

# **The Development of Relational Care in Formal Care Services for Older People: Its Dimensions, Role and Impact**

A Thesis Submitted to the University of Kent  
for the degree of Doctor of Philosophy  
by Published Works

*by*  
Jenny Kartupelis

School of Social Sciences  
April 2026

University of Kent student number 26017062

*This page intentionally left blank.*

## **Acknowledgements**

There are a number of people without whom my work and this thesis would never have been possible, and I am so grateful to them for helping me fulfil this ambition.

My heartfelt thanks to my brilliant supervisors Professor Emeritus Alisoun Milne, Dr Rasa Mikelyte and Dr Simon Bailey for their wisdom, patience, time and encouragement; to my ever-supportive Open University colleagues Professor Emeritus Mary Larkin and Dr Manik Deepak-Gopinath for sharing their knowledge and trust; to Rt Revd Christopher Herbert and Revd James Woodward for their guidance with the Abbeyfield studies; to the trailblazing Revd Elizabeth Baxter and the Holy Rood House community for their inspiration; to my faithful friends, particularly Wendy, Joanne and Franziska for their tolerance and humour; to my beloved family Trevor and John for their unwavering practical support over the years, and to Joy whose total enthusiasm brightens every day.

### **A note on references and citations of my work**

My published works are listed and numbered in a table (Appendix A) and cited in the text by their number in square brackets followed where relevant by page numbers in round brackets e.g. [1] (pp. 1-3).

## CONTENTS

- 1. Preface**
- 2. The dimensions, features and benefits of relational care**
- 3. Relational care and theoretical frameworks**
- 4. What distinguishes relational care from other care models**
- 5. The development of relational care**
- 6. The conditions needed for relational care to develop and flourish**
  - What are these conditions?
  - Changes in frontline practice and roles
  - Management support for changes to the role of care staff
  - Changes to the physical environment
  - Diagrammatic summary of conditions for relational care
  - Tools that promote relational care conditions and practice
  - What inhibits conditions favourable to relational care practice?
- 7. The wider impact and influence of relational care**
  - Impact on providers and provision
  - Impact on practice
  - Impact on care home settings
  - Impact on research
  - Wider influence on the older adult care sector
- 8. A critical lens on the concept and practice of relational care**
  - Structural issues: ageism and discrimination
  - Provider priorities and concerns
  - Potential tensions between human and organisational behaviour
  - Wider policy issues
  - Limitations of relational care
- 9. Reflection on the future of relational care**
- 10. Conclusion**

## References

## Appendices

- A.** Table of author's published works
- B.** Design guidelines and their fulfilment
- C.** Content of the relational care tools
- D.** A consultation on opportunities for, and barriers to relational care
- E.** Author's articles published in sector and other media
- F.** Seminars and presentations by the author

## 1. Preface

Belfast Airport, a late winter evening in 2014. My head is full of different voices and long conversations and little snippets that tell a story: “We all have a wee piece of cake together round the fire.” My overnight bag is heavy with a box of wee pieces of cake: “Take these for the journey home.”

Home. That was where I’d been in Northern Ireland, and Scotland, and various corners of England. Other people’s homes, the places they called home, felt to be their home. Or not. Over forty homes, talking at length with some 100 people: older people, care managers and workers, cooks, gardeners, maintenance people, trustees, volunteers. All part of the Abbeyfield Society, which had asked me to explore and report on wellbeing in these residential homes.

Gradually, mulling over, analysing and discussing all this information, the main reason underlying the contentment of so many people (not that all were content, that would hardly be credible) became more apparent, more coherent, more fascinating. These conversations, based on a semi-structured questionnaire, were about the minutiae of daily life, little incidents not forgotten. About the things that matter most: friendship, love, trust, security, faith, objects and places that hold a lifetime of meaning.

But above all, those that filled my head and demanded attention were about relationships. Not about being dependent, nor ceaselessly meeting the needs of others, nor fulfilling set roles; but about being part of a community based on a complex network of both giving and receiving support, a mutuality of care that valued everyone as a unique human being.

This thesis is about that initial study and how its findings, described in my first book [3] developed into the specific concept of ‘relational care’; how that understanding was further explored and developed through altogether over 140 interviews in a wider variety of care contexts [4] examining and evidencing its potential; how empirical research led to a seminal definition of the term and its key dimensions [7]; to practical tools for its

implementation in care settings [9,10]; and to capturing the influence and impact of relational care to date on older people's and staff wellbeing and long-term care settings.

## 2. The dimensions, features and benefits of relational care

Relational care is an approach to care; it has mainly been adopted in care home settings for older people. The most salient features of relational care, and those which distinguish it from other models (Section 4), stem from its emphasis on reciprocity, which enables contribution to shared relationships between residents, families, staff and the wider community. This dimension is consistent with Barnes's observation, that as caring relationships develop they 'unsettle the distinction between care givers and care receivers' (Barnes et al, 2018, p. 39). As addressed below and explored in my published works, this reciprocity must be purposefully enabled through a set of identifiable conditions: [3] (p. 69 and p.121).

The benefits of adopting relational care for those living and working in a care home include: a greater sense of security; finding more meaning and purpose in life; greater autonomy and empowerment in terms of choice and self-worth; improved resilience; the knowledge of acceptance, love and belonging and thus to an extent the re-creation of family life. These benefits arise from the principle of enabling reciprocity, and belief in the value that lives can be improved by a favourable environment (see Figure 5).

- Security in this context differs from the conventional focus on 'safety' in care settings. An over-emphasis on safety can limit the sense of control, choice and pleasure older people have in daily activities whereas security 'is rather different [from safety] in an emotional and practical sense; it is about... feeling known, accepted and part of a stable community' [4] (p. 24). This interpretation is closely related to ensuring dignity and trust, recognising the need for older people to contribute actively to life, rather than being passively 'kept safe'. My studies and the Open University (OU) research [7] identified practical approaches to enabling older people to contribute to their community in a secure way by constructively interpreting safety. For example, enabling residents and staff to cook and share together in the lounge [3] (p. 72) or a 'farmhouse kitchen' [4] (p. 72). Such interventions provide the security of knowing choices and preferences will be respected by mutual agreement rather than imposition. 'One lady wanted to brush the floor, and I asked why she wasn't allowed;

the member of staff said: “Health and Safety”, so I said, that lady’s been using a broom since before you were born probably. So I gave her the broom, and she did an amazing job; it’s become her job every day, and she has a sense of purpose (manager)’ (ibid. p. 73).

- Meaning and purpose in life are promoted by mutuality, with all members of the community of care being known and respected. ‘A good quality of life may be dependent on health, family, and so on... [but] most people will look beyond these issues and talk about ‘meaning’ in their lives: a feeling of purpose, belonging or fulfilment’ [3] (p. 42). In [4] I explore this concept in more detail (pp. 17-19) concluding that ‘Environments and interactions that sustain meaning in life are a critical part of relational care’. ‘Residents get purpose from having roles and jobs’ (care worker) and ‘I don’t want them to come here to die. I want them to come here and live’ (manager) (ibid. p. 19). ‘Making lives meaningful in old age is new. It therefore requires more imagination and invention than making them merely safe does’ (Gawande, 2014, p. 147).
- Resilience – the ability to recover from or adapt to adversity and change, for example managing a major life decision such as moving into a care home without feeling overwhelmed or disempowered – is promoted by relational care. ‘Resilience occurs when an individual experiences stressors and... cope[s] with them in a constructive manner’ [4, citing Storlie, 2015] (p. 19). Giving choices over daily life such as menus, decoration, and use of personal items confers power and self-worth, which in turn builds confidence in being able to tackle and survive major decisions. Milne (2020, p. 40) discusses the multi-dimensional nature of resilience, which relies in part on ‘emotional bonds with others and [feeling] part of the community’, which is a good summary of the state relational care engenders.
- Greater autonomy refers to a belief that one’s needs and decisions are recognised; it is therefore linked to the concept of agency. Again, this underlines the inevitable overlap between dimensions. The importance of older people and care workers alike

believing they are recognised as valid actors is explored in [3, 4] through examples from my work, such as ‘the team has brought [me] richness, people, skills and resources’ (clients of a community care team) [4] (p. 42) and ‘I’ve still got my marbles and I’m perfectly capable of doing things’ (ibid. p. 64). Ensuring choice and affording the dignity of then respecting it are presented in [4], (pp. 24-25) for example: ‘We had a lady who didn’t want to attend any meetings or activities, and it was important to respect that’ (manager) (ibid. p. 25). Promoting choice clearly affords greater autonomy: ‘people like to be cared *about*, not have care *done* to them’ (ibid. p. 42). Carers can consciously make it easier for an older person to control choices and decisions; sometimes referred to as ‘re-agency’, this is explicitly linked to relationships, whereby others recognise those decisions as valid.

- Empowerment – restoring or supporting the sense of self-worth and value as a person - is a critical factor in relational care. Casting one person as a ‘collection of needs’ to be met devalues them, while at the same time also devaluing the care worker who is cast into another set role. Inadvertently undermining the status of older people by depicting them as frail or vulnerable is widespread and was particularly prominent in the pandemic as a ‘shielding’ strategy. These issues are highlighted by the Centre for Ageing Better (Section 8). Similarly, care work is continually undervalued in terms of the skills needed and by casting it as ‘dirty work’. This sets up a dichotomy which is not true of a natural human relationship and forces people to enact roles they would not choose for themselves. A key facet of relational care is its ability to address dis-empowerment by challenging these imbalances and dichotomies through recognising the mutuality and reciprocity inherent in the care relationship.
- Re-creation of family life and the sense of belonging was frequently cited by interviewees in both my studies [3, 4] as desirable and as a benefit to be enjoyed in itself: ‘It’s like working with my family’ (carer) and ‘the carers are like family’ (resident) [3] (p. 66). Similarly, the sense of belonging was seen as critical: ‘Food and shelter may be basics, but then we start talking about relationships.... our sense of belonging. That’s the real stuff we should be providing’ (manager)’ [4] (p. 66). However, family life is not perfect and being together had to be balanced with respect for preferences

between privacy and company, for both older people and care staff: companionship ceases to be a pleasure if it is not an individual's choice. This applies equally to care staff, and the design guidelines generated by the study in [3] make this clear by calling for a variety of communal areas for residents and a 'retreat' for staff (ibid. p. 150).

A note here about the concept of empathy: while it is essential to relational care, it is not sufficient, nor a unique feature. Literature on health care, particularly nursing, references the critical role of empathy, for instance Cluff and Binstock, (2001, p. 21): 'Caring must address the emotions, and *empathy* is the characteristic term chosen to convey this.' While relationships would not flourish without empathy, and the practice of relational care encompasses this element, there is a clear distinction as empathy in itself does not create or rely on a two-way interaction. Watson (2018, p. 281) speaks of nursing older people as 'the truest form of nursing' because 'dignity, support, care, tenderness and respect matter most', describing some of the key elements of relational care but not referencing reciprocity, the dimension most clearly distinguishing it. Reciprocity is explored in more detail with reference to ethical models in the section below.

### **3. Relational care and theoretical frameworks: Ethic of Care, Practical Ethics of Care, the usage and delineation of ‘reciprocity’**

In this section my aim is to situate relational care in two relevant theoretical and applied ethical frameworks and to further explore its foregrounding of the concept of reciprocity. Relational care can be situated in a number of accepted ethical systems. For example, Aristotelian virtue ethics focusses on the moral character of the individual for its own sake rather than in relationship to others; utilitarian ethics considers the generation of overall happiness (or utility) in a society, and is concerned with aggregate rather than specific, individual needs; deontological ethics references the importance of moral principles in their own right, and their effects on each individual as an ethical entity rather than on interpersonal activity. In [3] (pp. 20-21) I consider relational care in the context of justice ethics (Barnes, 2019) and of Gallagher’s history of nursing ethics (Scott, 2017).

The previous section addressed the key concept of ‘reciprocity’: neither transactional nor transient but sustainable and mutually sustaining, with everyone in a community of care enabled to both give and receive through a network of relationships. To situate this concept of reciprocity within contemporary ethical approaches, I draw upon Joan Tronto’s ‘ethic of care’ and Molterer and colleagues’ ‘practical ethics of care’. These two frameworks offer a theoretical platform for exploring the nature and benefits of relational care and the environment which is required to create and sustain it. I then consider further the usage and delineation of ‘reciprocity’ in the context of relational care.

#### **‘Ethic of care’ (Joan Tronto)**

Milne & Larkin (2023, p. 125) outline Fisher & Tronto’s definition of ‘an ethic of care’ as having five core elements: attentiveness, responsibility, competence, responsiveness and solidarity. The elements of ‘trust’ and ‘respect’ (ibid. p. 126) were added subsequently. Drawing on the ethic of care, Tronto cites the suggestion by Barnes (2012), whose work is discussed below, that ‘care... is a product of interdependence

and reciprocity', (ibid). This reflects Tronto's definition of 'good care' as a moral orientation challenging the traditional understanding of care relationships as a 'dependent' person needing care from another 'independent' person' (ibid. p. 127).

Tronto herself states that 'care is always about meeting needs, and it is always *relational*' (2015, p. 4). However, while this theory embraces the possibility and value of a two-way flow, she describes a macro frame of overall lifetimes and state-wide society, that promotes and facilitates 'good care' alongside a micro care context between two people. Her answer to the question 'How can we turn this [situation] into something that is equal?' (ibid. p. 13) is that 'balancing of roles can occur on a social level' in an 'ongoing pattern of care' ...[so] that we can *trust* that over time, we will be able to reciprocate the care we received from fellow citizens, and they will reciprocate the care we've given to them' (ibid. p. 14; my italics).

This theory relies on the probity of individuals and groups to give and receive care freely, as required, so having received care when young, ill, or otherwise in need, they can give care when they have the capacity and expect, in return, to receive again themselves later in life. This implicitly rejects the transactional dynamic, as does relational care, but rather implies a 'gift economy', where there is not the expectation of 'repayment', but rather where there are accepted norms about the likelihood of giving and receiving care at times of 'need'. This model would seem to rely in part at least on the state supporting, or at least not undermining the possibility of such a gift economy.

While relational care is broadly consistent with and situated in Tronto's ethic of care, it - distinctively - places emphasis on every care interaction being reciprocal of itself, such that in individual care situations, each participant gains the immediate benefits of being able to contribute to the other, with the potential for improved self-value the interaction engenders. A relational care approach also helps to address the issues that Tronto raises about the risk of reduced status of people receiving care: 'When people are vulnerable, needy ... they somehow slip beyond our assumptions about what defines a "citizen"' (ibid. p. 15). The types of reciprocity underpinning Tronto's macro dynamic and distinguishing relational care are addressed later.

Tronto's solution to resolving this risk is primarily political: to address the current ideology of 'market-foremost democracy' (ibid. p. 19) by state support for households and communities to care for those who need it, reframing citizenship as 'throughout life'. A key challenge to this proposal is an expectation that the state can be trusted to 'hold the ring' and accommodate the process of care through time. If it cannot provide this support, care is privatised – left to the individual and the family to fund and/or provide. In the realm of family care, this privatised model currently dominates: there is little state support for carers and the attendant risks of exclusion, poverty and non-citizenship prevail.

Paid care reflects these risks too. It is worth noting that Tronto describes care as conceptualised by many as being 'dirty work' (ibid. p. 19). One implication is that of a social taint: the work is largely performed by stigmatised groups, and/or the groups who do it become stigmatised, creating a recursive cycle. At the same time, it is genuinely 'dirty' insofar as much personal care is about managing bodily functions and restoring cleanliness. Relational care can contribute to ameliorating this imbalance; moving away from a task-based approach helps to build more meaningful, sustained relationships into the work patterns.

An important assertion by Tronto is that 'care does not happen .... one-on-one between a single, powerful caregiver and a single needy care receiver. This kind of dyad gives rise to a ... outcome of domination' (2015, p. 35); she suggests subtle negotiations to break down hierarchies. Relational care can [4] (pp. 40-50) benefit from flattened hierarchies but also helps to prevent the inherently imbalanced dyad by ensuring that both people retain their sense of autonomy and self-value.

My work is focussed on paid care. While Tronto is primarily concerned with unpaid family care, she does explore how both paid and unpaid care form part of the social continuum that requires balance over time and within a defined care landscape. Interestingly, Milne and Larkin (2023) - although focusing mainly on family carers - propose there is need for an increased emphasis on reciprocity during (at least) the final

care stage if this shifts to a paid arrangement. Staff need to learn about the nature of the older person if they are to be enabled to treat them with ‘respect and dignity (which are) pivotal to good quality care’ (ibid. p. 135).

In contrast to Tronto’s exposition of care ethics based on reciprocity and balance occurring over time within a life course embedded relationship and a just and democratic society, the distinctive nature of the reciprocity of relational care imports the same ethical features into individual and small-network relationships, in a context where they are sustainable and more immediately rewarding. It aims to facilitate trust (conferring what Tronto might call full citizenship) in the micro context of a (formal) care relationship on a day-to-day basis. This does not mean that individual caring relationships in, for example, residential homes are not influenced by societal norms and structural inequalities; they are, in part, dependant on their immediate environment and are inevitably affected by societal attitudes to older people needing long term care (Section 8). Rewarding care relationships are dependent, to a large degree, on being ‘given permission’ by attitudes and cultures prevailing in their immediate setting or community. Embedding them in a specific environment shapes and influences care relationships thereby creating a ‘beneficial circle’.

### ***‘A Practical Ethics of Care’ (Molterer et al)***

Considering relational care through the lens of a practical ethics approach (Molterer et al, 2020) - who themselves reference Tronto’s understanding of ‘care as social practice’ (p. 97) - provides insights into a small community of practice, in contrast to a sovereign state.

They argue that ‘good care’ in care homes arises from two different practices in contest: one inspired by a ‘professional logic of care’ that aims for justice and non-maleficence; the other by a ‘relational logic of care’, which attends to the quality and meaning of interpersonal connectedness. ‘Along this distinction, previous attempts to improve the quality of care... unfolded as a struggle between two different and supposedly conflicting ‘logics’... each based on a different ethics’ (ibid. p. 95). Within this dialectic

between the two, ‘reciprocity is attached only to the relational logic, which embraces ‘mutually caring subjects’” (ibid. p. 97).

Their proposition thus sets up a dichotomy between two types of care logic, which I will argue may not always exist and where it does, the practice of relational care may be able to bridge between the two without taking the approach the authors propose: “tinkering’ between different ‘goods’ [and by implication logics]’ (ibid p. 97). The ‘professional’ logic, they note, ‘invites... task division’, while the ‘relational’ is less instrumental and much more mutual: ‘One moment you care and the next you are taken care of’ (ibid. p. 96). This makes the relational logic of care sound very similar to relational care, but as we will see, relational care can sometimes bridge and sometimes blur the distinction between the two logics.

The authors explore their proposition through observational research in a German residential care home for older people, where one of the team worked over six visits of three to four days taking ‘extensive field notes’ and having ‘various informal talks with different people’ (ibid p. 99). Their numerous real-life instances in fact reveal an important role for relational care in that it can ameliorate the need for ‘juggling’ and ‘tinkering’ which they advocate as a way of balancing between the two logics. I will take just two examples.

The first concerns their contrast between ‘drawing boundaries’ (‘professional logic’) and ‘integrating others’ (‘relational logic’). With relational care practice this need not present a dichotomy: because relational care involves dynamic understanding between two individuals, it enables sensitivity to boundaries while also being integrating in terms of drawing people into a sense of community. A second example: they describe attention to the autonomy of patients as being specifically confined to ‘professional logic’, yet one of the distinguishing features of relational care is that its mutuality can restore autonomy through engendering self-worth (Section 2).

### **Reflections on the two frameworks and relational care**

Considering relational care through the lenses of both Tronto's 'ethics of care' framework, which is universal and widely influential, and the smaller scale 'practical ethics' framework (Molterer et al., 2020) gives further insights into the potential of relational care. It enables more immediate benefits than an overarching model such as Tronto's and avoids the continuous interplay of decisions that juxtaposes 'professional' and 'relational' alternatives to achieve the best outcomes in a small community of care. One could argue that relational care is less ambitious than Tronto's vision as it focusses on change in the immediate environment, but it has the potential to influence wider practice.

### **The usage and delineation of 'reciprocity'**

Exploring, and further situating, relational care through the lenses of these two frameworks, foregrounds consideration of its central component: reciprocity. As we have seen above, Tronto recognises caring relationships between individuals - 'care is ... always *relational*' (2015, p. 4) but primarily frames the giving and receiving of care as 'balancing' (ibid. p. 14) across a life course and community; 'balancing' is not a description I use, as it is not a long term aim of relational care. Molterer et al (2020) describe a small community, the care home, but are concerned with balancing two 'logics' of care: the professional and the relational.

Situated in the broader ethics of care, relational care is consistent with the frameworks presented by both Tronto (2015) and Barnes (2012) but offers a unique point of development, starting from the 'bottom up', drawing on inductive processes rather than conceptual ones, yet reaching very similar conclusions. The reciprocity on which relational care centres is the moment of interaction – which may or may not be task-based – between two people or within a small group, that happens in a community of care, an example of which is the interaction between Joan and Sally in Section 6.

To distinguish further the place of reciprocity in the definition of relational care, it is also helpful to look at Barnes' (2012) writing; *Care in Everyday Life: An ethic of care in practice*. Considering the differences and similarities with her usage of 'reciprocity' with

that pertaining to the same terminology in relational care helps to distinguish the nature of the latter. It also helps to highlight the potential impact of relational care, which provides the essential lived experience that Barnes identifies as lacking in policymaking by politicians and public officials (ibid. pp151-152).

I believe I have been able to make a new and distinctive contribution to understanding the role of reciprocity in care interactions. I have positioned it as central to relational care. It emerged from, and was in turn developed by, my extensive in-depth qualitative fieldwork as described in Section 5. It is important to acknowledge that reciprocity is not unique to relational care. Barnes explores its usage in a range of contexts (see below). Her example of its use by Pettersen & Hem, who argue that ‘mature care calls attention to, among other things, the reciprocity of interests’ (2012, p. 78), is also relevant.

I have used the term ‘reciprocity’ specifically to describe the process of both giving and receiving recognition and response as an individual during a care interaction (of which there may be many over the time of that particular relationship). It does not describe the enactment of a care task such as assistance with cleanliness or dressing, nor is it transactional, but is about the recognition of each person by the other as a unique and valuable individual. This can occur in a number of relational interactions: during a care activity; during encounters in the care environment e.g. when older people sit together, perhaps over a jigsaw puzzle, in a lounge or garden; or when care workers have a conversation during a break.

It is this process and its facilitation which is both underpinned by, and generates, the benefits of the relational care dimensions described in Section 2. This ‘reciprocity’, which is present in small individual daily encounters, helps to promote broader relational connectivity in the wider world of the care home. Writing of my work, Gray says that ‘Care as a *relationship* is central to the work of Kartupelis (2021) on ‘relational care’. She calls for radical change in the care industry – for recognition of human interdependence; the need to do things *with* people rather than *to or for* them, focusing on them being respected in a framework of love and trust’ (2025, p. 96).

Barnes considers care to be ‘a collective responsibility’ (2012, p. 168) and a ‘relational practice’ (ibid. p. 35) and uses ‘reciprocity’ to describe many types of care-based encounters, from close and sustained interactions to ‘the comfort of strangers’ (ibid. p. 116). She also explores the use of the term ‘reciprocity’ in a variety of formal and informal care situations; in education and nursing (ibid. pp. 78-81), friendship and kinship (ibid. p. 88), input to decision-making about how one’s community is run (ibid. p. 99), and sharing experiences of living with mental or physical illness (ibid. p. 116). Barnes acknowledges that, ‘Reciprocity, like care itself, is subject to different meanings and interpretations’ (ibid. p.168).

The concept of responsiveness, which is Tronto’s fourth principle of care, resonates with relational care. This is extensively discussed by Barnes, who - in summary - takes responsiveness to mean attending to the specific needs of the person being cared for, not only practical needs but also feelings; not imposing what the carer thinks they need. Barnes says, ‘The principle of responsiveness refers to the need to understand how those receiving care respond to it – that is, it emphasises care *receiving* as a key part of the practice of care’ (my italics) (ibid. p 162).

Responsiveness is a key component of relational care; an inability to understand and respond to the needs of the other person would preclude reciprocity, which is delivered via responsiveness. However, responsiveness may be possible without reciprocity, if it does not move beyond a one-way flow of care. In the context of recognising the presence of reciprocity, it is important to acknowledge that care for ‘the other’ can be demonstrated in very small but vital ways as described in the case of my work with Francis House Families referenced in Sections 5 and 8, and by Kittay’s experience of caring for her non-verbal daughter Sesha, frequently cited by Barnes. As Barnes says, it is important ‘to be open and receptive to reciprocal contributions to the care process that might not be immediately obvious’ (ibid. p. 80). In summary, responsiveness is fundamental to reciprocity which is, in turn, central to relational care.

The nature of the 'reciprocity', however, is central and distinctive to relational care, and offers the particular benefits outlined in Section 2. No single interpretation of 'reciprocity' precludes the others, but recognising their different interpretations and meanings, especially as employed in care contexts, does help to distinguish one from the other. It also helps to delineate how the reciprocity of relational care can be facilitated and what support may be needed to encourage it to flourish.

In the context of policy, the practice of relational care has, I suggest, a realistic chance of implementation because it can be adopted incrementally by individual commissioning bodies and providers rather than relying on radical systemic changes. This observation extends Tronto's important insights and also helps to reconcile Molterer et al's professional and relational logics. As I note in [4] (p. 21): 'An environment that favours [reciprocity] may be based on a philosophical foundation, but achieving it is a very grounded process'.

#### **4. What distinguishes ‘relational care’ from other care models and approaches?**

In this section I explore the ways that relational care compares with, and develops other, related, approaches to care. These are practice-oriented models as distinct from theoretical frameworks which have been discussed above.

A dominant approach employed in a range of care settings is person-centred care (PCC). This was proposed by Kitwood in his landmark book *Dementia Reconsidered* (1997), in which he focusses on the importance of the ‘personhood’ of people who live with a dementia, as a counterpoint to prevailing, reductionist medical-based models. In their article ‘Person-centred dementia care: Moving beyond care-giving’ Vernooij-Dassen and Moniz-Cook (2016) summarise his thesis as ‘underpinning good dementia care within relationships, interconnectedness and communication between people. Thus, he defined personhood as a ‘status that is bestowed upon one human being by others in the context of relationship and social being’ (ibid. p. 667).

A nurse who started her training in 1975 attributes much of the positive change in dementia care to Kitwood and colleagues noting: ‘We have moved away, thankfully, from this stance of nihilism and of the person being lost to the disease while they are still alive, to one of personhood.’ (Dening, 2024). However, Kitwood’s original work has been gradually eroded such that his focus on the person as a unique individual has shifted to a focus on the individual’s needs: ‘The.... advances that have been achieved over the last 3 decades are constantly being placed at risk’ (ibid.) and Dening cites apparently ‘innocuous’ ways in which personhood can be undermined such as task-focused approaches that are disempowering, negative language, and a concern with loss of faculties rather than what remains possible.

The term PCC now encompasses a variety of approaches that focus on the individual rather than on relationships as originally proposed by Kitwood, setting up a paradigm of unidirectional care rather than interactive actors. Sheard (2022) argues that unless PCC is underpinned by ‘emotional intelligence’ and this requirement is acknowledged, there

will be an inevitable slippage away from its original vision; as Milne and Larkin (2021, p. 136) say: 'Bolton and Wibberley (2014) argue that the increased rationalisation of paid labour has squeezed out its affective dimension'. This erosion of PCC aspirations is likely to affect dementia, residential and community-based care.

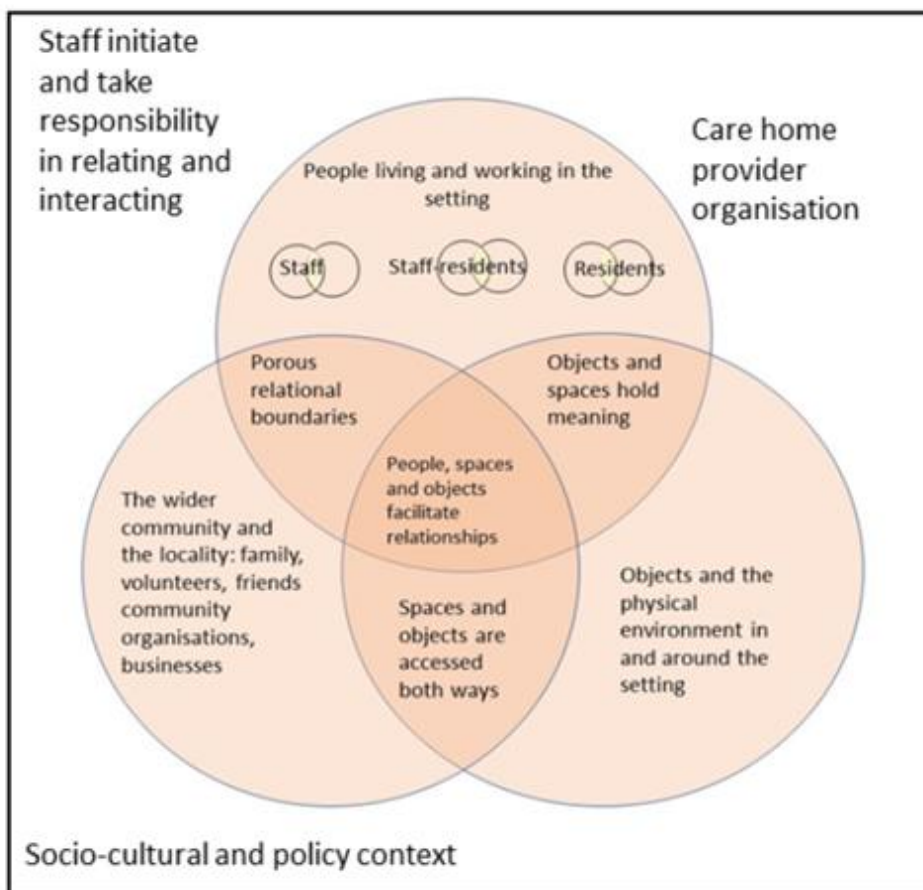
There is no single, accepted definition of PCC [4], (p.12-13): "Person-centred is an often-quoted but ill-defined concept that has nevertheless exerted a considerable influence on policy, practice and academic literatures' (Nolan, 2006, p.114). In *My Home Life* (Bridges, 2007): 'There are still theoretical concerns about what is meant by person-centred.' A key concern relates to outcomes; PCC is not only a rather abstract concept but what it is meant to achieve is opaque. Most services claim to be delivering PCC but there is no benchmark against which to test this claim.

Yet PCC continues to be cited as a desirable standard, for example in care home promotional material (although I discuss the move towards using relational care in this context later). Interestingly, the Care Quality Commission (CQC) will in 2026 revise its frameworks which reference PCC and the OU team of which I am a member is involved in this revision (Section 7). Another phrase related to, and developing on PCC is 'person-led'. David Wilson-Wynne of Stirling University summarises the difference: 'For myself as a practitioner of over 18 years, person-centred care is all I have ever known.... But what if, just for a moment, we removed [the person] from the centre? And placed them in front ... leading the way, knowing we are behind them, to guide and support when they want us to' (DSDC blog, accessed 21.10.25).

In our presentations the OU team frequently draw distinctions between PCC and relational care. Critical issues that distinguish the two approaches include: that PCC frames one person or people (care workers) as being 'givers' and another, the older person, as a 'receiver'. This does not represent the way that relationships are formed and sustained; and to an extent reflects the distinction, blurred by relational care, between 'professional' and 'relational' logics discussed in Section 3.

Further, PCC does not actively recognise the whole network of relationships in a care setting but focusses on dyads of cared-for and carer. The wealth and strength of networks which comprise relationships within and between groups – care staff, management, older people, families, local community – is summarised in Figure 1 below [8] (p. 5). Relational care encompasses everyone in a care setting, even extending to the local community [4] (p. 21). Although PCC moved the focus of care from medicalised and process-oriented to foregrounding the needs of the individual, and advocating for sensitive, well-informed care giving, relational care goes further, extending the focus on wellbeing to *all* those concerned in the care delivery process in the care setting.

**Figure 1: The dynamics of relational care**



‘Relationship-centred care’ (RCC), like PCC, is another term that is becoming more widely used by providers but is rarely defined with any specificity. It is therefore used to indicate a range of different approaches. I note in [4] (p.16): ‘Relationship-centred’ is used as a descriptor in the non-family sense by Nolan (2008, p. 1) in... ‘Moving from person-centred

care to relationship-centred care’. Milne (2020, p. 171) considers that ‘relationship-centred care was developed to address the focus on the person ... to the exclusion of those who provide support (Ryan et al, 2008)’. This does not suggest the key dimension of reciprocity which attaches to relational care, which Barnes et al come closer to when they ‘identify a ‘relational approach to wellbeing’ defining it as ‘understanding how everyday interactions with people, places, services and cultural representations impact on people’s sense of their own worth and their capacity *to contribute as well as receive* (2018, p. 131)’ (my italics) [4] (p. 16).

Although it may be cited by providers, evidence about the adoption of RCC as a model in service settings is limited. It was notable that when Professor Mary Larkin and I presented ‘Relational care practice: how can we make meaningful change happen?’ on 13 May 2025 to the Conference ‘Enhancing Residential Care: How Research Can Make a Difference to Practice’, two out of the three other academic speakers in our group used the descriptors PCC, RCC and relational care interchangeably.

The Butterfly Model developed by David Sheard, Professor of Emotional Intelligence, York St John University - who has published a series of books about this model under the overarching title ‘Feelings Matter Most’ (2008-2011) - indicates how PCC practice can be returned towards the more relationship-oriented approach that Kitwood originally envisioned.

**Figure 2: Essential features of the Butterfly Model** (Sheard, 2018, p. 21)

- \* love - returning a care home to Being Loving
- \* family - creating a sense of “We Are Family”
- \* feelings - really evidencing Feelings Matter Most
- \* spirituality - giving meaning to A Person’s Core Spirit
- \* vulnerability - focusing training on Our Own Vulnerability
- \* attachment - supporting Past Attachment Matters
- \* living - coming Alive Again Inside
- \* inclusion - ensuring People’s Mutual Regard
- \* households - feeling At Home Inside Ourselves

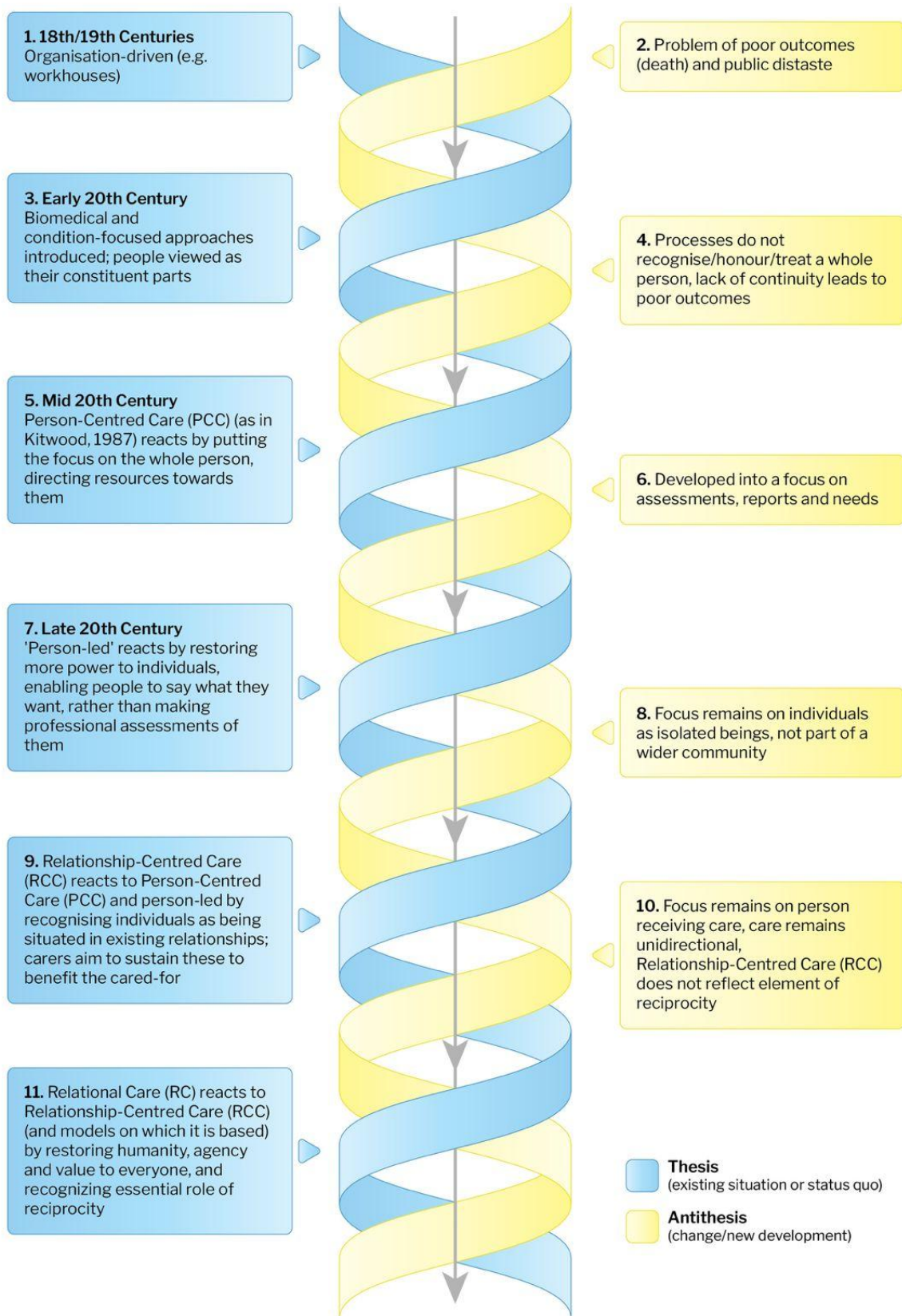
The main tenets of the Butterfly Model are concerned with ‘relationship focussed support’ rather than PCC and could be viewed as a bridge to relational care, as I suggest in [4] (p. 5). However, the distinguishing point between the Butterfly Model and relational care is that it does not make explicit the two-way nature of the care relationship.

Relational care is, in effect, both an evolution in thinking about what represents effective and positive care, and also the re-emergence of a more organic way of forming, maintaining and benefiting from human relationships, by recognising and enabling reciprocation. The concept builds on approaches which represent a development from earlier care models. At the same time relational care principles draw on a number of much longer-established ways of living in society and community, before there was a state-funded welfare ‘safety net’. Support systems though much of human history have been informal – family, community, the church - developed out of necessity. Arguably these have always been reciprocal, existing in families and smaller communities where people would traditionally know each other and build relationships based on need, friendship or love.

## **5. The development of relational care**

The principles that underpin relational care are: recognising the power of reciprocity and interdependence in communities of care; the facilitation of multidirectional relationships that enable all those involved to contribute as much as they can and wish to, to the lives of their peers and communities; and the purposeful creation of supportive networks through deliberative changes to attitudes (providers', care staff's and older people's) and environments. These principles have emerged from the methodology of my research as described below, and drive the development of relational care, which is the focus of this section.

**Figure 3: Conceptual framework of relational care development**



Considering this conceptual framework of development, it is clear how relationships, their existence or lack thereof, and their nature, profoundly affect the quality of the care older people receive. Relationships in families, friendships, partnerships and - sometimes – workplaces are based on interactions that happen in the spaces between people. When the ‘spaces between’ are not facilitated, relationships wither and are replaced by processes and transactions. To understand how these critical spaces can be supported by the right conditions, it is useful to trace the development of the relational care approach, both in the wider context of adult social care (Figure 3) and in the context of the development of the type of methodology I employed.

From the outset, my methodology was located inside the formal care sector, specifically care home provision. In undertaking the original Abbeyfield study, I designed semi-structured interviews (30 to 60 minutes) and field notes using ethnographic observational methods. These were developed in consultation with the funder, who commissioned an independent evaluation to explore how ‘universal human needs were being met’ in their care homes. Specifically, this covered how people could: ‘(1) feel valued and affirmed, (2) love and be loved, (3) hope in something in this life and beyond, (4) have faith or trust in someone or something and (5) know peace, security and tranquillity’.

Abbeyfield selected a sample of 25 care homes across England, which were broadly representative of their portfolio; the sample included larger/smaller, older/newer, and urban/rural facilities. Ten more homes were added, five from Northern Ireland and five from Scotland, to strengthen the sample geographically. In all the homes, I interviewed: the manager, a sample of care workers and other staff such as cleaners and gardeners, older people and volunteers. Participants signed ‘agreement forms’ based on ethical principles recommended by those Abbeyfield trustees who were employed in academic settings and were familiar with ethical considerations. In an additional five homes that specialised in dementia care, we adapted the forms so that proxy assent could be given by a relative.

I used thematic analysis - see Braun & Clarke (2006) - to interrogate the data generated from fieldwork in this total of 40 homes. Taking an inductive approach, I examined all the transcripts (n=100) three times, constructing key themes; I adopted a coding approach to structure the thematic analysis. Themes were both distinctive to a participant group, location or setting and some were also shared. This analysis formed the basis of recognising the nature and presence of relational care: as it was subsequently conceptualised and described in chapters three to six of book [3].

When writing the second book [4], I built on the former book's [3] foundations and methodological principles, focusing on a wider range of care settings that included residential care homes, sheltered housing, community-based care teams, homes based on intergenerational principles (e.g. also housing pre-school classes or accommodation designed for sharing by students and older people). In this work I used the same methodology to collect data as used in the first study, together with other material as described in Section 5.

The much more recent OU research report [7] focused on answering three key research questions pertaining to the presence and practice of relational care in the care of older people in five settings (four care homes and one day-care facility): '1. What does relational care feel and look like? 2. What processes and mechanisms are involved? 3. What features of the physical space enable this type of care?' (ibid. p. 18). We adopted a qualitative mixed method approach. This included semi-structured interviews and ethnographic observational methods with field notes, based on a model of Appreciative Inquiry to identify 'what already works and builds on it' (ibid. pp. 18-19).

The first stage of the research process for the OU study was a literature review (ibid. pp.10-17). This provided a foundation for the subsequent fieldwork and was a valuable learning experience for me, extending my understanding of how to conduct an academic literature review. The methodology of the subsequent fieldwork built on my previous work exploring the practice of relational care using qualitative methods and Appreciative Inquiry: semi-structured interviews with a variety of participants in five care settings that had adopted relational care (or many of its elements) and

observational notes of the environment over a full day in each care home/setting. Thematic analysis was then conducted on both sets of data. A key focus of the study was to ensure that critical learning was subsequently made available in a variety of forms, including practical tools that could be shared with a range of relevant stakeholders to support implementable change.

I also developed my methodological skills by contributing to the HREC ethics process; understanding how to conduct a systematic literature review; and learning about NVivo, including how transcripts could be effectively interrogated by this software package.

In essence, the concept of, and terminology related to relational care has emerged from this methodological journey. The qualitative methodology and inductive approach helped to facilitate the voices and experiences of all those living or working in these care settings to be heard and explored, and the environments to be captured and 'felt' as I engaged in the lives of the participants and facilities for the period of the fieldwork. This in turn influenced my thinking about the nature of 'lived' relational care and enabled each stage of the research journey to refine and build on the previous one, and on developing the terminology of relational care. The pivotal role of reciprocity in relational care has been foregrounded by the methods adopted.

'Relational care' had occasionally been used prior to my adoption of the term, for example in Rockwell's paper (2012) 'based on qualitative studies in four residential care facilities in Canada' [4] (p.16). Her concern was that while 'lip service' is paid to PCC, its role and importance were being eclipsed by medicalised care and organisational priorities. She concluded there should be a rebalancing towards valuing relationships. Rockwell does not explicitly define relational care; instead she uses a variety of phrases such as 'relational autonomy', 'relational focussed' and 'relational practice' (2012, p. 245). She also argues for 'bidirectional' (ibid. p. 242) and 'multidirectional relationships' (ibid. p. 243) to challenge 'the current framework of PCC.' (ibid. p. 247).

In the literature search forming a key part of the OU research [7] referenced above, the first stage was a rapid review of the term ‘relational care’ in academic and grey literature; this ‘yielded 44 papers’ [ibid. p. 10] which included reports and articles.

While we found references to ‘relational approaches’, there were no explicit definitions of relational care. The closest we found was: ‘drawing on feminist and nursing theorists, Novy et al (2022, p. 2) put forward a working definition of ‘relational care’ as ‘... a *bidirectional process, one in which the agency of both people – those who give and those who receive care – is recognised*’. In a similar vein Nolan et al., (2006) have advocated for a ‘relationship-centred approach in care homes that emphasises positive interdependent relationships extending beyond residents to include staff and family members as being fundamental to provision of good care and wellbeing’ (ibid. p. 11). This is consistent within the variety of RCC terminology described in Section 4.

A key output of the OU research is this first known definition of relational care [7] (p. 50):

*‘Relational care is based on the recognition that human wellbeing requires interdependence; it represents a move away from seeing individuals as a collection of needs to be met by others towards mutuality in caring relationships whereby no-one is solely a ‘giver’ or ‘receiver’ of care. Central to relational care is the role of emotional, physical, social and spiritual environments. These facilitate relationships where there is a multidirectional flow of care and create supportive networks, enabling all those involved to contribute as much as they can and wish to the lives of their peers and communities’*

This definition has real value as it helps people to recognise and discuss a *practice* that may (already) resonate with their experiences. It also enables them to refer to the benefits, dimensions and purpose of this way of working, which are addressed when delineating the influence and impact of our research in Section 7.

Book [4] addressed a range of settings where there was evidence of relational care being practiced, and delineated its shape, nature and outcomes to yield learning from the ways in which it is expressed in different contexts and therefore how it can be more widely applied. This broader approach considered how relational care principles, originally drawn from residential homes, could be employed in other settings and

generate benefits. Each section of the book addresses how these principles can be adapted more widely. However, much of my initial work, and research with the OU, primarily references residential care homes and it is therefore on this setting that many of the more widely applicable arguments in this thesis are focussed.

As discussed above, in both my books [3, 4], and in the OU research [7], an Appreciative Inquiry (AI) approach was adopted as a well-accepted methodology (Sharp et al., 2016, p. 4) for investigating interventions and practice in settings where things are 'going right' and for exploring innovative ways of working.

## **6. The conditions needed for relational care to develop and flourish**

If the dimensions and supporting conditions for relational care can be observed and accurately described, then they have the potential to be embedded elsewhere and promoted. I will now discuss the factors required to support its development and flourishing and will also consider the issues that inhibit relational care.

### *What are these conditions?*

My original study described in [1] identified that the presence of positive feelings such as ‘a sense of belonging’ and ‘security’ and the alleviation of negative feelings such as loneliness and lack of self-worth appeared to be closely associated with supportive reciprocal relationships, and that these relationships were in turn associated with certain key - observable - conditions. In [4] I developed the concept of relational care and, importantly, a further scoping of conditions favourable to its development in care settings for older people. In effect, this was intended to be a ‘guidebook’ on the questions: if relational care offers a range of positive benefits how can (other) care providers emulate these? What would relational care look like and what might be its benefits in our particular care setting, for people who use the service and for staff?

Our OU research [7] further investigated these questions and proposed that these ‘conditions’ operate in a number of intersecting dimensions: at the level of front-line practice, management, and the physical environment. These different dimensions influence and interact with one another (Figure 5).

### *Changes in frontline practice and roles*

Relational care requires a change in the role of care staff: both tasks and time. The dominant conceptual lens on ‘care work’ tends to construct it as a series of ‘instrumental tasks’ such as assistance with eating, dressing, toileting, medication and so on. This task-driven approach marginalises the emotional dimensions of care practice and undermines the ‘between spaces’ in which relationships form. It also breaks ‘care’ into ‘units of time’: time to do a set of practical tasks. This inevitably constrains emotional investment by staff into the more human facets of care and can lead to care being experienced as depersonalising by older

people. Hugo (2005) describes the dehumanising effects. This example is of an older lady failing to be dressed as a person, leaving her looking like a scarecrow: ‘someone who can no longer retain her dignity by dressing herself and has been left in a shapeless, once-white blouse, grey sweatpants... an old outgrown perm’ [4] (ibid. pp. 24-25).

In comparison, a care home group I visited, practising relational care, described how they advertise for staff: not ‘for qualified professionals who are reactive to tasks [but] for companions who can share emotions’ [4] (p. 88). By enabling essential tasks to simultaneously encompass emotional engagement, relational care creates another beneficial circle, which both thrives on and facilitates meaningful and supportive interactions. While staff providing care retain a critical role at the front line, in a relational setting all staff will be seen as front line, in the sense of having direct, reciprocal relationships with older people and each other: this will include, for example, cooks, gardeners, maintenance people and, most importantly, the registered manager.

There are strong indications for the importance of the manager in both advocating for, and also giving, relational care to residents, staff and families. ‘One of [my] most notable findings ... was the critical role of the manager and a number of respondents described them as the ‘hub’ of the home or even its ‘soul’” [3] (p. 58). Managers are often the lynchpin situated between care home owners, residents, families and the local community. One of the indicators of relational practice happening is the default position of the manager’s door: it should normally be open. Our OU research confirmed this [7] (p. 45): ‘The idea of managers having an ‘open door’ to all those who live, work in and visit a care setting could extend to the door literally staying open and being visible as well as a more figurative concept of the manager being approachable and receptive.’ The role of the manager is so critical to relational care that it is the subject of the next OU research project (Section 9).

Considering how relational care affects front line practice, in this example used in a podcast recorded on 21.3.25 for *The Outstanding Society* - a not-for-profit company enhancing standards in care homes by sharing best practice - I explain a typical care interaction in five short scenarios:

‘Start by imagining Sally, a care worker in a residential home, helping an older lady, Joan get dressed one morning. Here is how her approach changes the interaction on a continuum from task-oriented, through person-centred, to relational care.

- *1<sup>st</sup> scenario* – Sally finds any skirt, blouse and cardigan that have been stuffed in a drawer, and helps Joan dress without any real conversation (this is totally task driven)
- *2<sup>nd</sup> scenario* – Sally looks in the wardrobe, takes out the three garments checking the colours look OK together, and that each has the right label with Joan’s name on it. As she helps Joan dress, she chats about the weather (this now becoming person-centred)
- *3<sup>rd</sup> scenario* – Sally does all this but also notices a brooch on the cardigan. She asks Joan about it wondering, did she last wear the cardigan to go somewhere special? Joan tells Sally it was her niece’s wedding last week, and they have a few words about the event (person-centred with more interaction)
- *4<sup>th</sup> scenario* – same sequence as before, but Sally uses this opportunity to ask Joan what was most special about her own wedding, referring to a photo on the wall (arguably now person-led or relationship centred, acknowledging the importance of Joan’s relationships)
- *5<sup>th</sup> scenario* – Joan responds by asking Sally what meant most to her about her own wedding, which was much more recent, and what she’ll remember in the future about it (relational care: Joan is acknowledging Sally as a person with her own life, and the two women are sharing on a more mutual basis).’

Note that none of these interactions necessarily adds time to the task but do imply some continuity of relationship which is one of the distinguishing features of relational care. Continuity builds bonds of knowledge and trust that support staff and resident resilience, especially in times of challenge such as during the pandemic.

An appreciable outcome of relational care and associated working practices is staff retention and hence continuity [7] (p. 15). Flexibility can take a number of forms: it may be that staff

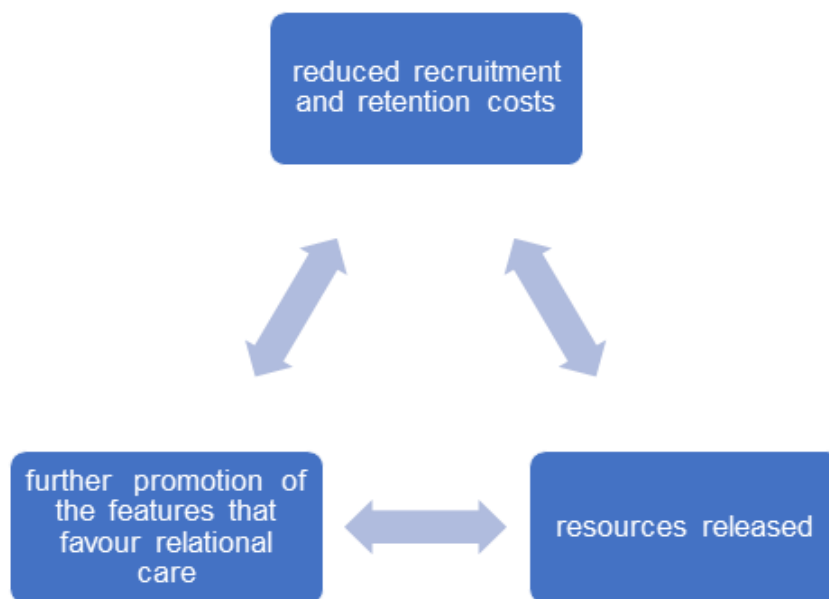
have influence over day-to-day practice such as rotas or sharing tasks; or that they are enabled to operate as a team and accommodate each other's personal lives; or that managers are willing and able to adjust rotas to meet individual needs or maintain continuity of staff/resident contact. Flexibility is enabled by a relational approach predicated on trust and respect, on building rather than inhibiting relationships, and on practical reciprocity ('give and take'). The OU research report summarises the value of flexible work patterns (ibid. p. 52): 'Relational approaches to care can influence staff recruitment and retention. Lack of attachment between residents and staff is a strong predictor of staff burnout and turnover (My Home Life, 2007)'. In [4], (p. 30) I note, 'Once relationships become established, less maintenance time is needed, making not only for a happier situation but a more cost-effective one. Continuity of care is both a moral and economic imperative.'

The OU report concludes with a detailed exposition of the impact of implementing relational care on the workforce: 'The research findings ... have the potential to address .... workforce issues by improving retention and thus reducing the costs of recruitment and induction; in creating an attractive and well-known workplace in its locality, a care setting can more readily recruit locally... with potential employees already being favourably disposed... new members of staff [non-local] can be more readily integrated with [staff and resident] support ... when there is an emphasis on forming a network of relationships.' [7] (pp. 53-4).

Another feature of relational care practice concerns training and, indirectly, career advancement. One of the ways employers can make clear they value staff is to proactively encourage managers to identify training needs: '... as relational care encompasses a two-way flow of information between management and staff, it enables informed requests for, and observations on, the need for training. These create more opportunities for staff to progress and have a [long term] career in one setting' (ibid. p. 54).

This illustration (ibid. p. 53) summarises the potential for iterative and beneficial circularity of improved staff satisfaction:

**Figure 4. Relational care and the social care workforce**



*Management support for changes to the role of care staff*

In [7] (p. 24) we note that some managers build in ‘additional staff time’ to deliver relational care, viewing this as an investment: ‘leadership also gave staff permission to talk, spend time, and nurture relationships with residents. Flourishing, authentic interaction would be difficult without sufficient staffing levels. One setting we visited reported recruiting to 120% to provide a buffer for holidays and staff training, and another 110%... this allowed for flexible access to training as well as opportunities for formal and informal learning conversations between staff and managers.’ In Section 7, I report a conversation with a care home manager [visited on 1.7.25] about how an understanding of the benefits of relational care influenced a similar decision to improve the staff:resident ratio, releasing more staff time for joint activities such as baking and crafts with residents.

However, whilst getting to know people may require more time initially this may be balanced by saving time later. For example, there is no need to keep repeating the same questions about preferences or interests. By combining task and human interaction i.e. talking and engaging, the practice of relational care adds little to the overall time that the task alone would have taken. Empowering managers to play their pivotal role in facilitating relational care practice by allocating more time to shared activities that create mutual memories, and building in flexibility is an important condition of relational care.

Speaking at the launch of [4], Professor John Swinton, Chair in Divinity and Religious Studies, University of Aberdeen (and a registered mental health nurse), warned that “Busyness kills compassion”, and “Care requires that we are *fully present*”. Making the task subservient to the relationship does not mean that it takes longer or is less efficient, but that it enhances the moment for both parties, making each feel more valued: ‘I feel as much as I give them [older people], I always get something back’ [3] (p. 94).

### Changes to the physical environment

Relational care also requires changes to the environment, to support natural interactions. Observations on these requirements and their links to delivering relational care have been described in [3,4] including specific design guidelines [3] (pp.149-150). The way in which these guidelines have been applied, and their direct impact on residents, staff and practice in three different care homes are described in detail in Appendix B.

Factors in the physical environment which affect the practice of relational care were also investigated in the OU’s research [7] (pp. 39-47) and are identified in the right-hand column of the table below.

### Diagrammatic summary of conditions favouring relational care

In 2023 the OU research delineated the dimensions of, and conditions that are needed for relational care to flourish. Figure 5: ‘A Model of Relational Care’ was produced describing them in detail [7] (p. 22):

**Figure 5: 'A Model of Relational Care'**

An <b>atmosphere</b> of respect, trust and inclusivity that nurtures belonging	A purposeful focus on <b>relationships</b>	A <b>physical environment</b> that facilitates relationships and autonomy
<ul style="list-style-type: none"> <li>• Leaders and managers create a home-like environment in which all those in it can flourish and thrive</li> <li>• Residents feel a sense of belonging and sufficiently 'at home' to enjoy freedom of expression and find meaning in their lives</li> <li>• Visitors experience the setting as welcoming and accommodating</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Between staff and residents e.g.</b> <ul style="list-style-type: none"> <li>○ Staff undertake activities 'with' rather than 'doing for' residents</li> <li>○ Residents can take active roles and are involved in decisions and planning</li> <li>○ There is mutual togetherness, reward, mourning, and fun</li> </ul> </li> <li>• <b>Amongst residents e.g.</b> <ul style="list-style-type: none"> <li>○ Residents have opportunities to support one another and develop friendships</li> <li>○ Mealtimes are protected and valued as opportunities for conversation</li> </ul> </li> <li>• <b>Amongst staff (including staff and management) e.g.</b> <ul style="list-style-type: none"> <li>• Communication systems support effective practice and teamwork</li> <li>• Trusting relationships and flexibility ease the management of actual or potential conflict</li> <li>• Work-life balance is supported and respected amongst the staff</li> <li>• Staff feel respected and valued, which empowers and enables them to nurture others</li> </ul> </li> <li>• <b>Between the care setting, the family and the wider community e.g.</b> <ul style="list-style-type: none"> <li>• Family relationships, friendships and relationships with significant animals are fostered</li> <li>• The setting acts as a focal point for the local community</li> <li>• The community/locality outside the setting is accessed/accessible</li> <li>• There are regular celebrations of national events and local milestones</li> </ul> </li> </ul>	<p>Examples include:</p> <ul style="list-style-type: none"> <li>• Room layouts allow for private and communal spaces (inside and outside)</li> <li>• Recognition and encouragement of meaningful objects and activities</li> <li>• Use of communication and other technologies to release staff time</li> <li>• Use of assistive technology to support autonomy and foster relationships such as mobility aids, gadgets and entertainment equipment</li> <li>• An 'Open door' to the manager's office</li> <li>• Private spaces for staff</li> </ul>

### Tools that promote relational care conditions and practice

Two 'practitioner tools' have been developed drawing on this body of work on relational care: a toolkit, *'Making Every Relationship Matter'* [9] and an OpenLearn module [10] for care workers and managers entitled *'Introducing Relational Care'*. This latter resource is a short (four hour) course using case studies, vignettes and audio/video to introduce the concept of relational care, what is different about it as a care practice and what facilitates it. The toolkit can be used as part of a formal learning programme, a discussion group, a team meeting, or something to be 'dipped into over a cup of tea'. It is targeted at everyone involved in the care setting: older people and their families, care staff, managers, maintenance workers, cleaners, gardeners, commissioners and also care providers. The latter are important as they tend not to be involved in daily care and yet they will also have the authority, flexibility and budgetary control to implement real change.

The uptake of both tools is noted in Section 7, and their contents listed in Appendix C.

### What inhibits conditions favourable to relational care practice?

It is important to recognise that some factors inhibit relational care development. These include: too little time allocated to staff to get to know residents and vice versa, high staff turnover or poor conditions; an organisational emphasis on 'processes' and 'tasks'; an environment that makes organic engagement more difficult due to noise, rushed or isolated meals, lack of familiar objects to facilitate conversation (see also Lee, K, Material Citizenship), dirt, poor lighting, a single large communal room, and seating arrangements or items such as a dominant TV that inhibit conversation and/or interaction.

In summary, the lack of any of the conditions which favour relational care will inhibit its practice, begging the question, is there unwillingness to adapt to it, or is there still a level of ignorance about the practice? Both can be true. Unwillingness could be related to concerns about the cost or upheaval of making the changes needed to meet the critical conditions, or to doubts about the efficacy of doing so. This in turn could be because there is insufficient knowledge about the financial or human implications, or little understanding about relational care as an approach.

Addressing these issues will involve more research to produce incisive evidence about benefits and outcomes of relational care, more information about costs, increased understanding of what matters to older people receiving care, and greater appreciation of staff who practice relational care and how it affects them. These are achievable aims but it will take time and funding; our OU team's plans to continue capturing impact and gathering evidence are briefly described in Section 9, and we recognise that we need to work in partnership with other organisations (including representative bodies, charities, providers, regulators and commissioners) to extend our knowledge, impact and influence.

## **7. The wider impact and influence of relational care**

There is a range of types of evidence cited in this section: empirical, testimonial, documentary and online access figures. The adoption and citation of relational care are dynamic and will continue to be so, due in part to the activity of the OU team of which I am a member. Here I focus on impact and influence beyond individual care homes, residents and staff.

### *Impact on providers and provision*

There is increasing interest by providers and sector representative bodies in adopting relational care, with the former Chair of Care England Avnish Goyal, wishing to make it a sector practice standard (see Section 9). We are in talks with CQC who have made their policy colleagues aware of relational care and will not only incorporate references to it into the guidance element of the new Single Assessment Framework on which they are consulting but have also asked the OU team to present at their upskilling programme for CQC Inspectors.

Care providers (mainly care homes) wishing to attract self-funders are also showcasing the features and benefits of relational care on their web sites, although they do not necessarily use the term itself. For example, the Nightingale Hammerson brochure reads: ‘We recognise that quality care only happens when there are strong relationships between everyone involved in the care [environment]’. This group now intend to use ‘relational care’ as the descriptor of their care approach.

Professor Martin Green, Chief Executive of Care England – Britain’s largest representative body for ASC providers - believes that relational care has an appreciable positive impact: “The concept of relational care is gaining significant support across the care sector and transforming the experience of care for older people and delivering improved wellbeing. The benefits of relational care are not only seen by the people who are supported, but also by the staff who deliver care.” [Professor Green by email, 11.4.25].

Input to organisations supporting care providers gives further testimonial evidence. We have had dialogue with the Skills for Care/Department for Health & Social Care Workforce Pathway team who have cited our OpenLearn module [11] as an example of 'good learning materials'; and who were represented at senior level at our 2024 relational care consultation [13].

The OU research offers empirical evidence that relational care has potential to support good quality providers by concluding that there is the opportunity for recognition of relational care to impact on public perception and policy-making: '... relational care can contribute to more positive perceptions of the social care sector, as one where people can thrive and flourish; which affords opportunities for creativity and innovation; and is a facilitator of community integration.' [7] (p. 54).

#### *Impact on practice*

The two tools arising from the OU research [9,10] both intended for a wide range of people working in any capacity in a care home or community service setting, are designed to introduce relational care and improve practice, and there is good statistical evidence for the uptake of these. Since its launch in 2024, the module has had 29,203 visits to its website location (not identifiable due to GDPR) and 881 enrolled learners, and the toolkit has been downloaded over 1,500 times. Both have been promoted to their members by professional bodies, for example, the British Association of Social Workers and *The Outstanding Society*, which 'serves as a platform for... best practices in social care'. They have been covered extensively in the sector press, including CQC's 'Care Connections' and 'Research in Practice' [11] (p. 1).

To take a specific example of practice-based evidence, the manager of Brandon Park care home in Suffolk (visited 1.7.25) uses the toolkit regularly with staff groups 'to raise discussion points in team meetings, and to encourage staff to see that they have free rein to try out things for themselves' such as 'focusing on the interaction rather than the task.' The toolkit is also used to help answer 'How do we express these relationship-based ideas in practice?'

Another example of impact on practice relates to residential care of young adults with life-limiting conditions in Stockport, Francis House Families. They cite my work as ‘foundational’ (Murphy, 2025) to their thinking about how relationships are sustained, and in developing the practice of awareness, ‘Moments of Realisation’ (ibid.), that enables staff themselves to observe and describe critical instances of interaction with residents (a number of whom are non-verbal). I returned to visit Francis House Families to co-sign a document of commitment to relational care, attended by the Mayor of Manchester, Andy Burnham.

Stephen Burke, CEO of funders Hallmark Foundation, says it “was delighted to support the relational care research project by Jenny Kartupelis and Open University. The quality of an older person’s relationships are central to the quality of their care and later life experiences. There is growing interest nationally and locally in implementing relational care thanks to Jenny’s work in this area for almost a decade. I also know that the growth of intergenerational care, linking care homes with local schools and nurseries, has its roots in relational care. Jenny has been a real champion.”

There are about 16,700 care homes in the UK of which some 70 per cent are residential settings (carehome.co.uk) and estimates suggest that the number of residents and employees are around 278,000 and 495,000 respectively (homecare.co.uk, Skills for care, 2024) so the area of potential influence is wide.

#### *Impact on care home settings*

My studies and the OU research have shown that there is a close link between the environmental design of care settings and implementation of relational care practice (Figure 5), and there are numerous examples in [3, 4] of how this interaction works in communal spaces, and also individual rooms [12] (p. 54).

Design guidance comprising ten points, was developed by myself and the Abbeyfield Director of Development [3] (p. 150). I later followed up on whether and how these guidelines had been implemented. In fact, all ‘ten points’ had been purposefully

included in three of Abbeyfield's major new developments [4] (pp. 79-81), with a total value in tens of millions, indicating strong practical evidence of a willingness to invest in changes required by relational care.

The interpretation of each guideline can be read in full in Appendix B where the value and impact of each is given in detail with supporting quotes from residents and staff. To take three examples: one guideline was to have a garden room; the response to this is: 'Having direct access to a garden room... is hugely important for residents ... all this adds to a wonderful feeling of contentment' [4] (p. 80). Another guideline was that dining rooms should optimise natural light and views; the response from a manager to following this guideline is that this has: 'stimulate[d] appetite... and increased opportunity for sociability' (ibid. p. 81). The guideline that staff should have a peaceful retreat away from residents drew the response that two staff areas had been created, one 'is very peaceful... away from residents, who can be hard work.' (ibid.)

To take a very recent example, Brandon Park, mentioned above (visited on 1.7.25): in order to embed relational care principles, the fabric and décor of the building are being substantially altered. The demolition of internal walls will create new, smaller and more varied common areas in response to the design guideline aimed at facilitating easier conversation and encouraging relationships to form.

### Impact on research

Over the last three years, the OU team has been in dialogue with other academics active in the field of social care for older people; we are seeing our work being cited, and influencing theirs. Two examples: Associate Professor Dr Alison Pooley, co-author of the extensive report *Almshouse Resilient Communities (ARC) for the Future project* intends to re-code and re-interpret its findings through a relational care lens. Professor of Emotional Intelligence in Care at York St John University David Sheard extended his November 2025 presentation to the 2025 UK Dementia Congress with slides specifically about relational care provided by our team and I have been asked to speak at the 2026 Congress.

### **The wider influence on the older adult care sector**

Influence can manifest at the level of a whole sector, an organisation, a staff team, and/or individual lives. There can be direct influence on perceptions and behaviour as described above, or more subtle changes where a new approach gradually becomes recognised, valued and part of the sector landscape. The various types of influence intersect. The increasing profile of relational care in sector publications, forums such as Housing LIN and conferences such as Care England have resulted in the OU team being contacted by representative organisations like Social Care Future and the National Association of Care and Support Workers, and care home groups, with a view to shared projects. Some providers already practicing relational care wish to be associated with our work and evidence.

The Almshouse Association (TAA) with over 1600 members providing for some 36,000 residents, is one good example of relational care being articulated and amplified by an influential organisation. Almshouses were founded around 1,000 years ago on principles very similar to those of relational care, and research shows that moving into an almshouse increases resilience and extends life by an average of 2.5 years (Callahan et al, 2024). TAA now uses the term relational care in its publications, conferences and podcasts (which feature our team). CEO Nick Phillips says: 'The almshouse model is built on care... that is reciprocal rather than transactional. Using 'relational care' to describe ... [this] model is proving helpful in encouraging this approach.' (quote by email, 17.4.25).

Welcoming the OU research report [7], Professor Martin Green, (Chief Executive of Care England) said: 'In this study, there is clear evidence of what factors influence high quality care, and this research has messages for everyone in the care sector and its conclusions are far-reaching.' [7] (p. 2). Evidence of penetrating both the sector and the discourse confirm his comments. Since then, the OU team has worked with representative organisations and government departments to have direct input to policy documents. One example is the addition of a section on mutuality in relationships, which I drafted, to the Re-imagining Care Commission's report (Dixon and Newcome,

2022); and submissions to and attendance by members of the OU team at All Party Parliamentary Groups on *Ageing and Older People* and on *Housing and Older People*.

My articles and blogs for sector publications [Appendix E] have generally been by invitation, indicating a growing awareness of and interest in the effects of relational care. I have also given presentations to conferences, academe and sector organisations [Appendix F] including Sheffield University Centre for Care (23.1.24); University of East Anglia (3.3.21); Worcester University MA Module (19.2.21) and the International Longevity Centre UK Future of Ageing Conference (December 2020).

## **8. A critical lens on the concept and practice of relational care**

It is important to reflect critically on relational care as a term and an approach: if it is so ‘in tune’ with the way most people live, and if it has so much to offer on a personal and organisational level, why is it not happening in most care settings? In this section I discuss some of the structural and organisational barriers to the implementation of relational care; these exist at a number of levels.

### *Structural Issues: Ageism and Discrimination*

The persistent public image of older people, particularly of those living with dementia, is about dependency, frailty, and non-agency: a process of ‘infra-humanisation’, ‘being stripped of the status of being fully human’ (Milne, 2020, p. 189). Exacerbated by the pandemic, as my survey for Anna Chaplaincy revealed ‘stereotypes and [negative] attitudes... have become more entrenched’ [5] (p. 7). The near-tacit ageist acceptance that older people need protection more than self-determination has some irony - there was little actual protection for them in the pandemic, as the 2025 enquiry reveals. Because these perceptions are so embedded, changing them is a real challenge; the Centre for Ageing Better draws attention to a study which identifies that ‘Ageist attitudes are already evident in pre- and early-school children’ (web site accessed June 2025).

Further, marginalising older people, especially those who use care services, may make it more acceptable - or less noticeable - to direct resource away from them and onto other, higher profile groups. In the NHS, elderly patients may be spoken of as ‘bed blockers’ and in welfare services, ‘Reductions in time spent with older patients is one of the key consequences of recent cuts’ (Milne, 2020, p. 96). Addressing the issue of abuse in care homes, Milne notes that ‘ageism plays a role... it normalises discriminatory attitudes and practices’ (ibid. p. 118). As I note, the gift of old age can become a ‘poisoned chalice’: ‘Far from the aged being the blessed ones, their presence now risks being calculated in terms of a burden and expenditure.’ [4] (p. 126).

Relational care is distinguished by the primacy of reciprocity. This, in itself, has the potential to help shift negative attitudes to old age. For example, as staff engage more

fully with older people, and actively appreciate and enable their mutual contribution to relationships, carers may develop a more positive picture of them.

### Structural Issues: Other Discriminations

‘As women account for over two thirds of older users of community care services, and many carers are female too, women are disproportionately affected by [budget reductions]’ (Milne, 2020, p. 96). Sexism is also a key part of the story of discrimination. As I noted in Section 3, Tronto refers to care as ‘dirty work’ not only in the literal sense, but as stigmatised in its nature and for those who deliver it. The question of exploitation of care workers in residential care is referenced below, where the article cited makes clear that those exploited were female and, largely, of a different ethnicity to those being cared for.

These issues of structural racism as well as sexism in the profile and treatment of the care workforce remain embedded, with their work generally seen as unskilled and menial. A 2025 report based on Skills for Care research found indicators of racism: ‘81% of adult social care staff [employed in English councils] were white... in line with the wider population’ but ‘Black, Asian and minority ethnic social care staff continue to face worse outcomes... across most indicators.’ For example, they were ‘half as likely to be appointed from a shortlist and almost 40% more likely to face disciplinaries’ than their white counterparts (Samuel, *Community Care*, 14.5.25). The 2024 IPC/Oxford Brookes University positioning paper, ‘Structural Racism Within Social Care’ proposes that these issues can only be addressed on a sector-wide basis.

Interestingly, the application of relational care principles by Francis House Families (Section 5) suggests that they also have the potential to address ableism for similar reasons: reciprocity need not be based on specific faculties such as sight, verbalisation or memory, but can be felt or sensed in numerous ways. As Murphy (2024, p. 8) says in the poem ‘No Words Needed’: ‘It’s enough to be here, to share the weight, to feel the warmth of company, without pity or pretence’.

In services, particularly care homes for older people, we can see an overlapping arena of discriminations and inhumanisation. The implementation of relational care principles has the potential to engender self-worth in all involved in care and therefore perhaps support carers to challenge the *status quo*.

#### Provider priorities and concerns

To adopt relational care practice, providers need evidence that it is at least cost-neutral and at best cost saving, e.g. in terms of staff retention, attractiveness to commissioners and self-funders, and improved outcomes for older people. Accruing such evidence will be pivotal and is the next ambition of the OU team.

There is also the question of complementarity between relational care and other improvements that providers may be adopt, including technology-based advances. A guest chapter in [4] (pp. 108 to 125) is devoted to the roles of technology in services for older people, drawing the broad conclusion that it can be a ‘friend’ by releasing staff and managerial time for increased personal interaction; but becomes a ‘foe’ if it substitutes for the development of care relationships. One these conclusions is that ‘Products with the most impact are generally those that have been developed in collaboration with the groups of people that will use or benefit from them.’ (ibid. p. 123). This collaboration refers to development work in four ‘living labs’ where older people engaged with real-life situations to assess technologies. The technology interventions they chose proved to be those which, when implemented, solved problems; had the highest levels of adoption; and were the best market fit. These interventions subsequently proved to offer improvements in communication with family and friends; undertaking everyday tasks; and finding it easier to use technological assistance.

#### Potential tensions between human and organisational behaviour

There are a number of more subtle behavioural and ideological issues which may constrain either an initial openness to relational care, or an enthusiasm to implement it. Care organisations are not necessarily established with human nurture as their key objective: they have overriding concerns about financial stability, profits (in the case of businesses), meeting their charitable or corporate objectives and legal obligations,

limiting their liabilities and so on. Whatever their mission statement, these issues will dominate decision-making, but they can be partially addressed through some of the benefits of relational care, particularly if it improves staff retention, reducing recruitment risks and induction costs and is a pull factor for self-funders or commissioners.

To meet legal or insurance obligations, safeguarding considerations must be accommodated. One example: to hug or not to hug? Are all hugs acceptable/positive? I have discussed this with managers and care workers, who believe that this question should be addressed through carers' 'antennae'. People may ask for a hug, or hold out their arms, or hold back. 'Reading' a person in this way, deciding when it would be inappropriate not to hug, comes with experience and emotional intelligence. Some care workers may need support to feel confident in their judgements. There may also be rules, written or unwritten: know the person's background, only hug in the presence of others, but recognise the importance of touch to human flourishing.

Institutional norms can help to find sensible accommodations: in some care homes hugs are part of life, and the same would apply to other 'options' such as style and formality of conversation. Norms and professional boundaries together can enable interaction without introducing risk. These issues have been discussed when considering the questions of safety and security in Section 2.

A serious potential negative of relational care is that providers may misuse the approach. An excellent example of how this can happen is described by Dodson and Zinzavage (2007), where pressure is put on staff to 'go the extra mile', as they would for their own grandparents. Care workers who are away from their own home and culture can be even more vulnerable to this type of exploitation. The authors summarise: 'Reflecting a subordinate and racialized version of being "part of the family," we call for an ethic of reciprocity and for concrete change toward valuing equally the humanity of those who need and those who give care' (ibid. p. 905). Positive relationships should not be misused; however, because relational care plays a part in improving self-worth, it

can increase appreciation that care workers deserve proper recognition and financial recompense for what is highly skilled work.

Turning to another challenge, although a key element of the (re)-creation of a home-like environment is the presence of individual possessions (furniture, rugs, pictures, etc), these could (sometimes) represent trip and/or fire hazards. Similarly, supporting contribution to the community may need risk amelioration. One instance would be the lady who liked to help in the kitchen preparing vegetables; staff worked alongside her so that she did not control a sharp knife but was part of the team. Our OU report [7] acknowledged this, summarising: ‘Sometimes, enabling the autonomy of residents could present a challenge for staff to protect a person’s safety. On these occasions, staff needed to assess the level of risk and work with the resident and if necessary, their family, to come to an acceptable resolution’ [7] (p. 29).

Implementation of the Butterfly Model (Section 4) addressed similar issues: ‘Some regulators are critical of Butterfly Home environments with their ‘busy’ feel and lots of things in hallways [but] a bright and engaging environment can meet ... safety [regulations]. Teams ... put in place appropriate fire safety checks and cleaning regimes which support this... social connections also promoted better physical health’ (Meaningful Care Matters, 2020, p. 2).

Because continuity of relationships is critical, relational care thrives in stable settings, which not all financing models favour. ‘Big businesses providing services for older people do not have a good track record of survival’ [4] (p. 138), and their survival may be at the cost of the public purse, self-funders, and staff conditions. Low pay and poor perceived value of care workers promote high turnover of staff, as people seek better pay and recognition. The combination of high reliance on immigrant workers, limited work visas and insufficient state funding all create time pressure and threaten continuity of employment, potentially constraining relational care.

### Wider policy issues

In [4] (p.141) I propose that ‘Current policy in the UK presents two major challenges to the adoption of relational care that must be addressed: silo working – particularly but not only the dislocation between health and personal (social) care in terms of funding, provision and accountability – and assumptions about the value of people (of older citizens and of the care workforce) and their place in society.’

This observation was written at the time of a different administration but turning these issues around remains a huge challenge. In 2023 I was invited to contribute to *The Fabian Review* [6] on the basis of a submission to Labour policy review. However, change may not happen at any speed, as I conclude: ‘Both challenges arise from established theories shared across the political divide’ (ibid.) and quote Horesh: ‘Governments... are happy to pursue failed policies as long as these policies have been done before, [this] is less risky... than supporting a new one, even one that is far more likely to succeed (2008, p. 157).’ Policies that would favour relational care need to be long term; relational care does not necessarily require much higher expenditure on a day-to-day basis, but can be promoted by greater investment, as we have seen in the way that capital expenditure on new or adapted build enables the embedding of relational care and its benefits. This demands expenditure in the short term, but clearly some care groups are willing to make this investment for the future.

Providers, whether charitable, private businesses or publicly quoted, have to remain financially viable as their closure can be disastrous to older people and carers. Of these, we are seeing more enlightened, relational-friendly policies from the two former types of care home, who have a little more room for manoeuvre than large businesses which are legally obliged to prioritise shareholder returns. Further, it is concerning that providers owned by private equity firms funnel money out of the care system into tax havens (Murray, 2025). Not-for-profits, on the other hand, also have the advantage of being less constrained by rent commitments as a lower proportion of their income is spent in this way [4] (p.137). I discuss these issues in ‘Can the costs of relational care be assessed?’ (ibid. pp.131-134).

### Limitations of relational care

While action can address some barriers, and there is scope for much wider implementation of relational care, it is also the case that it is not a panacea and demands changes in funding, culture and discourse which will take time and will certainly demand associated national, local and business policy change.

In summary, providing the environment for relational care to thrive does potentially require: a greater (realistic) allocation of time to deliver care as relationships form and for staff engagement in mutual activities; higher (realistic) pay for care staff that reflects the value and skill of the job; and an understanding by the public and policy makers that good quality care costs money, some of which needs to come from the public purse. Some of these costs could be offset by improved recruitment and retention; fewer complaints and reputational risk; and (possibly) reduced use of medication [4] (p. 90).

There is also a change needed to current working conventions, which must be supported by employers and recognised by, for instance Skills for Care and CQC. For example, a shift away from focussing on tasks to developing a meaningful relationship with an older person may be emotionally challenging, at least initially, needing space and time for supportive supervision and discussion to address distress or discomfort. Recruitment is also important: some people may not have the level of emotional intelligence required to deliver relational care or wish to do so. This can be addressed in part by recruiting for attitude, and also by a collegiate culture, training and flexible time practices.

## **9. Reflections on the future of relational care**

The OU research report concludes: ‘Although laudable strides have been made into understanding the benefits of relational care, evaluations of these benefits can be problematic – measuring improvements in the wellbeing of those living and working in care settings is challenging in the absence of a control group and funding for longitudinal studies is rare. The same applies to other established benefits of relational care, most notably improved health and resilience in older people; and staff satisfaction, creativity, motivation and retention.’ [7] (p. 55). This conclusion is based on the limitations of the research; while it may be possible to measure variations related to specific interventions, there was neither capacity nor funding for this.

In 2024, with funding from the OU Open Societal Challenge Fund, we held multi-stakeholder consultative events on the future of relational care, which were attended by 20 sector leaders in person and 40 older people and practitioners online. The aim was to capture views on opportunities and barriers to implementing relational care; the key findings and overarching themes of the report [13] are summarised in Appendix D. To give two indicative examples emerging from the wide-ranging discussions: moving away from task-focused imperatives was seen as an important advance by older people and care staff; environmental design and the nature of funding for older adult care services should be reviewed as they currently inhibit human connections.

The OU team has secured two research bids to define critical issues in the delivery of relational care: the key role of the registered manager, and older people’s perceptions of their priorities. With substantial funding from the Rayne Foundation, we will be undertaking a two-year project on the former and with one-year funding by the Hallmark Foundation are starting the latter project. This external commitment of resources represents an endorsement of relational care and its value, and our work will offer new and additional evidence about its effectiveness and critical role in the development of older adult care.

Looking back since that distant evening in Belfast airport, my journey of understanding and appreciating what all those voices of older people, care staff, relatives and providers had shared with me; what life tells us about relational care, and relational care contributes to life; has been a transformative experience, enriched by the ideas, knowledge and companionship of so many inspiring people.

## 10. Conclusion

This thesis presents my work of the last 12 years, on relational care as a new approach to the care of older people. It also captures the ways in which this work has built foundations for change and improvements to practice and to the landscape of the formal care environment. I have achieved this firstly, by focussing attention on a vital dimension of human flourishing: the need for connectivity to other people, and to the physical world. Secondly, I have distilled the conceptual, organisational and practical shifts required to implement relational care; and thirdly have presented existing examples of how relational care can be incorporated into formal care delivery and settings.

The scope of my work has encompassed a series of critical stages, each building on the previous one. As a body of work, it has made a coherent and ongoing contribution to knowledge about an approach to improving quality of life and wellbeing in formal care settings in the UK. Its continuation, both in evidencing the distinctiveness of relational care and promoting its positive impact on care home environments and the wellbeing of those living and working in them, is reaching a range of critical audiences. These include providers, regulators, trainers, policymakers, representative organisations and academe. Impact on practice, with changes to provider delivery; and impact on research programmes, are both discussed in Section 7. Impact on training includes new practitioner tools, and presentations to a range of organisations such as the British Association of Social Workers and Skills for Care.

My work is not only relevant but timely. In *Radical Approaches to the Care Crisis* (2025) Anne Gray cites 'relational care' as 'a foundational concept' for 'engaging the community to address the care deficit' (p. 94) and states 'her [my] approach resonates with other recent writing' (ibid. p. 96). Talking about positive developments in the care sector, she says 'setting the scene, the work of Kartupelis emphasises the importance of compassion, empathy and friendship in formal care.' (ibid. p. 115).

The care regulator in England, CQC, and provider representatives e.g. Care England, are discussing the importance of adopting relational care principles and practices across care settings, particularly care homes. CQC has invited me to make a presentation to their inspectors in early May 2026 which will introduce them to the key expressions of, and conditions for relational care so that they can be aware of these and possibly incorporate them into reports and decisions about ratings. Evidence of influential agencies being interested in implementing relational care includes a future presentation to ADASS (Association of Directors of Adult Social Care) and 'Partners in Health and Care' (ADASS and Local Government Association group); see also Section 9.

At recent visits to care homes, as part of the OU Relational Care research team, I have been told that they are seeing a change of approach in the application of regulations: 'I have recently seen a shift in emphasis by CQC away from statistics alone towards considering wellbeing issues, and by Local Authorities' monitoring teams towards capturing evidence about older people's feelings' (manager of three care homes over last seven years). She also commented that relational care helps to address problems of distress associated with feeling unsettled or unrecognised that lead to multiple placements, which Local Authorities see as money-saving.

It is fair to say that, taken together, such changes indicate a 'groundswell', a growing commitment in the care sector to move towards provision that recognises the value of mutual relationships supporting human self-worth, empowerment and improved wellbeing for older people, families and staff; and a shift towards the adoption of relational care as an approach.

Barnes (2012) proposes that, for change in care practice to be meaningfully adopted at scale, there needs to be change at the level of policymaking. By appreciating the significance of care to social policy and 'normative frameworks', care may cease to be seen as 'marginal' (2012, p. 149). As discussed in Section 3, she proposes that we should cease to assume that policy makers have any lived experience of care and that 'participative governance' (ibid. p. 151) may help to address this; the importance of

restoring this lived experience, which the OU will contribute to through its work cited in this thesis, may offer impetus to change at local government level.

Barnes (2012) also advocates that meaningful change in social care must include 'participative research processes' (ibid. p. 173). It is reassuring that this type of research in care is being taken forward by the OU team to which I belong. Our forthcoming projects with partners including Local Authorities and care homes will generate further practice guidance co-designed with three groups of care home managers by consulting and drafting guidance with one group; obtaining feedback on it from a second group; and enabling it to be tested over six months by a third group.

Relational care is an important part of a wider paradigmatic shift in discourse about social care. It has helped to challenge the dominant perspectives – initially medicalised and subsequently based on a unidirectional flow of care and task-focused attitudes to practice. It foregrounds recognition of human self-worth, relational reciprocity, and the value of everyone as members of a dynamic community. Relational care has a critical role to play in improving care. Building on its development as a concept and practice, current research not only extends understanding of the impact of relational care on the wellbeing and quality of life for older people and for all types of care staff, but also provides evidence of how it works in practice; thereby offering ways to take forward its benefits in the formal care sector.

## References (Harvard 12<sup>th</sup> Edition)

Alber, E. & Drotbohm, H. (2015) *Anthropological perspectives on care: Work kinship and the life-course*. Springer.

Barnes, M. (2006) *Caring and Social Justice*. Palgrave.

Barnes, M. (2012) *Care in Everyday Life: An ethic of care in practice*. Policy Press.

Barnes, M., Gahagan, B. & Ward, L. (2018) *Re-imagining Old Age: Wellbeing, Care and Participation*. Vernon Press.

Barnes, M. (2019) 'Community care: The ethics of care in a residential community', *Ethics and Social Welfare*. DOI: 10.1080/17496535.2019.1652334.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology', *Qualitative Research in Psychology*, 3:2, 77-101, DOI: [10.1191/1478088706qp0630a](https://doi.org/10.1191/1478088706qp0630a)

Callahan, E., Murtagh, N., Pannell, J. & Pooley, A. (2024) *The Knowledge Hub on Resilience in Almshouse Communities*. Available at: <https://www.ustsc.org.uk/arc-for-the-future> (Accessed: 18 November 2025).

Carehome.co.uk (2025) *Care Homes & Nursing Homes UK – Care Home Reviews & Nursing Home Reviews*. Available at: <https://www.carehome.co.uk/> (Accessed: May 2025).

Centre for Ageing Better (2025) *The State of Ageing 2025*. Available at: <https://ageing-better.org.uk/state-ageing-2025> (Accessed: June 2025).

Cluff, M.D. & Binstock, R.H. (eds.) (2001) *The Lost Art of Caring*. Johns Hopkins University Press.

Dening, K.H. (2024) 'What would Tom Kitwood have thought?', *British Journal of Community Nursing*, 2 June.

Dixon, A. & Newcome, J. (2022) *Final report of the Reimagining Care Commission*. Available at: <https://www.churchofengland.org/about/archbishops-commissions/reimagining-care/final-report-reimagining-care-commission> (Accessed: 24 April 2022).

Dodson, L. & Zincaavage, R. (2007) "'It's like a family": Caring labor, exploitation and race in nursing homes', *Gender and Society*, 21(6), pp. 905–928.

Gawande, A. (2014) *Being Mortal, Illness, Medicine and What Matters in the End*. Profile Books.

Gray, A. (2025) *Radical Approaches to the Care Crisis*. Policy Press.

Help the Aged, National Care Forum and National Care Homes Research and Development Forum (2007) My Home Life report. Available at: <http://www.helptheaged.org.uk/> (Accessed: 2020).

Higgs, P. & Gilleard, C. (2016) 'Interrogating personhood and dementia', *Aging and Mental Health*, 20(8), pp. 773–780.

Homecare.co.uk (2025) Home Care UK: Live in Care, Nursing Care & Homecare Reviews. Available at: <https://www.homecare.co.uk/> (Accessed: May 2025).

Hugo, L. (2005) *Where the Trail Grows Faint: A Year in the Life of a Dog Therapy Team*. Lincoln: University of Nebraska Press.

Jaquet, J. et al. (2025) 'Ageist attitudes are already evident in pre- and early-school children: A multi-method examination', *British Journal of Developmental Psychology*. Available at: Wiley Online Library (Accessed: June 2025).

Kartupelis, J. (2025) Podcast interview for The Outstanding Society. Available at: <https://careology.podbean.com/e/episode-8-relational-care/> (Accessed: 2 April 2025).

The King's Fund (2025) Social Care 360. Available at: <https://www.kingsfund.org.uk/insight-and-analysis/long-reads/social-care-360> (Accessed: 28 August 2025).

Kitwood, T. (1997) *Dementia reconsidered: the person comes first*. Open University Press.

Lee, K. (2021) 'Material Citizenship: An ethnographic study exploring object–person relations in the context of people with dementia in care homes', *Sociology of Health and Illness*, 43(6), pp. 1471–1485.

Marsaa, K.E. et al. (2025) 'When life is lived with dignity and decline: integration of rehabilitation and palliation in dementia care - a case report', *BMC Palliative Care*, 24(1), p. 87. doi: 10.1186/s12904-025-01727-0.

Meaningful Care Matters (2020) What is the Butterfly Approach? Available at: <https://meaningfulcarematters.com/wp-content/uploads/2021/11/What-is-the-Butterfly-Approach.pdf> (Accessed: May 2025).

Milne, A. (2020) *Mental Health in Later Life: Taking a life course approach*. Policy Press.

Molterer, K., Hoyer, P. & Stayaert, C. (2020) 'A Practical Ethics of Care: Tinkering with Different 'Goods' in Residential Nursing Homes', *Journal of Business Ethics*, 165, pp. 95–111.

Murphy, D. (2024) *In the Quiet Light: Reflections on life, disability and meaning*. New Generation Publishing.

Murphy, D. (2025) *Moments of Realisation: Bridging Strategy, Purpose and Intuition in Organisational Growth*. Under review (revision stage) with *Journal of Social Work Practice*

Murray, J. (2025) 'Private care providers in three English regions make £250m in three years', *The Guardian*, 12 November. Available at: <https://www.theguardian.com/society/2025/nov/12/private-care-providers-in-three-english-regions-make-250m-in-three-years> (Accessed: 18 November 2025).

Nightingale Hammerson (2025) *Relationship-centred Care brochure*. Shared with author, June 2025.

Nolan, M.R. (2008) 'Relationship-centred care and the senses framework', *Journal of Dementia Care*, 16(1), pp. 26–28.

Nolan, M.R. et al. (2006) *The Senses Framework: Improving Care for Older People through a Relationship-centred approach*. University of Sheffield.

Oxford Brookes University (2024) *Structural Racism within Social Care*. Available at: <https://ipc.brookes.ac.uk/wp-content/uploads/2024/10/Structural-Racism-Within-Social-Care.pdf> (Accessed: November 2024).

Rockwell, J. (2012) 'From person-centred to relational care: expanding the focus in residential care facilities', *Journal of Gerontological Social Work*, 55(3), pp. 233–248. doi: 10.1080/01634371.2011.639438.

Samuel, M. (2025) 'Minority ethnic social care staff continue to face worse outcomes than white colleagues – report', *Community Care*, 14 May. Available at: <https://www.communitycare.co.uk/2025/05/14/minority-ethnic-social-care-staff-continue-to-face-worse-outcomes-than-white-colleagues-report/> (Accessed: May 2025).

Scott, P.A. (2017) *Key Concepts in Nursing Ethics*. Springer.

Sharp, C., Dewar, B. and Barrie, K. (2016) 'Forming new futures through appreciative inquiry', *Iriss Insight*, 33. Available at: <https://www.iriss.org.uk/resources/insights/forming-new-futures-through-appreciative-inquiry> (Accessed: 24 April 2022).

Sheard, D. (2022) 'Valuing “nous”': injecting care with a booster of emotional intelligence', *Journal of Dementia Care*, 30(2), pp. 26–29.

Sheard, D. (2018) 'Being a Disruptor in Dementia Care', *Journal of Dementia Care*, November/December, pp. 20–23.

Sheard, D. (2013) *Mattering in a Dementia Care Home – The Butterfly Approach*. Brighton: Dementia Care Matters.

Swinton, J. (2021) Presentation at launch of Making Relational Care Work for Older People, 3 September. Available at:  
<https://www.youtube.com/watch?v=X6779U9z5xo&t=11s> (Accessed: 2021).

Vernooij-Dassen, M. & Moniz-Cook, E. (2016) 'Person-centred dementia care: moving beyond caregiving', *Aging & Mental Health*, 20(7), pp. 667–668. doi: 10.1080/13607863.2016.1154017.

Watson, C. (2018) *The Language of Kindness*. Penguin Random House

Wilson-Wynne, D. (2025) 'Person Centred vs Person Led', Dementia Services Development Centre blog. Available at:  
<https://www.dementia.stir.ac.uk/newsblog/person-centred-vs-person-led> (Accessed: 21 October 2025).

## APPENDICES

**Appendix A: Table of Published Works in date order. Text numbers refer to numbering system used in thesis**

Text number	Publication	Responsibility	Description
1	Kartupelis, J. (2015). Exploring the Dynamics of Spiritual Life in Residential Care Communities. <i>Journal for the Study of Spirituality</i> , 5(2), 170-177 (DOI: 10.1179/2044024315Z.00000000049)	Sole author	This article offers insights into the nature of individual and communal spiritual life in care homes and sheltered housing for older people, exploring critical points of interaction between the social and physical environment, and spiritual flourishing. Drawing on a series of surveys commissioned by the Abbeyfield Society, I consider how needs that directly affect spiritual health may be met and identify the key relational factors that lead to the transformation of lives in community settings
2	Kartupelis, J. (2015). Spiritual life in homes shared by older people. <i>Working with Older People</i> , 19(3), 150-156	Sole author	This conceptual paper describes the findings of the Abbeyfield study, in particular the ‘clusters’ of factors relating to wellbeing and the common factor underlying them: the nature of relationships formed in the home and the important interplay between spiritual, mental and physical flourishing. It offers a commentary on practical and social implications arising.

3	Woodward, J and Kartupelis, J, (2018) <i>Developing a Model of Relational Care for Older People</i> , London and Philadelphia: Jessica Kingsley Publishers	Author of approx. 40,000 words out of a total of approx. 70,000 words	Book based on the 100 in-depth interviews (private and semi-structured) that I undertook in 40 care homes across the UK with residents, managers, care workers, volunteers and trustees. Co-author James Woodward wrote opening and concluding chapters (three in total) setting the scene and considering retirement choices. I wrote the middle five chapters providing an analysis and commentary of the interviews; also sections of guidance: on choosing a care home and on the design of care homes.
4	Kartupelis, J (2021) <i>Making Relational Care Work for Older People: Exploring Innovation and Best Practice in Everyday Life</i> , Abingdon and New York: Routledge	Sole author (except for a specialist chapter on technology written by Dr Lorraine Morley who led Age-Tech Accelerator UK)	This book draws on an additional 50 interviews in 15 new settings, combining these with the original study to offer wider analysis of, and applications for relational care. It gives an overview of the nature of relational care in a wider intellectual and practical context; considers its presence and benefits in community and residential settings; looks at new approaches such as Montessori and how these draw on relational care principles; considers the role of technology; and includes an appendix on 'Measuring and evaluating wellbeing'.
5	Burton-Jones, J and Kartupelis, J (2021), <i>Anna Chaplaincy Impact Report 2021</i> , London: BRF	Sole author of report; Co-	I wrote the entire report, based on my qualitative research, and my co-author's

		author in terms of findings	quantitative research. It considers the value of Anna Chaplaincy over a period of 10 years, with particular reference to the practice and value of relational care and older people in this context.
6	'Social Care and Older People: where thriving, practice and policy intersect' <i>The Fabian Review</i> , March 2023	Sole author	I was invited to write this on the basis of my submission to Labour Party policy.
7	<i>The value and practice of relational care with older people</i> , 2023, Gopinath, M, DeLappe, J, Kartupelis, J, Larkin, M, Wilson, A DOI: <a href="https://doi.org/10.21954/ou.ro.00015a63">https://doi.org/10.21954/ou.ro.00015a63</a> <a href="#">Relational care report_ORO VERSION EDIT.pdf (open.ac.uk)</a>	Co-author	This research document was launched in May 2023 in the House of Lords to about 100 people; the findings were based on interviews and observations conducted by the Open University. I was closely involved in the design and analysis of the research, which was directly based on my own work. The research was grant-funded.
8	<i>The value and practice of relational care with older people</i> , 2023, Gopinath, M, DeLappe, J, Kartupelis, J, Larkin, M, Wilson, A <a href="#">Relational care report summary_ORO.pdf (open.ac.uk)</a>		Summary of research used at launch and at events.
9	<i>Making every relationship matter</i> <a href="#">Relational care toolkit ORO VERSION EDIT.pdf (open.ac.uk)</a>		Free toolkit available to download (see Appendix C)
10	<i>Introducing relational care</i> <a href="#">Introducing Relational Care</a>		Free OpenLearn course (see Appendix C)
11	'Relational Care: Precedent, practice and potential', <i>Research in Practice</i> , 20 May 2024	Sole author	Article describing relational care as a natural and positive transition from person-centred care, and the new, empirical research underpinning it

12	<i>Theology and Human Flourishing</i> , ed. Leathard, H, (2024), Sacristy Press	Author of one chapter	Chapter on relational care in a retreat setting, considering its practicalities, benefits and contribution to human flourishing
13	Opportunities and Barriers in Implementing Relational Care: A study on maximising the benefits (2024)	Co-author	Circulated by OU as a pdf, see Appendix D for more details

## **Appendix B: Design guidelines and their fulfilment**

### **Recreating home and family models in new build and conversions**

From *Making relational care work for older people* [4] (pp. 79-81)

While so much can be done to adapt existing homes, their ethos, practice and layout, there are clearly limitations: in terms of staff who may not be comfortable with a new regime, and buildings which simply do not have the space for internal reconfiguration, or get planning permission and funding for extension. When a group decides on a new build, it has far more flexibility to incorporate relational design.

Following the extensive study with Abbeyfield already described in Chapter One and above, the charity's Development department and myself, working with an architect with considerable experience of care homes drew up design guidelines to reflect the impact of the research on the built environment and its influence on emotional and spiritual as well as physical life. As the French philosopher and clergyman Ernest Dimnet said in *What We Live By* (1932), 'Architecture, of all the arts, is the one which acts the most slowly, but the most surely, on the soul'.

Good examples of how 'bricks and mortar' really matter are to be found in The Abbeyfield Society's Hope Bank View independent living in Silksworth, Sunderland (built in 2017), their dementia-friendly care home in Winnersh near Wokingham (2016) and Abbeyfield Bristol and Keynsham Society's new developments.

All these schemes were designed to incorporate as many as possible of the 'top ten' built environment requirements (detailed in Woodward and Kartupelis, 2018, pp. 149 - 150). Many of these guidelines are listed below, with responses and comments from the scheme manager about how they are working in practice.

*Guideline*

*To provide residents with variety and choice, at least two communal rooms should be provided in a small home and at least three in a larger home*

Response

‘There is always activity in the main lounge. The second lounge tends to get used mostly in the evenings when the men retire to the smaller lounge and the women stay in the main lounge. If the football is on then it’s the other way round. The second lounge has become the ‘quiet lounge’ and a sanctuary. In addition, the local church group use the second lounge as it is away from the main lounge that can get quite noisy. In the main lounge, there was often bickering about sitting in particular seats or wanting to sit with a particular group of people. The staff change the furniture layout regularly because of this.’

*Guideline*

*A garden room such as an orangery or conservatory should be considered*

Response

‘Having direct access to the garden room and outside area is also hugely important for residents, many of whom spend much of their day within the house. Connecting with nature, feeling sunshine and a warm breeze on their face, seeing spring bulbs come up, watching birds and squirrels visiting the feeding tables, noting when the pears and apples are ready for picking – all of this adds to a wonderful feeling of contentment, of being in the right place at this stage of their lives.’

*Guideline*

*A sheltered outdoor space such as a summerhouse should be provided in the garden to encourage residents to maximise their time in the garden.*

Response

‘Here at Abbeyfield Winnersh we have a lovely big secure garden and two summer houses, both with toilets and one with a kitchenette. Both the summer houses we are planning to open this spring. One we will use as a Vintage Tea Shop where residents and their families can come and visit and have afternoon tea and cake and look around the summer house which will be decorated with vintage pictures and memorabilia. The

second summer house we are aiming more towards an activities area to include a train set amongst other activities with a slant towards a 'man cave' to more support our gentleman here. Both the summer houses will promote the feeling that residents are going out and will enjoy the short walk through the garden to reach them.'

*Guideline*

*Dining rooms should be designed to maximise natural light with attractive views out into the garden and beyond to ensure a pleasant experience, with plenty of light for the visually impaired*

Response

'The need to have natural light and good ventilation in dining areas is absolutely essential. The creation of an airy, spacious environment stimulates appetite and a heightened sense of their surroundings for our residents (many of whom have some degree of visual impairment) and encourages them to linger after meals, thereby promoting increased opportunity for sociability and enhancing well-being.'

*Guideline*

*The lounge should be family-oriented, with access to safe drinks preparation by occupants.*

Response

'The main lounge has an area for making tea and coffee. It is used throughout the day by residents, their families and visitors. Residents do like to be able to offer a cup of tea to guests – anyone visiting. It is the main focus of the lounge.'

*Guideline*

*Staff should have a peaceful retreat away from residents to enjoy their breaks.*

Response

'There are two staff areas in the property. The one that is used the most is next to the kitchen. It is the kitchen staff room but is used by most staff for a break and to eat their lunch. It is very peaceful and allows staff to get away from residents who can be hard work sometimes.'

The other staff room is between two apartments and staff tend not to use it because they fear being overheard.' *(this second comment is worth bearing in mind for future design)*

#### *Guideline*

*Whilst efficient, long straight corridors should be avoided wherever possible to ensure that circulation spaces do not feel institutional*

#### Response

'The corridors at Silksworth do have alcoves which help to break up the view down a corridor but these have been wasted space so far. The staff are currently planning some fundraising to convert these to a reading area/library and a sewing area.'

## **Appendix C: Content of the relational care tools**

### **Making every relationship matter: a practitioner toolkit for relational care with older people**

To download: [Relational care toolkit ORO VERSION EDIT.pdf \(open.ac.uk\)](#)

#### Contents

1. Why this toolkit?
2. How can it be used?
3. How the toolkit came about
4. Relational care and its key components
5. Relational care in action
6. What makes relational care practice work?
7. Illustrative vignettes for individual and group reflection
8. Questions and Answers
9. Acknowledgements

### **Free course (online learning module, 4 hours)**

#### **Introducing relational care**

To access: [Introducing Relational Care](#)

#### Course description

‘Relational care’ is a developing approach to care which can help address many of the challenges faced by the older adult care sector. It provides benefits not only for older people but also all those involved in their care.

This free course is for providers, managers and staff of older adult residential and day care facilities. It explains what relational care means and how relational care practice can be introduced or extended. Studying this course will enable you to apply a toolkit developed from research for use in your own care settings, with groups and/or individuals. You can work through the course independently or with others. Case studies, vignettes and audio/video material developed through empirical research are used to bring alive the value and application of the toolkit.

#### Sections

Introduction

Learning outcomes

Understanding relational care and why it matters

The practice of relational care

Deepening your learning

Conclusion

Further resources

References

Acknowledgements

## **Appendix D: A consultation on opportunities for, and barriers to relational care**

The OU team believed it sufficiently important, to apply for funding in order to undertake the consultation project outlined in the report [13] which was published in June 2025.

The project included an in-person one-day 'round table' discussion with 20 sector leaders, three webinars with 40 people involved in day-to-day (paid) care interactions; analysis of the transcripts and notes to draw out perceptions of barriers and opportunities. These in turn produced an action plan under five themes. The purpose was to identify areas for future action by the OU team; its partners; or other sector organisations. Most of these (but not all) will only be possible with funding.

The work was carried out by the OU Relational Care team of three people including myself; my role in producing the report was to carry out an initial analysis of the webinar recordings; merge these with the analysis of the round table to produce a summary of key findings; and write a sample 'action plan' of how to take RC forward. In this appendix, I will draw on this report as well as observations from my published work.

We identified these key opportunities to overcome barriers and challenges:

### Priorities for the wellbeing of older people

*Opportunities:* Use the relational care approach to enhance visibility of older people; increase agency and control; encourage proactive planning

*Challenges:* Raising awareness of existing models that favour these opportunities; ensuring advisers and gatekeepers have information and support on relational care

### Care workforce issues

*Opportunities:* develop and advocate for aspects of relational care practice that will enhance career satisfaction e.g. moving away from task-focused imperatives

*Challenges:* perceived and actual undervaluation of care work impedes relational care implementation

### Provision of accommodation, services and facilities

*Opportunities:* adoption of ideas such as ‘lifetime neighbourhoods’, ‘age-friendly neighbourhoods’ and technology that facilitates human interaction will favour relational care

*Challenges:* environmental design and nature of funding for older adult care services currently inhibit human connections and continuity of mutual relationships

### Regulation

*Opportunities:* The way regulations are framed does not prevent innovation and there are opportunities to incorporate relational care and its benefits into guidance

*Challenges:* Some of the vital aspects of care work are not measured nor recognised, and neither is the wellbeing of care workers. Person-centred care is still a reference point

### Economic and policy impacts

*Opportunities:* An evidence dossier of how and why relational care works is an essential tool for the advocacy effort with providers and policy influencers.

*Challenges:* The separation of the NHS and social care is a continuing barrier to appreciating the impact of the latter on health spend and delivery, and hence of the potential benefits of relational care to the NHS; there is also a risk of relational care being seen as a substitute for improved pay, conditions and investment.

It should be appreciated that this is a summary of material that yielded a considerable amount of information about barriers to relational care, balanced by considerable amount of enthusiasm for it amongst the 60+ consultees. The report’s extensive appendices explaining the process and giving the full consultation material and its analysis underpin the summary.

### **Opportunities to address challenges through realistic action**

These conclusions were brought together into five overarching themes for change and action from which I drew up a sample action plan for potential funders and partners as follows:

### ***Theme 1: Valuing care, care workforce and older people***

#### **Action points:**

'Older people should be seen as assets' and

'Relational care helps to empower older people, more advocacy is required'

#### **How?**

These action points are linked. We will collaborate with partners to evidence examples of older people making a difference to their community through contribution, demonstrate how relational care enabled that contribution, and how the older people felt about it.

#### **Who?**

We will identify examples (small and greater) with partners such as Centre for Ageing Better, Anchor Homes, Hallmark Foundation, Ageing without Children, Nightingale Hammerson, Embracing Age

### ***Theme 2: The current culture of elder care delivery***

#### **Action points:**

'Promote messages about relational care benefits to domiciliary workers and providers working in this area'

'Focus on 'efficiency' promotes task and time-oriented work cultures'

#### **How?**

Using the findings of this research to address concerns and opportunities mentioned by homecare workers, develop publicity to reach them with information about how they can advocate for and use relational care e.g. presentations, blogs, podcasts. Also seek examples from them.

Collaborate with residential and domiciliary care providers to evidence how relational care can offer an antidote to the issue of focus on 'efficiency' promotes task and time-oriented work cultures'

#### **Who?**

Work closely with Care Workers Charity, NACAS and a Local Authority (e.g. Leeds City Council with whom we already have a relationship and who have access to a group of homecare workers). Also consult with The Almshouse Association, whose residents often have domiciliary care, and with home care providers such as Bellevie and Home Instead

Collaborate with providers as above involved in provision and delivery of care in residential and domiciliary settings. For example, working closely with residential care home managers

The Open University team aims to identify care models currently used in practice and develop training materials that help care providers and managers understand how their current approaches align with relational care principles."

### ***Theme 3: Economic, regulatory and policy factors***

#### **Action point:**

‘Addressing inequality of access to good relational care – role of Local Authorities’

[Note: our proposed actions under this point will also assist with addressing issues about gatekeepers]

#### **How?**

Identify the circumstances under which older people can access residential care where relational care is practiced: are those settings state as well as privately funded; to what extent do settings cater for ‘mixed funding’; are cultures based on type of funding? This will require a relatively small but significant sample, which we hope would be possible through our proposed project with Leeds City Council and Anchor Homes.

#### **Who?**

One or more of the Local Authorities with which the OU team already has contacts; two different care home providers who accept state and privately funded clients; My Home Life; ADASS

### ***Theme 4: Envisioning the future***

#### **Action point:**

‘Role of volunteers – is this changing and how can they advocate for relational care?’

#### **How?**

On a national level, locate and work with relevant people on volunteer-supporting organisations such as Get Volunteering and the NCVO to advocate for the benefits of relational care to people helping in elder care settings. On a local level, help managers of those settings to find and enthuse volunteers in their community by providing succinct advisory material about the role of a relational care environment in attracting and retaining volunteers.

#### **Who?**

Develop collaborations with charities such as, Embracing Age and United for All Ages

### ***Theme 5: Evidencing the impact of relational care***

#### **Action point:**

‘An evidence dossier (easily accessible) is essential’

#### **How?**

This will be based on exemplars (inc. longstanding and more recent) linking relational care to outcomes and quality of care. The findings given in this report are full of good examples and quotes, and we can go back to its contributors to get more information. There is currently a lack of relational care cost benefit analysis for providers and policymakers.

#### **Who?**

Having gathered evidence as above and from other contacts with whom we are currently working, we will work with an already established group such as Care England and the Centre for Ageing Better, and with our media contacts to launch and publicise the pack, and to draw up a target list for circulation.

**Appendix E: Author's articles published in care sector and other media  
(all single-authored by the candidate)**

'Relational Care: Precedent, practice and potential', *Research in Practice*, April 2024

'Valuing Care Staff and Managers', *ICG Making Care Matter*, April 2024

'The Transformative Power of Relational Care', *Care Talk*, August 2023

'Solution of the week: Fulfilling the potential of mutual relationships', *International Longevity Centre*, August 2023

'Relational Care: Challenges, benefits and implementation', *Care Talk*, July 2023

'A New Vision for Adult Social Care', *Central Bylines*, June 2023 (chosen to feature in the national Bylines Gazette)

'Caring Better, Together' *The Fabian Review*, April 2023

'Another wave of Covid? Some thoughts on building resilience to isolation', *The Carer*, 17 August 2022

'Care and older people: changing the emphasis from the individual to the relational' Blog for *Faith in Older People*, August 2021

'Meeting the challenge of adult social care: good practice is based on good relationships', *Yorkshire Bylines*, August 2021

'Activities and purpose: ensuring a meaningful life', *Care England*, June 2021

'Relational care: its role in fostering resilience' and 'Relational care: independence and the almshouse environment', *The Almshouse Gazette*, February and March 2021

'Environment, Engagement and Enterprise', *The Care Home Environment*, February 2021

Relational Care: some implications for care staff policy', *Care England*, February 2021

'Relational Care: the benefits and challenges for public policy', *Care England*, November 2020

'Why relationships matter in the care home', *Caring UK magazine*, early 2019 (series of articles)

'Why does Relational Care matter?' *Caring Times*, 9 November 2018

'Relational care and older people: a challenge to accepted wisdom', *RSA blog*, June 2018

‘The role of management in fostering good relationships and improving wellbeing: how managers can favour a positive environment’, *Care Management Matters*, 30 May 2018

‘How the right environment can favour positive relationships in homes for older people’, *The Care Home Environment*, 21 May 2018

**Appendix F: Seminars and presentations**  
**(all given by the candidate alone or with one other member of the OU team)**

13 May 2025, *Relational care practice: how can we make meaningful change happen?*  
Presentation to Enhancing Residential Care Conference

30 Jan. 2025, *Relational care in the context of 'community living'* Presentation to The Almshouse Association annual research conference

9 October 2024, 'Relational care: its value and implementation', presentation to National Care Show Birmingham (resulted in NACAS asking us to discuss working with them)

19 August 2024, Presentation to British Association of Social Workers' 80:20 Group (resulted in Leeds City Council asking us to discuss a joint project with them)

July 2024, 'Relational Care Practice with Older People', presentation to British Association of Social Workers' Special Interest Group

23 Jan. 2024, Sheffield University Centre for Care: Seminar: The value and practice of relational care with older people

11 Jan. 2024, Presentation to The Almshouse Association annual research conference

7 July 2023, Webinar for The Almshouses Association

18 April 2023, Presentation to Housing LIN: 'Care and Support Re-imagined: changes to practice and the environment of care'

21 March 2023, 'The Value and Practice of Relational Care', presentation to MHA Research Symposium on Ageing

March 2023, Submission to the National Policy Forum of the Labour Party

8 Feb. 2023, Submission to Prevention in Health and Social Care Inquiry: Health & Social Care Select Committee

3 March 2021, 'Relational care: community-based care and policy implications', presentation to the University of East Anglia

11 March 2021, 'Relational care: older people, newer challenges' presentation for the Northern Baptist College

19 February 2021, 'Relational Care and Restoring Autonomy' presentation to Worcester University: Dementia in the Family Context module (Masters level)

December 2021, submission to the Re-imagining Care Commission: 'Mutuality in the caring relationship: what does it mean in reality?' (this paper was incorporated into the final report)

December 2020, 'Relational Care Holds the Key to the Future', ILCUK Future of Ageing Conference

May 2018, 'The spiritual aspect of care relationships: Listening to older voices'  
Presentation to Research Institute for Spirituality and Health European Conference

*This page intentionally left blank.*