabilities.

- There are grave doubts whether, in the current property slump, authorities will be able to find the extra accommodation needed to maintain the shift to supported living.
- Connecting thinking between commissioners and providers of care and housing. Many commissioners may struggle with connected thinking which could prevent new creative, long-term solutions.

Supported living in practice

There is no doubt that supported living is good for many people and can help to transform their lives. Studies by *in Control* suggest most of those who benefited from self-directed support had greater choice and control over their lives.

However, a study by the Joseph Rowntree Foundation found greatly increased availability of supported living but many of the shared tenancies were virtually indistinguishable from residential care. Conversely, many living alone suffered from social isolation. There was also a tension between maximising independence and maintaining safety and security.

Care Service Improvement Partnership's (CSIP) *A Measure of Success* report suggests that although the extra care housing schemes studied were largely successful, they proved to be much more expensive than anticipated. Councils were also unused to the fact that planning some of these schemes could take years.

Most local authorities are now looking to expand their supported living arrangements. Some, particularly in the North and the Midlands, are well ahead of the game. Oldham Metropolitan Borough Council, for instance, only has 20 people left in residential care. Others are taking a more gradualist approach, especially to those already in residential care.

Obstacles

Many care homes are looking to deregister and set themselves up as supported living units. But they are encountering a number of obstacles:

The Turnbull ruling raised doubts over whether landlords can charge more than the market rate for rents. This would make many schemes economically unviable.

The Alternatives Futures case suggests that successful conversion from care home to supported housing may have to satisfy a number of requirements, including that the tenant has complete control of their own property. The CSCI has issued guidance but that has highlighted other areas of uncertainty.

There are also concerns that deregistration could reduce safeguards for users. And supported living does not offer the economies of scale provided by residential care. This is leading to huge uncertainty in the market, especially among small providers. There are also concerns that local authorities are not helping sufficiently with transition costs.

Impact on user

Care home owners believe it is important to retain a mix of residential care and supported living for the following reasons:

- Residential care remains the most appropriate setting for many of those who are profoundly disabled.
- In addition some with moderate needs may prefer the security of a residential care home.
- There is the danger of limiting people's choice if residential care is cut back.
- Residential care offers a vital alternative if a supported living placement breaks down.

Comparative costs

The evidence is still unclear about the relative costs of supported living and residential care. Many of the claims that supported living is the cheaper option seem to be based on a small *in Control* pilot study involving just 31 people.

But the *A Measure of Success* study showed that many extra care housing schemes had cost far more than anticipated and often proved to be more expensive than the previous residential care option.

Staffing

The shift to supported living raises major staffing issues and poses daunting challenges for planners, managers and care providers.

The switch will require a cultural transformation among existing care home staff and has big training implications. The fear is that this change could lead to an exodus of existing staff just when services will need all their resources.

Personal and individual budgets raise another issue. People using direct payments are already employing 5% to 12% of the direct care workforce. Some see this as liberating. Others are concerned it is creating an untrained and unregulated workforce and could put people with learning disabilities at greater risk of abuse.

Conclusion

Residential care is under threat. But the extent of that threat remains uncertain. There are a number of factors that could slow down the shift to supported living, including the property slump and commissioner inertia.

A divide may be emerging. For new placements the default position now appears to be supported living. But most of those already in residential care may well remain there.

Nevertheless care home providers face a big upheaval. The biggest impact will be on small providers who can't afford to keep their options open until the lie of the land becomes clearer. If they are forced out, that could destabilise the whole market and reduce choice for the user.

2 - Introduction

There is no doubt that attitudes to people with learning disabilities and their care have been transformed in the last decade. At the heart of that transformation has been the Government's ground-breaking White Paper *Valuing People*.

Published in 2001, *Valuing People* spelt out a new deal for people with learning disabilities. Accepting that they were among some of the most vulnerable and socially excluded people in society, it pledged a transformation of services to enable them to lead full and independent lives as part of their communities.

This new future was to be based on four overarching principles: rights, independence, choice and inclusion.

As part of the new strategy the Government signalled the closure of the last remaining learning disability institutions, the NHS campuses, by 2010 and a significant shift from residential care to supported living in ordinary housing in the community.

It backed this up with extra money and new initiatives, most notably the £1.4 billion *Supporting People* programme, to support transition from institutional care to more independent living models. The programme was new however it incorporated the support cost element from rent that was retained in the housing benefit scheme.

Since then a number of wider-ranging policy initiatives, including the Department of Health's social care Green Paper, *Independence, Well-being and Choice*, the community care White Paper, *Our Health, Our Care, Our Say*, and the 2008 follow-up to *Valuing People*, *Valuing People Now*, have built on these foundations and offered greater detail on the direction of travel.

The new approach was given added momentum by the 2007 *Putting People First* concordat, agreed by nineteen government departments, representative bodies and members of the independent sector.

The overall vision, spelt out in this document, is that the state should empower citizens to shape their own lives and the services they receive. Everyone should be able to live independently, exercise maximum control over their own lives, participate as active and equal citizens and retain maximum dignity and respect.

One of the key methods by which services are to be genuinely shaped around the needs of the individual is by giving users control over the money to be spent on them. The concordat pledged that all people receiving social care would have their own personal budget by 2011.

For many adults with learning disabilities, a central plank of this new personalisation agenda is the shift from residential care into supported living – that is, group or individual homes in the community with support services either provided in-house or on an ad hoc basis when required.

Supported living arrangements have already been put in place in many parts of the country but there is evidence that, as a result of the new government drive, the number of new placements is now accelerating. Some local authorities are indicating they want all future placements to be in some form of supported living.

Indeed it would seem the question is no longer whether supported living will become the dominant care model but when and how fast will be the process of change?

And that of course raises a further question: what will this revolution in care provision mean for residential care providers?

3 - Current market

There are an estimated 800,000 adults with learning disabilities in England, of whom around 170,000 receive some form of health or social care paid for by public services.

Those numbers are set to rise substantially in coming years. The Government estimates the number of people with learning disabilities will increase by 1% a year over the next 15 years, with a 36% increase over the same period in over 60 year-olds.

At the same time the number of people needing support is set to rise, as is the complexity of their needs. One of the biggest factors in this trend is the growing number of children and young people with complex and multiple disabilities who are surviving into adulthood. There has also been a sharp rise in school age children with autistic spectrum disorders.

The latest figures from Laing and Buisson indicate that around 40,000 adults in England with learning disabilities or mental illness are currently cared for in residential homes with a further 22,000 in supported living and 27,000 receiving domiciliary support in their own home. Overall, it is estimated that 75,000 to 80,000 people with learning disabilities are living in care homes, hospitals or supported living.

Nearly all learning disability care home residents and home care recipients are funded by the public sector. Most of the provision, on the other hand, is now in the independent sector with 88% of residential care provided by the private and voluntary sectors.

Most low dependency clients are looked after in not-for-profit homes or non-corporate for-profit homes, meanwhile most corporate for-profit providers focus on intermediate and high dependency users. The fees tend to reflect this divide, ranging from £300 a week at the lower dependency end to £3,000 a week for those with the greatest needs. Around 34% of adults are living in homes outside their own local authority because of their specialist needs.

The last ten years have seen a significant increase in supported living and home care provision. The proportion of the learning disability budget spent on supported living, for example, rose from 2% to 7% between 1995/6 and 2005/6 while home care rose from 3% to 10%. Between 2001 and 2006, the number of supported living placements for people with a learning disability or mental illness rose from 14,500 to 22,245 and home care recipients rose from 16,800 to 27,000.

This would seem to have been marginally at the expense of the care home sector, which has seen a 1.7% overall fall in the same period although the independent sector's share has not suffered so much, remaining effectively static. But perhaps a better indication of future trends is the fact that the last three years has seen a steep drop in permanent care home admissions, which fell 9.2% a year during this time.

At the same time public spending on all learning disability services, including residential care has continued to rise.

In fact, local authorities' gross spending on social care for adults with learning disabilities doubled in the last ten years, rising from £1.4 billion in 1995 to £2.9 billion by 2005/6. Over the past three years, the average increase in public spending on learning disabilities has been 6.8% - higher than any other group. In the last decade, the proportion of the total social care budget spent on adults with learning disabilities rose from 13% to 16%.

That also creates a problem. Growing financial constraints are simultaneously forcing many councils to tighten their eligibility criteria, with around three quarters now only providing services to those deemed to have 'substantial' or 'critical' needs – an approach that fuels the paradoxical syndrome whereby more money is being spent on a diminishing number of clients. In fact, in 2007 four councils announced they would only fund those people whose needs were judged to be 'critical'.

However, this policy has now been put on hold following a

court ruling that one of those councils, Harrow, was contravening the Disability Discrimination Act in excluding an estimated 500 disabled people from its care. Harrow maintains it was forced into this position because of 'consistently low government grants' and is currently reviewing its options.

Nevertheless, there is every sign that money is going to be even tighter in the years to come as public spending is reined in. After expenditure level increases of 7% to 8% in

the previous three years, local authority spending on adult personal services is expected to fall to 2.7% in 2006/7 and 4% in 2007/8. This more challenging financial climate is likely to continue for at least the next three years.

Meanwhile demand continues to grow. One recent study by Professor Eric Emerson and colleagues estimated around 25,000 people with learning disabilities need, but are failing to get, places in supported housing living or residential care because of this funding shortfall.

Learning disabilities market - facts and figures

- Learning disabilities services represent the second largest segment of the UK independent sector healthcare market after elderly care.
- In 2007, the total worth of the learning disabilities and mental illness market in England was an estimated £5.6 billion in England, around 60% of which was in the care home sector.
- The value of the independent sector care home market is estimated at £2.5 billion and the non-residential sector at £1.1 billion.
- The independent sector supplies 83% of all learning disability and mental illness services by capacity and 75% by value.
- The bulk of residential care for people with learning disabilities (88%) is outsourced to the independent sector compared to 68% of home care and 23% of day care.
- 51% of council spending on social care for adults with learning disabilities goes on nursing or residential care. The unit cost of a care home placement was £892 a week in 2005/6, up 18% since 2000/1. The unit cost for home care was £346 a week, a 42% increase in the same period.
- The number of adults with learning disabilities in residential care in England in 2006 was 39,940 (down from 41,674 in 1998); in supported living 22,245 (up from 14,554 in 1998) and in home care 27,000 (up from 16,800 in 2001).
- The average learning disability care home has nine beds compared to 34 in elderly care. The average occupancy rate is 90%.
- The likelihood of someone with learning disabilities being in residential care increases with age. Around 30% of those between 20 and 29 live in care homes compared to 80% of those over 70.

The top four major providers for learning disability and mentally ill adults are:

Name	Sector	Total homes	Total Beds
Craegmoor Ltd	For-profit	154	1,760
Voyage	For-profit	181	1,414
Dimension (UK) Ltd	Not-for-profit	152	1,008
MENCAP	Not-for-profit	102	733

- Most residents who are low dependency and pay low fees are in voluntary or non-corporate private homes. Most corporate for-profit providers cater for people with intermediate and high levels of dependency. They also tend to charge higher fees.
- The proportion of care homes owned by major providers (three or more care homes) rose from 42% in 2003 to 54% in 2007. The biggest consolidation has taken place in the not-for-profit sector where 82% are now major providers compared with 39% in the for-profit sector.
- The for-profit providers manage nearly two thirds (63%) of all residential home beds.
- Newly-registered care home capacity is running at about half the rate it was in the late 1990s, reflecting a diminution of NHS capacity and the new focus on supported living in the community.

Figures from Laing and Buisson UK Market Report 2007, Mental Health and Specialist Care Services, Community Care Market News June 2008 and Personal Social Services Expenditure and Units Costs England 2005-6. The Information Centre for Health and Social Care, Feb 2007.

4 - Trends in learning disability care

One thing is clear. The increase in the number of people with learning disabilities requiring social services support combined with a tightening of the public sector purse strings means things cannot continue as they have in the past.

These pressures, linked to the personalisation agenda giving disabled people more control over their lives, are driving many local authority commissioners to seek to place people with learning disabilities, particularly those coming into the adult social care system for the first time, in supported living rather than residential care.

Although it is still unclear whether the overall costs of supported living are more or less than residential care (see chapter 6.4), for social services a big attraction is that part of the funding will come not from their own constrained budgets but from sources such as housing benefits and personal disability allowances. So it saves money on the social care budget.

The recent Local Authority Circular on *Transforming Social Care* set out the vision for a radical reform of public services within the next three years. The new-look services should, it says, 'mean that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity'.

Making this happen, it says, will mean working across boundaries to take in housing, benefits, leisure, transport and health and looking at a range of income streams going well beyond adult social services.

In fact, several new sources of funding are already in the system, thanks to the policy initiatives including the *Independent Living Fund* and those that followed the release of *Valuing People*, including the *Learning Disability Development Fund*, the *Central Implementation Support Fund* and, most importantly in this context, the *Supporting People* grant.

Supporting People pulls together housing benefit, the housing corporation grant and home improvement agency grants in a single fund specifically designed to encourage individuals to move into supported living in the community. It aims to separate out 'bricks and mortar' housing costs, which continue to be paid as rent or mortgage repayments, from the cost of housing-related support.

The funding is not available to support individuals who live in care homes. Instead it seeks to promote a supported living style of housing and support, which encourages independence and control. It is strictly cash-limited but for its first three years was also ring-fenced.

The money, around £450 million for people with learning disabilities in its first two years of operation, has had a big impact on the market. Encouraged by the new funding on offer, a number of care homes have deregistered and reconfigured themselves as 'supported housing' in order to take advantage of this new funding, which is additional to local authorities' personal social services funding.

Perhaps an even bigger catalyst in the shift to supported living is likely to be personal budgets, which hand over control of the purse strings to individual users, and in the process, turn the traditional relationship between user and provider on its head. Personal budgets allow the client to bring together a range of different income streams and then, with the support of others, spend that money on what they see as their priorities.

The proportion of users who currently have access to a personal budget, either through individual budgets or direct payments, is still small (14% of adults with learning disabilities use direct payments, for example). But the *Putting People First* concordat anticipates that by 2011 all those who qualify for local authority social care will be in charge, directly or indirectly, of how that money is spent.

Some early evidence of how this might work in practice is coming from the *in Control* pilot schemes that were set up

in 2003 in six English councils, and encourage a self-directed model of care where users have almost complete control over purchasing decisions through personal budgets.

A total of 121 councils have now joined the *in Control* programme, a social enterprise scheme set up by a number of partners including the Department of Health, and ten councils have committed to introduce personalised budgets for 50% of all their clients by 2009. Early results suggest they have already had a big impact with four out of five users saying they changed how their money was spent once they had control over the purse strings.

The authors of the evaluation suggest that if all councils adopt this approach, as is now widely expected, they will be entering 'deeply uncharted territory'. It would clearly usher in a very different relationship between user and provider. But it could also have a huge impact on councils' commissioning role since, theoretically at least, each individual budget holder would be making their own purchasing decisions. That could jeopardise not only strategic purchasing but planning as well.

Underpinning many of these moves is the belief that all adults with learning disabilities, no matter how challenging their behaviour or how severe their disability, will be better served living in the community than in residential settings.

Indeed an influential Department of Health-sponsored report from Professor Jim Mansell and colleagues (*Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs: revised edition*) argues that supporting disabled people in the community as equal citizens is an issue of human rights. 'The segregation of disabled people in institutions is a human rights violation in itself,' it claims.

Pursuing a similar theme, last year's updated government report on services for people with learning disabilities and challenging behaviour, produced by a panel chaired by Professor Mansell, states bluntly that commissioners should stop using services 'which are too large to provide individualised support or are serving people too far from their homes and concentrate instead on developing more individualised, local solutions'.

Far from accepting the argument that challenging behaviour may be a step too far for supported living, Professor Mansell argues that it is the acid test of the whole policy. 'Whether community services continue to get better depends in part on how they respond to challenging behaviour, not just in the small number of people who present exceptional problems at any one time, but throughout their service.

'If they develop the capacity to work with people who present challenges in small, local services they will keep the size of the problem to a minimum and they will provide a good service to individuals in both their mainstream and specialised services.'

If local services are not developed, he warns, 'then a trickle of expensive out of area placements will become a rush as more people are excluded from mainstream community services by being defined as unmanageable in the community... The policy of community care will be said to have failed.'

5 - Future for care homes

In 2005, one of the local authority speakers at the Association for Real Change annual conference shocked delegates by predicting that the rapid shift towards supported living meant the days of residential care were numbered.

Few people in the sector would share that apocalyptic vision. Nevertheless, there are clear signs that the pace of change is accelerating. Mencap, one of the largest providers in the field, says that its provision has shifted from mainly

residential care to predominantly supported living in the last three years, for instance, and they are by no means alone.

And that leaves many care home providers, especially the small providers owning one or two homes, deeply anxious about their future. One provider, who has been in the field for 40 years, said she had never been so fearful about the sector's future.

5.1 Factors that could decrease demand

Care homes are facing a range of pressures from different sources at the moment.

One of the most intense is from local authority commissioners who are looking to reduce the spiralling costs spent on learning disability services by introducing a new costing model. This 'cost calculator' was developed by the South East Centre of Excellence and is due to be rolled out to regions and then to all local authorities in the coming months.

The model aims to deliver efficiencies in buying residential care placements for people with learning disabilities by developing a more standardised procurement approach to accommodation and care costs.

This includes producing indicative costs for a range of services as well as on-costs such as staffing and the value of the property. So far the trial scheme has produced overall savings of around 10% on prices quoted by providers with some areas reporting savings of up to 30%.

However, the model has been strongly criticised by care home providers who feel it is too rigid to take account of individual differences and fails to recognise all the costs involved in providing high quality residential care. There is

particular concern that the extra costs of staffing and investment have been badly under-estimated. There are also real worries that the cost calculator will be too inflexible to take account of high quality, high price services and these could therefore be forced out of the market.

Critically, providers insist the calculator will only have merit if it is used as the basis for negotiation and not the equivalent of holding a gun to their head. There is even a suspicion among some that the real purpose of the whole exercise is to reduce fees to an unsustainable level and so accelerate the shift of residents into supported living.

There is also dismay that councils appear to be pressing for ever higher standards while at the same time offering significantly reduced funds to pay for them.

The English Community Care Association, which represents independent care homes, is now pressing for a protocol, developed in agreement with providers that would set out the expectations of how commissioners and providers should use the costing tool.

At the same time, care home providers are also, like all other businesses, facing a credit squeeze and falling property prices as a result of the worldwide credit crunch.

As one commentator noted, the temptation for many small providers who are already facing an increasingly uncertain future must be to capitalise now on their one substantial asset, their property, before the bottom falls out of the housing market.

There is a growing feeling among care home providers that they are between a rock and a hard place. And the Government's ever-expanding personalisation agenda only adds to this sense of entrapment. Most homeowners welcome a more person-centred approach to care, wherever that care is provided. But increasingly they feel that official policy is excluding residential care from the equation.

Indeed *Valuing People Now*, the Government's consultative document that spells out the priorities for the next three years, states explicitly that its aim is independent living 'for the vast majority, if not all people with a learning disability'.

The message that many are taking from this is that residential care has had its day. Faced with this prospect they feel they only have two options – transfer into supported living or quit the market altogether.

5.2 Factors that could maintain demand

Set against that, however, are a number of factors that could help to maintain the demand for residential care, despite this sense that it is swimming against the prevailing tide.

For a start, the number of people with learning disabilities continues to grow, they are living much longer than in the past, and because of medical advances, a higher proportion are likely to have very profound disabilities and will be highly dependent.

Another influx into the market is expected when many of those currently living at home are forced to find alternative accommodation when their elderly parents die. Moreover, the closure of the remaining NHS campuses by 2010 will see a further 3,000 people moving from in-patient NHS provision to varying models of community care, some of whom, it must be assumed, would be best suited to residential care.

Many would also maintain that residential care continues to provide the best environment for that significant proportion of the learning disabilities population who are severely and profoundly disabled or who have very challenging behaviour. This is not only because it provides the expertise and safety these clients require but also because it offers significant economies of scale. Where a user needs 24-hour support and monitoring, they would argue, the care home offers both a safer and a cheaper option than supported living.

There also have to be doubts whether in the current climate local authorities will be able to find sufficient, affordable domestic property to meet their needs for supported living. In that case they will be forced to rely on existing residential accommodation whether they like it or not.

6 - Supported living

Although most people may think they understand the term supported living, agreeing a definition is more difficult.

The definition within *Valuing People* simply refers to 'designing services around the particular needs and wishes of individuals' and that the accommodation is more likely to be small scale rather than 'congregate'. *Supporting People* goes a little further, referring to 'housing-related support to help vulnerable people to live as independently as possible in the community whether in their own homes or in hostels, sheltered housing or specialist supported housing'.

A more detailed definition is provided by Wiltshire County Council, which suggest that the key principles are that

people live independently in the community and have a tenancy agreement which stipulates that the tenant has exclusive occupation of their premises, whether that be a house, flat or room. In all cases the tenant has control over visitors and can refuse access if they so wish.

The two main models developed so far are shared tenancies with in-house support, often on a 24-hour basis and individual tenancies with 'floating' support from staff who come in to provide help, advice and guidance for a specified number of hours. In each case, the accommodation will be situated in the community, close to facilities and there will be a clear demarcation between the provision of housing and the provision of support.

6.1 Supported living in practice

The idea of supported living for adults with learning disabilities is not a new one and has been operating in parts of the UK for some time. And there is no doubt that when implemented successfully it can have a dramatic impact on people's lives.

The *in Control* programme suggests that with the right support and preparation adults with learning disabilities can thrive in a community environment.

Between January 2004 and February 2007, *in Control* helped six councils to introduce self-directed support for 469 people with learning disabilities. An evaluation of the first 31 people showed that all those in residential care had left and moved to a house of their own, while overall satisfaction rose from 48% to 98%. On average, people achieved eight of the ten goals they had set themselves in the first year and average costs were 12% lower than in the old system.

A second evaluation of 196 users, 58% of whom had

learning disabilities, appears to bear out many of these conclusions. It found that three quarters of those handed their own budgets reported an improved quality of life and a similar number had greater control and choice. Two thirds said they were able to take part more and contribute to their communities and 59% said their personal dignity had improved.

Changes in health and economic wellbeing were less marked with 47% reporting improved health and 36% improved economic wellbeing. Interestingly, people with learning disabilities who had not previously been receiving support from social services reported more marked improvements in quality of life and economic wellbeing. And, as will be discussed in greater detail in chapter 6.4, the study was unable to say whether the new arrangements were more or less costly than the old.

A number of other reports have emerged recently evaluating how supported living is operating in practice. Two of the most significant are the Joseph Rowntree

Foundation study of the impact of the Government's *Supporting People* programme and Care Services Improvement Partnership's analysis of ten extra care housing schemes for people with learning disabilities.

• The Joseph Rowntree Foundation

The Joseph Rowntree Foundation study found that the introduction of *Supporting People* had significantly increased the availability of supported living services. However, it is concerned that many of the shared tenancy schemes that resulted were 'indistinguishable from residential care'.

It emphasises that most of the tenants were delighted with their new homes and pleased with the support they received. But it also notes significant differences in how authorities applied the *Supporting People* money with some limiting the amount of support or capping the costs and others effectively restricting the scheme to those who had low support needs in the first place.

The study identified two basic models of care, both of which had weaknesses. Some of the shared tenancy arrangements were much the same as 'high-quality small-scale registered care homes'. Conversely, many tenants who were living alone were very isolated with their support staff often being their only point of social contact.

Part of the reason for this, says the study, is that *Supporting People* guidelines generally preclude money being used to provide support for either social or employment-related activities. So tenants could find themselves well-supported in practical aspects of day-to-day life but socially isolated. The problems could be exacerbated by bullying and abuse from neighbours or other members of the public.

This is particularly worrying, it suggests, because most authorities appear to envisage that in the future, supported living will be based on individual rather than shared tenancies.

Over and above this, it highlights the constant tension in schemes such as this between the desire, on the one hand, to maximise independence, and, on the other, to maintain people's safety and security.

The researchers conclude that without a significant increase in the provision of jointly-funded support and care packages (covering housing, social care and health) people with high support needs are unlikely to get access to supported living, although there may well be better provision for individuals with low support needs.

• A Measure of Success

The Care Services Improvement Partnership's Housing Learning Improvement Network examined ten extra care housing projects for people with learning disabilities funded by a £2.5 million Department of Health grant in 2004.

None of the schemes involved more than two people sharing a property and they covered a wide range of disabilities from mild and moderate to severe and profound. Some of the residents had moved from residential care.

Some of the schemes have proved to be highly successful. Residents have thrived in their new environment. Many reported learning new skills. Most appreciated the greater control and responsibility they enjoyed – even including cleaning and housework. But the schemes also threw up some significant challenges. One challenge was that the costs of most of these projects was much greater than anticipated and in some cases double that of the scheme they replaced.

The programmes also underlined the divide that often exists between social care and housing departments and the difficulties in 'understanding each other's requirements and constraints'.

It also highlighted the difficulties in putting in place effective strategies for disabled people when the need was

often immediate yet the planning involved could sometimes take years. As the authors noted, 'The need to think, act and plan development taking three or four years often does not sit well with a social care department wanting a response in days to a particular "crisis".'

They also warn of a potential tension between the logic of personal budgets, where each individual is free to make their own purchasing decision, and that of commissioning authorities trying 'to work in a strategic way to create a new kind of service'.

One other common theme to emerge from the evaluation is the critical importance of assistive technology, that is, devices such as alarms and movement detectors, to manage risks such as epilepsy or physical frailty relatively cheaply while maintaining the user's independence. In fact, the authors suggest assistive technology can be seen as 'a tool to help square the circle of independence, privacy, control and choice, while producing economic benefits for the commissioner'.

Sometimes the technology was incorporated from the start but in others it had to be added later at much greater expense. One of the biggest hurdles, says the study, was care managers' lack of knowledge about assistive technology and the possible devices and applications that were available.

What both these reports underline is that successful supported living is by no means assured and, in fact, depends on a combination of planning, partnership and adequate funding to make it work. Where any one of those factors is not present, then the scheme is likely to fail, leaving residents in a worse situation than they started in. It can also take months or even years to put in place.

One of the worst examples led to an inquiry by the Healthcare Commission into abuses in treatment centres and supported living homes within the Cornwall Partnership NHS Trust. The inquiry found that staff in

many of the Trust's 46 supported living homes were using physical restraint on clients as well as imposing a range of unacceptable restrictions such as locking internal doors as a way of dealing with people with challenging behaviour. It also identified widespread abuse in care homes and the local hospital. But the abuse in the supported living environment raises particular concerns because of the possibility of fewer staff, lower levels of regulation and less scope to monitor what is happening behind closed doors.

Nevertheless, most local authorities are now looking to expand their supported living arrangements. Indeed some authorities, especially in the North and Midlands, are well ahead of the game and have been placing all clients in domestic housing rather than care homes for some time.

Oldham, a pilot site for *in Control*, for instance, now has only 20 residents in care homes, ten of whom are living outside the borough, with around 150 in supported living and a similar number in 'KeyRing networks'. Moreover, everyone in supported living now has some form of personal budget.

Lancashire County Council has also moved the majority of its clients into the community, 335 people living in supported tenancies with 248 residents in care homes. Its policy is 'to continue to move away from [the] residential model, and where appropriate, support people currently in residential facilities to move into supported living schemes'.

Other councils, such as West Sussex and Sandwell, have unambiguously signalled their intention to place new clients in supported living, wherever possible.

Sandwell has nearly twice as many clients in supported living (123) as in care homes (74). Meanwhile West Sussex, with a much larger client base of almost 1,500, has slightly more who are supported in the community rather than in residential care and aims to shift that balance further in the coming years. Self-directed support is the 'default option', says a spokesperson, because this gives

individuals as much choice and control over their lives as possible. ‘We do make residential home placements but these are generally in response to a lack of suitable tenancy-based accommodation and are often time-limited.’

Some are taking a more gradualist approach. Surrey County Council, for instance, has around 2,500 people in residential care at the moment. Although it has signalled its view that supported living is the preferred environment for adults with learning disabilities, it recognises that residential care will also have an important part to play for the foreseeable future.

So far it has identified around 160-170 residents who could be moved into the community. But a spokesperson acknowledged it would not be feasible to transfer most of those with severe and challenging behaviour in the foreseeable future.

Gloucestershire County Council has also adopted an evolutionary approach, contracting with one care provider to set up supported living services for half its care home residents over the next ten years.

The aim has been to shape the market and encourage change while giving some security and stability to the care provider. The agreement allows for the extra transitional costs in shifting from one service to another and covers the provider regardless of the number of beds left empty by the process.

The agreement between Gloucestershire County Council and the care provider ‘is characterised by mutual obligations and shared incentives,’ notes an early evaluation of the scheme. ‘The pricing mechanism that is at the heart of the project agreement means no one party can benefit in isolation from the others... The contract transforms the rhetoric of partnership into reality.’

6.2 Obstacles to supported living

Many care home owners, often pressurised by their local authorities, are seriously considering deregistering their care homes so they can provide supported living instead or a mix of residential and supported housing. However, providers that have gone down this route have run into a number of problems that are making others think twice about following in their footsteps.

One hurdle has been the ruling in 2006 by Social Security Commissioner Charles Turnbull that Sheffield housing association Rivendell was acting illegally in charging supported living residents rents above the local market rate. This has been a common practice among providers moving into supported living as a means of covering the cost of overheads and conversion, especially for those who have had to convert from care homes.

The association had based its action on a clause of the 1995 housing benefit regulations which states that people living in accommodation where the provider also offered support were exempt from the rule limiting rents to the market rate. It claimed support was being provided on its behalf by another organisation, Supported Living Services. However, Turnbull decided the support was being provided not on behalf of Rivendell but the local council, which actually funded the support.

Several similar cases have arisen since this ruling. As providers of supported living cannot be sure at the time of accepting a new tenant whether or not they will receive the necessary higher benefit that will enable them to meet the rent, all new tenants carry an element of risk. The issue is still going through the courts and no final decision has yet been reached.

At the same time there are concerns that the chief engine of the shift to supported living, the Government's *Supporting People* grant, may be drying up. It was capped at £1.7 billion in 2007/8 and will no longer be ring-fenced in 2008/9. With the huge financial pressures faced by councils across the country there must be fears that much of this money will no longer find its way through to supported living.

But perhaps the biggest cloud on the horizon for care homes wishing to deregister has been the *Alternatives Future* case. *Alternative Futures Ltd* was a registered provider of a number of care homes that sought to deregister its homes in order to provide supported living. However, although a care standards tribunal agreed to cancel some registrations, it ruled that others had not changed sufficiently and so remained care homes. This ruling has since been upheld by both the High Court and the House of Lords.

The ruling makes it clear that converting from care home to supported living has to be much more than simply a change of designation. Separating accommodation from care will not necessarily be sufficient nor will setting up tenancy agreements with all the clients.

The key to successful conversion appears to be the nature of that tenancy agreement and whether the tenant is really master of their own property. This not only covers the right of entry to the home but also the freedom to stay in that property regardless of which care provider they use. So, for instance, tenants should be able to change their care provider without jeopardising their accommodation rights as well as retaining a care provider after moving somewhere else.

This, of course, raises a huge number of issues, not least the problems of balancing independence with the duty of care and protection. The Commission for Social Care and Inspection (CSCI) has promised to produce an assessment tool to help inspectors and care homes work out the

practical implications of the ruling. But so far this has not materialised.

In the meantime, it has issued guidance spelling out the key principles of the ruling. But this has also highlighted further areas of uncertainty. For instance, currently only establishments providing the first level of personal care – that is, assistance with bodily functions – qualify for care home registration. However, the CSCI want this criterion to be reviewed, which could lead to any of the other levels of care, from touching to emotional and psychological support, coming within the definition of a care home.

That, in turn, could lead to a review of the registration status of new or even previously unregistered services that are providing care at levels 2, 3 and 4. As a guidance alert from Lester Aldridge LLP's Local Authority Care Sector Team puts it: 'There is a clear indication that the CSCI will be looking more closely at assisted living services and may well regard units that are currently unregistered as registrable.'

In fact it seems this is already happening. A supported housing scheme run by Dorset County Council shut down last year, four years after it was set up, because the CSCI now considered it to fall within the legal definition of a care home. And while care providers agonise about the increasingly obstacle-strewn route to deregistration, many are concerned that deregistration will reduce safeguards for users since the CSCI will no longer have an automatic right to enter and inspect the premises and can indeed only enter the premises at the invitation of the user.

Indeed, as one care home provider notes, although supported living offers many advantages, the client loses some things in the transition as well. In particular, they lose some protection from the regulators and some security if they have a short-term tenancy. Another concern about supported living must be that it cannot offer the economies of scale provided by bringing together half a dozen or more clients with similar needs under one roof and then

organising the specialised care and support around them.

All this is leading to a huge uncertainty in the care home market and a very real threat of destabilisation. And at a time of huge flux it is the small providers who are most exposed. Large providers are, to an extent, able to hedge their bets and to switch the balance of provision according to the needs of the market. But for owners of one or two homes it is much more a case of all or nothing.

In addition, putting together home care packages for, say, three clients and then moving them out of a residential home could make the difference between viability and closure for a small care home. Equally, if a care provider arranges with a local authority to close three of its ten

homes over the next three years to enable a proportion of its residents to return to the community, this will still be enormously disruptive for those who remain, with many having to be transferred to other homes.

Providers are also concerned that they are being left to negotiate this transition by themselves. Many report that their local authorities are demanding change but are giving few clues as to how, and at what pace, this change is to be made. Some commissioners are offering to work in partnership with providers to support them along this road. But even here, few are offering any bridging finance or administrative help to cover the significant additional costs of running down one system and setting up another at the same time.

6.3 Impact on the user

Over and above these issues, the most fundamental question, of course, is what is best for the service user themselves? The implicit, and sometimes explicit, message in many recent policy initiatives is supported living good, residential care bad. But care home owners would put forward some strong counter-arguments:

- Although supported living has considerable benefits for some users, it does not suit everyone. In particular, residential care may offer the protection and specialist expertise required by those who are profoundly disabled and highly dependent. For these people, living in the community may simply put them at higher risk. Indeed, there are some conditions such as Prader Willi syndrome where some experts believe the clients would be in serious danger of killing themselves through over-eating if they were not able to be monitored 24 hours a day.
- In addition, others who may only have moderate needs may nevertheless prefer the care home environment because it offers greater security as well as a ready-made community.
- There are also fears that staff may not be as well managed or coordinated in the community and, because there will be less supervision, staffing levels may be reduced and users placed at risk.
- To provide genuine choice there needs to be a full spectrum of care on offer from living in one's own home at one end to residential care at the other. Indeed, it is increasingly recognised that each individual may want to move through this spectrum at different points in their lives. A policy that goes full tilt for supported living omits this crucial component of the personalisation agenda – choice. If users are to be given genuine choice about their care options, then surely residential care has to be part of that menu of choices.
- People with learning disabilities are individuals with

different needs and desires. There is no one size that fits all. One care home manager in Wales, for instance, supports nine people with learning disabilities, six of whom were moved out of hospital into the community but eventually decided this was not for them. ‘Some people’s needs are not met in the goldfish bowl atmosphere of a small family house,’ he says. ‘It is stressful for them and the staff who support them.’

- Finally, of course, if all adults with learning disabilities are placed in supported living and the placement, for whatever reason, fails or is unable to meet their needs, without any operational care homes they may be left without suitable support.

6.4 Comparative costs

The strong presumption underpinning the shift to community care, in general, and supported living, in particular, is that the cost of supporting someone in the community is significantly cheaper than in residential or institutional care. There can be little doubt that, over and above the desirability of the personalisation agenda, it is this prospect that is motivating many local authorities’ drive towards supported living.

It is certainly true that, in recent times, councils themselves have had to pay less for supported living than residential care. But this is mainly because government grants such as *Supporting People* ensure that a significant proportion of the costs are met from other sources.

When it comes to a direct comparison between the overall costs of the two systems, the evidence is much less clear. The Department of Health-backed Care Services Improvement Partnership (CSIP) claims that supported living costs ‘may be the same or less than for residential care’.

But this and several similar claims seem to be largely based on one piece of early research from the *in Control* pilots involving just 31 users. Interestingly, a second study, published in 2008, of a larger cohort of *in Control* users does not repeat the claim that costs are lower, mainly, it says, because an insufficient number of councils were able to provide the relevant data.

Clearly, one of the difficulties is actually making genuine like-for-like comparisons. Each supported living project will differ from the last because of the individual’s particular needs. Equally, care homes are far from monolithic and the unit costs of supporting people with similar needs vary greatly from one to another.

A further complication is that whereas residential care costs are fairly transparent, the very nature of supported living, involving a range of different budgets and a complex, fragmented nexus of support, makes it anything but. To some extent the costing of supported living is going to depend on how widely ‘support’ is defined.

Many in the learning disabilities field would nevertheless maintain that if like is compared with like residential care offers economies of scale – particularly for those with profound and severe disabilities – that cannot be replicated by domestic housing in the community where support has to be organised on a one-to-one basis.

This contention appears to be supported by CSIP’s *Measure of Success* study (see chapter 6.1). In many cases the people moving into supported living had previously been in residential care and one of the most striking conclusions was that time and again the costs of the move were far greater than had been anticipated and were often much higher than in residential care.

So, for instance, a scheme involving Birmingham City Council and the local branch of Mencap to provide 24 self-contained flats went well above budget. The authority says it would be 'keenly interested in cost comparisons, particularly comparing residential unit costs with supported living'.

In Dudley too, the authority expressed concern that the costs of installing two clients in a two-bedroom house proved much more expensive than residential care. Similarly, a scheme to build a block of flats for people with learning disabilities in Wakefield proved to be significantly more expensive than budgeted for.

As the report notes, there were a number of factors behind these overruns. Some of the costs related to one-off start-

up or transition expenses. It also suggests there may be some hidden residential care costs that were not taken into account. Nevertheless, this highlights the fact that individual one-to-one care, possibly involving a range of different professionals, is a very expensive business. The report urges councils to 'think creatively about alternatives to reliance on professional paid support'. Some possibilities might include mutual support, support tenants and assistive technology.

So the jury is still out on whether supported living is cheaper or costlier than residential care. What can be said is that the evidence for the contention that supported living is the cheaper option remains weak. And in the absence of hard facts, each side of the argument will continue to claim that their system represents the best value for money.

6.5 Staffing issues

The main focus of the personalisation agenda and the shift to supported living has, not unnaturally, been on the user. But there is a real danger that in the process the needs of staff are ignored.

Staffing has always posed a problem in social care. Vacancies are commonplace, turnover rapid and the skills level still relatively low.

The total adult social care workforce is now nearly 1.4 million with half working part-time and over two-thirds employed by the independent sector. Most of these staff are working as care assistants or home care workers and 83% are women. In the independent sector, the turnover rate for care workers is 22% - meaning that the complete workforce will have to be renewed every five years - and the vacancy rate is 4.5%. Regarding training, around 60% hold an NVQ at level 2 or higher.

Given the instability of the workforce the shift of learning

disability services from residential care to supported living raises a number of staffing issues, many of which seem likely to exacerbate rather than improve the situation, at least in the short term.

This year's Local Authority Circular on *Transforming Social Care* acknowledges that the future workforce 'will have to change radically' if its objectives are to be achieved, and that managers will have to 'win the hearts and minds of frontline staff' to do this.

It is vital, it says, that 'local workforce development strategies are co-produced, co-developed, co-provided and co-evaluated with private and voluntary sector partners, as well as users and carers, with a focus on raising skill levels and providing career development opportunities'. With this in mind the Department of Health, in conjunction with its partners, is developing an *Adult Workforce Strategy*. In addition extra funding is being made available to develop NVQs.

The clear presumption is that the new models of care will, at least initially, rely largely on the same cadre of staff as the old models. But this, of course, raises a number of questions. Perhaps the most pressing is whether it will be possible to make the cultural transformation necessary to equip existing staff to become enablers rather than carers. This, as everyone acknowledges, requires not simply new skills but a change of mindset in which they learn to support while simultaneously relinquishing control.

There are huge training implications for such a shift in the balance of power that has been likened to 'turning social care on its head'. The fear is that all these changes may prove too demanding for many staff, leading to a further exodus at just the time when the service will need all its staffing resources.

In the eyes of some proponents of supported living, the answer lies in personal budgets, which, in giving users freedom to choose their own care workers and supporters, could have the effect of liberating the employment market at a stroke.

Indeed there is already some evidence of this happening with latest CSCI figures showing that last year direct payments recipients in England employed somewhere between 50,000 and 113,000 'personal assistants'. That represents between 5% and 12% of the total direct care workforce.

Some see this as a hugely liberating development, which allows the individual with a learning disability and their family to take control, rather than the process being externally driven and imposed. In effect, their expertise in their condition and consequent needs becomes acknowledged and they are given the power to employ the people who will meet those needs.

But for others this raises the spectre of a dangerously fragmented service supported by a 'cottage industry' of workers with little job security and protection as well as being ill equipped for the job in hand.

There are also real fears for the user. At the moment personal assistants, unlike all other care workers, can be untrained and unregulated, and because of the nature of one-to-one care they could be largely unmonitored. They could be the user's relative or neighbour or simply someone who answers an advert in the local newsagents. There has to be a concern that this could put someone with a learning disability living on their own at a significantly greater risk of abuse.

All this is happening, of course, at a time when the statutory services are increasing the regulation and training of their workforce.

At the moment it remains unclear how many staff will be needed to drive the supported living model of care. However, it seems highly probable that it will require more people than residential care where some economies of scale apply. It also seems likely they will need a wider perhaps less specialised range of skills and that many will have to hold a number of part-time jobs to generate a living wage.

This represents a daunting challenge for planners, managers and care providers. But it is one that will have to be resolved if supported living is to flourish – choice and control for the user may be the watchwords but none of it will be possible without expert staff in large numbers.

7 - Conclusion

There is no doubt that residential care in its present form is under threat. But the extent of that threat remains uncertain. As one care home provider put it: 'The train has left the station but we still don't know what its destination is!'

There are a number of awkward practicalities that could still undermine the high-flying rhetoric of the move away from residential care to supported living.

The first is the current property market. With the credit crunch still biting hard, this is a bad time to be attempting to buy up extra housing and that is particularly so in the South East where property is scarce and expensive. It is by no means coincidental that authorities in the Midlands and the North, where housing is more plentiful, have moved much faster in implementing supported living than in the South. Although there are areas of exception such as Kent, Medway and Hampshire plus many London boroughs that have implemented supported living.

There must also be doubts whether the private providers – of either support or housing – will be queuing up to take on the new challenge, given the financial uncertainties hanging over the enterprise. Self-evidently, they will only make the very considerable investment needed if they are paid an adequate price and have clear assurances about the project's long-term viability.

So, somewhat ironically, the main housing stock that offers itself to commissioners could be vacated care homes. This, of course, raises further problems. Even where the owners are willing to make the shift, recent legal rulings have raised serious doubts about its practicality. Moreover, no matter how much it is revamped, a ten-bedded home may simply not be suitable for domestic, personal accommodation. There will also be a real need for creative and connected thinking by commissioners to find suitable provision.

It seems that faced with these obstacles, some councils are redrawing their plans and accepting that some groups,

especially those with profound disabilities and challenging behaviour, will continue to be housed in care homes. In some areas, such as Scotland, councils have even indicated they will need to recommission some care home places because of a dearth of suitable domestic housing within the requisite timescale.

The cash-limited nature of the *Supporting People* grant is also pushing some authorities in the same direction. According to the Joseph Rowntree Foundation study, for example, councils are capping the number of support hours, the amount they're prepared to pay per hour or the cost of support per person per week.

All this inevitably tends to favour those with more moderate needs at the expense of the severely disabled. Others have decided the grant can only be used for those who are not eligible for social care support. In these areas, as the authors note, 'the availability of *Supporting People* was to all intents and purposes limited to people with learning disabilities who had low support needs'.

Another not-to-be-underestimated factor in slowing down the pace of change is commissioner inertia. The fact is that most social care resources are still tied up in block contracts. To dismantle that whole edifice in order to allow individual users to make their own purchasing decisions through direct payments and then to plan individual, tailored solutions to each person's unique needs goes completely against the grain of all past council planning. It is going to be a monumental task and it is not even clear they currently have the necessary expertise for the task.

Although *in Control* suggests this can be done, so far it has been on a tiny scale and in just a few trail-blazing authorities. Most believe this is going to be a much slower process than the Government likes to think. And there are others who suspect that, given the financial and time constraints facing all planners, the new models of supported living may turn out to be not that dissimilar to old-style residential care.

It seems that a divide may be emerging. The default position for new placements, apart from possibly the most severely disabled, is increasingly becoming supported living. Meanwhile most of those who are in residential care look likely to remain there, with the exception of some with mild or moderate disability.

That in turn suggests that, given a likely over-provision of care home beds, the prospects for new companies coming into the market offering residential services is limited. Even here, though, there may still be room for niche specialist areas to emerge.

Nevertheless, there is no doubt that all care providers face a massive upheaval in the coming years. And most agree that in residential care the changes will have the biggest impact on small providers who cannot afford to keep all options open until the new landscape has become clear.

Many of the large companies have already diversified so that they now operate a portfolio of residential and

supported living schemes, allowing them to shift the balance of provision according to the prevailing needs. But small providers do not have that luxury, leaving them far more vulnerable to being squeezed out of the market altogether.

That would not only spell disaster for the owner and residents of the home. It could also destabilise the market.

If small providers are forced out, their business will at best be bought up by one of the larger providers and at worst be lost to the market altogether. It will also deprive the market of much-needed expertise and commitment. And critically, their disappearance would leave a big hole in the spectrum of care that commissioners are able to offer people with learning disabilities.

The ultimate irony is that this would mean significantly less, rather than more, choice for the user.

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