findings

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Establishing a regulatory system for single registered care homes

The Department of Health is reviewing the whole system of the regulation of social services. Malcolm Johnson and Lesley Hoyes of the School for Policy Studies at the University of Bristol consider how a single registered care home could replace the current distinction between nursing and residential care homes. They propose a model for standard setting and the regulation of a spectrum of care.

Arguments for single registration include:

The distinction between nursing and social care which underpins the current separate systems of provision is no longer tenable as residents become older and increasingly frail. Dual registration has not succeeded in bridging the regulatory gap.

A spectrum of care homes registered under a single system would offer a range of care along a continuum.

Key elements of the proposed model are:

The setting of nationally agreed criteria for initial and on-going assessment of health and social care needs. **Individual care plans would specify assessed needs and would also trigger changes in the level of care. Assessment would be linked to a scale of fees based on provision for individual needs rather than type of home.**

A level and mix of staffing in each home dependent upon the assessed levels of needs of residents. **Accredited training courses, producing a wider skill mix amongst care staff, would enable a more efficient use of qualified nurses.**

The development of 'Gerontological Nurse Specialists' **who may work as established staff in homes or be based in support agencies, allowing the flexible and appropriate use of specialist nursing skills.**

The establishment of an independent and broadly self-financing National Office for Standards of Care **to oversee the setting of national standards and the registration and inspection of all care services.**

The development of a regionally based registration and inspection system, **with a multi-disciplinary core of staff, supplemented by panels of 'lay experts', including service users and carers.**

The appointment of an Ombudsman **to deal with complaints.**

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The case for single registration

Nursing homes have always been largely in private ownership, whilst residential care has been a shared arena between local authorities, charities and commercial businesses. The NHS and Community Care Act 1990 separated the providing and purchasing functions in health and social services and promoted the 'mixed economy'. These factors together have led to a preponderance of the private sector, expansion of not-for-profit enterprises and vastly reduced local authority provision of long-term care.

Throughout this period of profound structural change, the regulation of long-term care has rested with local health and social services authorities. In the past, it could be argued that public provision was accountable by democratic process. But the structural inappropriateness of these arrangements has become increasingly apparent and there is a broad acceptance that more independent and more effective procedures are essential, across all sectors.

This study puts forward a new organisational and regulatory framework for care homes. Issues addressed relate both to the establishment of a single category of care home and also to a single registration authority. The two concepts are not of necessity linked. It would be possible to create a single registered care home without a single registration system or to establish a single registration authority to regulate distinct categories of homes. However, the current Government review offers the opportunity to unify both provision and regulation which would maximise the benefits on both economic and social grounds.

A spectrum of care homes

The current distinction between nursing and residential homes is based on an historical split between professionally defined models of 'medical' and 'social' care. The regulatory system embodied in the Registered Homes Act 1984 is determined by these two professional models. The current provision for dual registration might have led to the development of a more unified type of provision. In reality, differing regulations, guidelines and procedures followed by health and local authority inspectors have often placed unreasonable regulatory burdens on homes seeking to provide a wide range of care. In consequence, the successful establishment of dually registered homes has been limited.

The proposed organisational and regulatory framework will facilitate a broad spectrum of styles of provision, enabling a degree of mobility between different styles, which reflects the changing needs of individuals over time. This is not to advocate a single category of care home catering for any person with support needs. There are powerful arguments against a general mixing of different age and client groups within residential settings. However, instances of couples being split up because of differing care needs are clearly unacceptable and could be avoided with a single registered home.

Equally the proposed system does not imply that all homes will be expected to provide for all levels of dependency. Providers must be able to choose the type of care they are prepared to offer and residents must be able to choose the type of home they wish to live in. The concept of a single care home is about enabling flexibility, not about imposing a universal model of provision.

The aim is a continuum of long-term care, from small family placement schemes for individuals with support needs, through care homes offering a home for life, to establishments caring almost exclusively for frail or sick people with substantial nursing needs. Along this continuum, providers could opt to offer a range of care, some quite narrow, some very broad, which would be clearly set out in their brochures and information for prospective residents.

Elements of the proposed model for individual homes

The Care and Business Plan

Each home would be required to produce, as part of the initial registration procedure and then annually, a Care and Business Plan. This Plan would set out the range of care and services the home offers and the contractual arrangements for the continuous assessment of residents' health care needs. The Plan would need to specify agreed contingency arrangements for meeting changing health care needs. This might be through direct employment of nursing staff or through contractual arrangements with community nursing services or commercial nursing 'banks'. Following initial registration, the Care and Business Plan would be revised annually, forecasting the likely care needs of residents and the consequent demands on staffing for the next twelve months. It would map the requirements of existing residents, based on computerised individual care plans. Changes in the needs of residents or changes in the prospectus of provision would result in modifying the mix of skills and services. This Plan would form a central part of the inspection process.

Individual assessments and care plans

The key feature of the single registered home would be its ability to adapt to the ageing and increasing frailty of residents, and to provide a home for life in all but exceptional circumstances. The major challenge is to achieve an appropriate skill mix amongst staff, in particular the level of professional nursing input. Provision in the single registered care home would be geared to the needs of each individual resident. The comprehensive assessment of needs, both prior to initial admission and on an on-going basis, is an essential element. A number of existing and proposed assessment methods could form the basis of a nationally agreed system. Such assessments would encompass health care needs and lead to a care plan which specifies how these needs are to be met. The levels and mix of staffing at any point in time would depend upon these individual care plans. Care plans would also specify potential changes in circumstances and care needs which would act as 'triggers' to changes in the nature or level of care to be provided and implications for staffing skills and levels. Each home would be expected to maintain computerised records of all residents' care plans and concomitant staffing arrangements, accessible to inspectors at all times.

The role of 'Gerontological Nurse Specialists'

It would be impractical and unnecessary for all single registered care homes to be headed by or to employ registered nurses. But each resident must have access to an individually appropriate level and type of health care. A distinction can be made between 'nursing care' and 'nursing management'. Residents with major and continuing health care needs will require nursing management, that is, health care planned and overseen by a qualified nurse. Relatively few will require 24 hour on-duty nursing care. The need is for highly skilled nurses to carry out assessments, to plan health care for individuals and, where appropriate, to delegate designated health care tasks to suitably trained care staff.

Such a need could be met by an increase over a period of a few years in the number of 'Gerontological Nurse Specialists' with particular expertise in assessment and health care planning for older people. Gerontological Nurse Specialists could be employed by long-term care establishments or might be members of Primary Health Care Teams or Community Nursing Teams employed by Health Trusts. They may operate from private agencies. Care homes whose residents' needs would not justify direct employment of nurses would contract to buy the assessment and nursing management skills of Gerontological Nurse Specialists. Details of such contractual arrangements would need to be specified in the Care and Business Plan. The regulatory system would need to verify such arrangements.

Achieving the right mix of staff skills

Delegation of certain nursing procedures, sometimes under written protocols, to competent care staff under the supervision of an accountable trained nurse is already established practice in some areas. The 'multi-skilling' of care staff requires the further development of accredited training and qualifications, clearly linked to the levels and range of caring activities and nursing procedures they are competent to perform.

This proposed combination of Gerontological Nurse Specialists and better trained care staff would enable a more flexible and cost-effective use of nursing skills, which would be available in non-hospitalised settings to a larger proportion of the elderly population.

Charges for long-term care

Fees payable for long-term care from public funds would be linked to individual needs as defined through the assessment and re-assessment process and as specified in individual care plans. This represents a major change from the current position where fees are largely set according to the type of home. It is a change which would dispel current claims that people with health care needs are being denied their rights to skilled nursing care by placement in less costly residential homes, whilst at the same time avoiding alleged unnecessary over-staffing (and over-charging) in some nursing homes.

Proposals for a single regulatory framework

The purpose of a regulatory system for long-term care should be to protect vulnerable residents by ensuring an agreed acceptable standard of provision. It should not aim to control the number of providers or the prices charged for services, to offer a consultancy service to providers or to monitor contract compliance for service purchasers.

Principles and functions of regulation

Any change to the existing regulatory system must be justifiable on the grounds that it offers an effective way of achieving the key principles of even-handedness (through elimination of conflicts of interest), consistency, transparency, accessibility, assured quality and value for money.

A regulatory system for long-term care would encompass a number of different functions, including:

- the setting of standards below which no provider can be allowed to fall;
- the enforcement of those standards through registration and taking action against non-compliance;
- the monitoring of compliance with those standards.

Whilst these functions do not necessarily have to be carried out by the same agency, there seems little reason to split responsibility between different agencies.

A National Office for Standards of Care

The researchers propose a National Office for Standards of Care (NOSC), accountable to the Secretary of State for Health and independent of all providers and direct purchasers of care. Initial set-up funding would be needed from the Department of Health, possibly through joint finance funds. Running costs would continue to be through fee income from providers, with variable rates to reflect the scale and complexity of operations, though central government should meet the central infrastructure costs.

The remit of NOSC would be to:

- set national standards for each range of the single care home spectrum;
- develop tools and methods for monitoring compliance with standards;
- carry out the statutory functions of registration and inspection;
- monitor consistency in the performance of functions and the application of standards;
- carry out/commission research into standards/outcomes of regulation/methods of inspection;
- encourage accredited quality assurance mechanisms and training;
- develop accredited training for registration and inspection officers.

The setting of national standards would be aided by the establishment by NOSC of an Advisory Council of interested parties, central amongst whom would

be users of long-term care services and their relatives and advocates. Service providers and purchasers would also be represented.

Operational issues

Whilst national standards are essential, the regulatory process must be easily accessible to both providers and users of long-term care. NOSC would discharge its registration and inspection functions through a network of sub-regional or local offices, based on existing health regions. A core of directly employed staff would include a mix of professional expertise, including qualified nurses and specialists in the care of people with other support needs who use long-term care. Nationally accredited training courses for all core staff would have to be developed, supported and validated by NOSC.

Inspections would be carried out by one or more members of the core staff, accompanied by one or more 'lay experts', drawn from locally recruited and trained panels which would include long-term care users and carers. Large establishments would be inspected by teams of core staff and 'lay experts'. NOSC would provide training for all panel members.

The focus of registration and inspection is quality control, not quality assurance. Registration confers on providers a 'licence to trade' based on statutory requirements. Inspection monitors compliance with those standards. Advice from inspectors to providers should be limited to achieving those standards. There should be a clear separation of these activities from the developmental/consultancy roles which quality assurance techniques might employ. NOSC would, however, encourage the development and use of accredited quality assurance mechanisms in care homes and would take good practice in this respect into account in determining the frequency and intensity of inspection activity.

Complaints

Under present arrangements, complaints not resolved within a home may be taken up by the local inspection body. In order to provide a clearer and more independent adjudication of complaints, the researchers propose that there be an Ombudsman for Continuing Care associated, nationally, with the NOSC.

About the study

The Joseph Rowntree Foundation commissioned the authors to suggest how the concept of a single registered care home might be put into practice. The researchers consulted 48 bodies representing the main interest groups, of which 36 responded. These included local authority and health authority associations, health and social care professional bodies, voluntary organisations and consumer groups, as well as a range of not-for-profit and commercial providers of long-term care. A small number of key agencies were interviewed by telephone. Whilst there was not a simple consensus, there was an overwhelming opinion in favour of the concept of a single registered care home and a system of regulation based on national standards, independent of local health and social services authorities.

Further information

A full report, **Registering long-term care: proposals for a single registered care home**, is available free of charge from The Policy Press, Rodney Lodge, Grange Road, Bristol BS8 4EA, tell 0117 973 8797, fax: 0117 973 7308. The Foundation is also currently developing a National Certificate in Care with the University of Humberside and Lincolnshire which will provide a model for the training of multi-skilled care staff.

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The Homestead, 40 Water End
York YO3 6LP
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