

The independent care homes sector

**Implications of care staff shortages on
service delivery**

Stephen O'Kell

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Abbreviations

The following abbreviations are used within the project report:

AP(E)L	Assessment of prior (experiential) learning	NHSE	National Health Service Executive
BGS	British Geriatrics Society	NISW	National Institute for Social Work
CCETSW	Central Council for Education and Training in Social Work	NMS	National Minimum Standards
CPD	Continuous professional development	NSF	National Service Framework
DHSS	Department of Health and Social Security	NTO	National Training Organisation
DoH	Department of Health	NVQ	National Vocational Qualification
DTI	Department of Trade and Industry	QCA	Qualifications and Curriculum Authority
EMI	Elderly mentally infirm	RCN	Royal College of Nursing
GSCC	General Social Care Council	RCP	Royal College of Physicians
IHA	Independent Healthcare Association	RHS	<i>Registered Homes & Services</i>
NAHA	National Association of Health Authorities in England and Wales	RNCC	Registered Nurse Care Contribution
NCSC	National Care Standards Commission	SSI	Social Services Inspectorate
NHS	National Health Service	TOPSS	Training Organisation for Personal Social Services
		UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

Glossary

The following definitions have been used throughout this project report:

AP(E)L	Assessment of prior (experiential) learning that is used as a basis for gaining entry to, or exemption from, parts of a course of study.
Best value	Maximising the quality of service provision in line with available resources and government policy.
National Occupational Standard	Defines good practice by describing the competence required for specific occupational roles. They are intended for UK-wide use.
National Minimum Standards	A set of national quality standards on long-term care that will supersede the Registered Homes Act 1984 standards and form the basis by which the National Care Standards Commission will be able to assess whether care homes meet the needs, and secure the welfare and social inclusion, of the people who live in them.
Protocol	A set of written recommendations, rules or standards that are to be followed in a specific health-care situation. They are used where rational procedures for some aspect of care have been developed.

Summary

The independent care home sector

In England, this sector of the market is characterised by:

- a continuing oversupply of long-term care beds
- the closure of many small private homes
- profit margins being squeezed, leading to homes having to become more efficient
- threatened boycotts of local authority placements because of the low fees on offer
- the reassignment of clients from nursing home care to residential care.

The large number of overlapping government initiatives that are currently being implemented are causing confusion within the care sector. It will be interesting to note over the next few years whether the needs and interests of all the interested parties in the independent care home market can be met by successfully managing the following problems:

- funding shortages for long-term care
- the need for close collaboration between health and social care
- ensuring that there are enough residential homes and nursing homes
- ensuring consistency and excellence of care service delivery
- the need for intermediate care facilities in all parts of the country.

Accessing care home services

The National Service Framework for Older People and the Charter for Long-term Care are expected to enable the National Health Service (NHS) and local authorities to collaborate on the planning, resourcing and delivery of services for older people.

Because the quality of needs assessment undertaken by care managers can be very variable, it is strongly suggested that care home managers do their own assessment on prospective residents before accepting them into the home. This is one area where national collaboration is needed in agreeing a single assessment process for all older people, and in setting centrally determined eligibility criteria and care home fees.

Finally, clarification is needed for care home residents and relatives on precisely what care services are available and who has to pay for those services. It is essential that individuals should have a clear estimate of how much they are required to pay before a client is admitted to a care home.

Care staff recruitment

The reality is that public services are no longer attractive as a career option to many people. There are better jobs, offering more money, available in other occupational areas, especially within the private sector.

In order to minimise the shortages of care staff, the NHS Workforce Development Confederations are going to have to work collaboratively with regional training forums and the independent care sector in developing integrated manpower planning strategies that

meet the needs of all participants in the care sector. Unfortunately, the staff shortages are expected to get worse before they start to get better, especially within the independent sector. This may require some flexibility from registration and inspection units.

The planned Code of Practice, workforce registers, Consultancy List and the TSO Enterprises Clearing House Initiative, when they are available, should all be welcomed as they are likely to make the recruitment of care support workers easier and enable employers to identify those individuals who should not be working with vulnerable people.

Care staff retention

Staff motivation is identified as the best way to overcome many of the problems of care staff retention. In the new care homes, where it is expected that very little care will be designated as 'nursing care', it is likely that extended care roles for care support workers will be encouraged by home managers and primary care groups. The need for extended care roles for care support workers will be even more important when there are no nurses employed by a home and/or where there is a limit to the amount of health care support that can be provided to individual residents by NHS community nurses.

The National Minimum Standards specify a range of issues that have to be addressed by care homes in relation to staff supervision and training. Many home owners will feel that they have neither the time nor the resources to properly meet these standards.

In terms of access to training opportunities, even if care homes can stimulate their care staff

to undertake further study, outside help is going to be required so that innovative solutions can be found to the problems of involving the independent sector in local training needs analysis and in overcoming the problems of expensive course fees, limited access to academic libraries, etc.

The new occupational standards that have been developed for induction and foundation courses, registered manager award, etc. will require a review of the NVQ in Care awards so that they can be integrated within the National Vocational Qualification (NVQ) framework, as well as being stand-alone awards.

Finally, a local review of available gerontological skills will be needed in each district to see how best to facilitate gerontological nurse specialist input into all care homes.

Registration and inspection

Registration and inspection is, currently, in a state of flux. Care home owners are having to prepare for the implementation of the National Minimum Standards by working towards the achievement of those standards. At the same time, many of the inspectors working for registration and inspection units are applying for posts as regulators within the National Care Standards Commission (NCSC) and working towards the achievement of the national occupational standards that have been specified for regulators.

It is going to be a while before the regional and local offices of the National Care Standards Commission are established. In 2002, when these offices become operative, it is going to be interesting to see how well they are going to be resourced and whether or not they can avoid

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the allegations of 'inconsistency' that are currently being levelled at registration and inspection units.

A further important point to note is that, because the National Minimum Standards are no better than the Registered Homes Act standards in terms of concentrating on issues

other than structure and process, consideration may need to be given to linking the National Minimum Standards to the results of the Minimum Data Set Resident Assessment Instrument that is likely to be used by care homes, so that the outcomes of care can be incorporated into the inspection process.

1 Introduction

This project has been undertaken to provide a snapshot of the issues affecting the independent care home sector at the present time. The impetus behind the project has been the growing amounts of anecdotal evidence on: the shortages of care staff; homes going bankrupt; education and training difficulties; the problems of providing high quality care; difficulties experienced with the registration and inspection process; plus a range of legislation that is currently being implemented that is likely to significantly affect this sector of the care market.

Terms of reference

- 1 To undertake a literature review that illuminates the debate associated with the pressures that are currently being experienced by the independent care home sector.
- 2 To explore the extent of staff shortages within the care sector as a whole.
- 3 To identify best practice in terms of recruitment and retention of care staff.
- 4 To review the education and training opportunities for care staff in the independent care home sector.
- 5 To assess the impact of registration and inspection on the independent care home sector.
- 6 To review the provision of care within the independent care home sector, prior to the implementation of the National Minimum Standards.

Methodology

This is an exploratory study, which utilises an 'action-centred' approach in order to highlight relevant issues arising from contemporary literature and focused interviews. The project design does not exclude the formulation of specific conclusions and recommendations, but focuses on current debates, developments and issues within the independent care home sector, prior to the implementation of the National Minimum Standards.

The following methodology was adopted:

- 1 A comprehensive literature review, looking for relevant information from appropriate subject areas that illuminates the debate associated with: the availability of care staff, independent care homes market sector, education and training opportunities, care provision in nursing and residential homes, registration and inspection, current legislation affecting care homes.
- 2 A series of focused interviews were held with a purposive sample of: national organisations that have an interest in the provision of care within care homes; corporate providers of care homes.
- 3 Because it was necessary to collect data from as wide an area as possible in England, the country was split up into six 'regions'. A list of registration and inspection units that covered each of the regions was then made so that one area could be chosen at random. The local authority and health authority registration and inspection units that covered that area were then contacted to

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organise focused interviews. Only one registration and inspection unit declined to be interviewed.

- 4 One nursing home, one residential home and one dually registered home from each area were then chosen at random for focused interviews.
- 5 A number of research methods were considered for this project. The interview was chosen as the most appropriate method of obtaining information, as it would provide an opportunity to explore in greater depth the official and/or personal views expressed by interviewees.

- 6 The parts of the country that were visited during this study were:
 - Bath, Bristol and Avon
 - Croydon
 - Cumbria
 - Kent
 - Newcastle
 - Northampton.

The individuals interviewed as part of this project are listed in the Acknowledgements section of this report.

2 The independent care homes sector

Nearly all care home providers have reported higher dependency levels of clients and a higher age of admission since the implementation of the community care reforms in 1993. The reason for this is simply that there are more very old people in the population who are requiring care.

One of the key impacts of demographic change over the next few years is the fact that the number of individuals aged 85 years and over is set to rise from the 1.1 million in 1999 to at least 3.3 million by 2056 (Laing & Buisson, 2000b).

The Times (2000b) reports that long life does not necessarily mean a healthier life. Quoting from the National Office of Statistics, it highlights that a boy born in the early 1980s has a life expectancy of 70.9 years with 6.4 years of ill health. However, a boy born in 1997 can expect to live for 74.6 years, with 7.7 of them marked by ill health.

Evans (1999) points out that most people will die in an institution and, of those people who reach the age of 65, one in seven men and one in three women will spend a year or more in an institution before dying.

Current issues for the independent care homes market

Laing & Buisson (2000b) highlight that 1999 was an awful year for the independent care homes sector, which resulted in a range of high-profile corporate bankruptcies and the closure of many small, privately owned care homes. *Registered Homes & Services* (RHS) (2000a) outlines how 760 homes have closed over the financial year 1999/2000 with a loss of 15,000 beds and it expects this trend to continue. It points out that

a decline in the number of homes on this scale could lead to a very restricted choice of homes for clients in the future.

Local authority care homes have experienced additional problems. The first is the recently enacted Competition Act (DTI, 1998c). This Act prevents large companies from abusing their dominant market positions. The second is the Local Government Act (Home Office, 1999), which demands that local authorities achieve 'best value' from all purchasing. This will affect all local authorities that are both owners and operators of Part III residential care homes, and are also the major purchasers and regulators of community care. The overall result is that local authorities will no longer be able to subsidise their Part III homes, nor insist that clients go to these homes, rather than have a free choice of care home.

This is good news for the independent care home sector, which, according to Luntz (2000, p. 12), has been asking for many years 'for an even playing field in which to compete' on care home provision. Hall (2000) outlines how this is required to ensure that both local authorities and health authorities are treated the same as other care providers by being party to an open and equitable system of payment and regulation.

Back in 1998, Laing calculated that around £350 per week offered a reasonable profit to an efficient provider of good quality residential home care, but pointed out that Department of Social Security (DSS) rates and the fees that local councils were willing to pay were well below this level. Since that time, Lunn (2000) highlights that profit margins have been squeezed still further by:

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- local authority fees not keeping up with inflation
- the introduction of the National Minimum Wage Act (DTI, 1998b) and the Working Time Directive (DTI, 1998a, 1999)
- the national shortage of qualified nurses, which requires nursing homes to pay overtime or employ expensive agency nurses
- the rates of pay for qualified nurses having increased well above the rate of inflation.

Private Healthcare UK (2000) has highlighted that the operation of nursing homes can no longer be called a high-margin service industry. After stripping out all of the costs, the typical nursing home makes hardly 50 pence profit per available care home bed per day. Therefore, a proposal from Counsel and Care, an advisory and campaigning group for older people, has responded to this crisis by saying that the National Care Standards Commission should be responsible for setting a national and fair fee structure for the provision of care that would enable homes to provide a decent quality of care without having to 'penny pinch' (RHS, 2001k). RHS (2001r), however, points out that some providers (not just the large companies) continue to expand and make a healthy profit.

Hurden (2000) outlines how a range of smaller and lower quality homes have had to close because of their income either remaining static or falling when local authorities have set fees below the level of inflation. An alternative discovered in the more affluent areas of the country during this study is that all residents (or

their relatives) pay a top-up fee to the home, in addition to the fees provided by the local authority. This has led to some residents being transferred to neighbouring districts where the top-up fees are smaller, or not required. A further reason that residents are transferred out of the district is when a resident needs a dementia care, nursing home bed, but the nearest available one is miles away. This can cause resentment when the relatives are expecting a local placement.

A further pressure on homes is the over-capacity of care home beds. This has resulted in homes that cannot maintain high occupancy rates becoming vulnerable to market pressures.

Laing & Buisson (2000a) have estimated that, at April 2000, there was still an oversupply of 33,000 beds in long-term care for the older person. They predict that the oversupply is likely to disappear over the next two years because the cost of upgrading homes to meet the National Minimum Standards (NMS) being proposed by the Care Standards Act (DoH, 2000a) will make those homes financially non-viable. Also, RHS (2000b), quoting from a Marketing and Business Development report, suggest that, by 2005, there will be a further reduction in nursing homes of 11 per cent and in residential care homes of 9 per cent.

Luntz (2000) outlines how the NMS will lead to an industry 'shake-out' over the next few years when there will be a better balance between supply and demand with the sector having fewer local authority providers and a more efficient and higher quality independent sector.

In Devon, the County Council and two health authorities are working together to offer selected nursing homes an additional £30 per

week per resident on top of the current fee of £350 because of the shortage of nursing home places caused by the recent closure of a number of nursing homes (RHS, 2001q). Despite the county having a general excess of residential home places, they are hoping that they can draw attention to the problem of nursing home closures and force the Government to provide additional funds for places in independent nursing homes.

RHS (2001s) has highlighted that, although many homes are not members of their national associations and, therefore, cannot speak with a united voice, local groups such as those in Birmingham and Devon have threatened to boycott local authority placements because of the low fees on offer. In Scotland (RHS, 2001t), they have taken the dispute a stage further, in Aberdeen. In June, Scottish Care (over 75 per cent of local homes are members, including the large corporate organisations) have implemented their threat not to admit older people to their homes. The report also highlights the fact that voluntary organisations have to draw on their reserves in order to maintain the resourcing of their homes. This results in them subsidising the state, along with private clients whose higher fees are being used to subsidise local authority-funded clients.

Laing & Buisson (2000b) point out that the recent increase in the number of residential care home beds in the independent sector has happened because there continues to be a large number of clients transferred from nursing home care to (less expensive) residential home care so that local authorities can make savings. According to Bradford (2000), this is occurring because local authority funding for community care is not keeping pace with demand and

cross-subsidy from other council services is impossible. One of the consequences of this problem is that the number of dually registered homes has grown from 750 in 1995 to the current figure of approximately 2,500 (RHS, 2001c). Many nursing home owners have worked out that the only way to remain viable is to offer their empty rooms to residential home clients.

The closure of a care home has a range of disruptive effects on both clients and their families (Laing & Buisson, 2000b). Counsel and Care, a charity for older people, has asked the Government to set up systems to protect residents when homes have to be closed (RHS, 2001f). The help could include:

- the provision of advice to home owners in difficulty
- consultation with residents on alternative accommodation, including a chance to visit new homes
- a full review of each resident's care plans.

The corporate sector (large-scale care home providers) has sought competitive advantage by seeking economies of scale in order to obtain greater efficiency and economy in the running of homes. This has been achieved by centralising certain functions like personnel and purchasing, and by having throughout their homes consistent management policies that are linked to improved opportunities for staff training and development (Hurden, 2000).

RHS (2000a, p. 113) highlights that the smaller-scale care home providers are under financial pressure to stay in business and this leads to 'service trimming' where there is little scope for improving the skill mix or the quality

of the living environment. It quotes the National Care Homes Association which identifies a 'real crisis of confidence in the private sector as to their ability to provide care within existing financial constraints'. A further warning about the 'perilous financial state of many providers of nursing homes' has been outlined by RHS (2001c, p. 140). The problem for many providers is the suppression of fee levels by local authorities, together with the costs of meeting the Minimum Care Standards and the threat of steeply rising registration and inspection fees. The King's Fund (2001a) emphasises that commissioning bodies have a 'damaging preoccupation' with containing costs, rather than promoting quality in care services.

The effects of recent legislation and policies

Denham (2000) outlines the aims of the Department of Health's policy for the care of older people:

- the promotion of independence and health: extended years of healthy life; dignity, security and autonomy in old age
- better services: tailored to individual needs, quality assured, integrated
- a fairer system of care: improved access to services, consistency of services across the country, adequate levels of funding for those services.

A lot of legislation and statute relating to the planning and provision of care services has been produced in the last few years. The main ones have been outlined and reviewed below.

'Modernising Social Services'

The pressure to coordinate health and social services arising from the current raft of legislation was primarily stimulated by the 'Modernising Social Services' (DoH, 1998) agenda where the emphasis was on overcoming the following problems:

- safeguards not being in place to prevent vulnerable people from being abused by the people who are supposed to care for them
- elderly people becoming 'bed blockers' in local hospitals whilst different authorities argue over whom should pay for their care
- inflexibility in service provision: care services meet the needs of the care providers, rather than the needs of the clients
- a lack of clarity on the care services that the public can expect from health and social services
- a lack of consistency in terms of levels and standards of care services and the fees that should be paid for them by clients.

National Service Framework for Older People

This policy initiative is a ten-year programme linking services to the independence and good health of older people and sets standards for older people's health and care across health and social services. The National Service Framework for Older People (NSF) (DoH, 2001a) has set a clear programme of action to achieve new ways of working and tackle the ongoing problems of:

- age discrimination
- failure to treat older people with dignity and respect by allowing organisations to become barriers to assessment of need and access to care
- the provision of evidence-based practice.

It is pointed out that the National Service Framework (NSF) will be resourced using a mixture of targeted funding and the general increases in funding that are being made for health and social care. Links are made with the NHS Plan (DoH, 2000b) for the workforce development of health service staff and the Care Standards Act (DoH, 2000a). The emphasis is on rooting out age discrimination, providing person-centred care, promoting older people's health and independence, and fitting services around people's needs. Also, there is an emphasis on providing information to those individuals who deploy health and care resources on the most cost-effective ways of achieving identified 'best practice'.

The emphasis is on involving older people and their carers in the planning and implementation of the NSF. Local arrangements for implementing and evaluating the NSF should be in place by the end of June 2001 and these should link with local Health Improvement Plans.

Quality Strategy for Social Care

The Quality Strategy for Social Care (DoH, 2000g) admits to there being problems in the delivery of social care services: staff not properly trained; bureaucracy, inflexible or inaccessible services; lack of coordination within social services and with health services; service

inconsistencies across different parts of the country.

The following proposals for change are identified:

- tackling inconsistencies in services by developing a Social Care Institute for Excellence
- developing a new quality framework so that there are clear lines of accountability where the ultimate responsibility for the quality of care rests with the director of social services
- delivering excellence at local level via a new quality framework so that services are matched to people's needs, rather than the other way round – a commitment to developing new ways of delivering services
- improving workforce training by having an emphasis on lifelong learning and the stimulation of training activities in the independent care sector.

NHS Plan

The NHS Plan (DoH, 2000b) empowers local authorities and health authorities to pool budgets, with one or other of the authorities taking the lead in purchasing. Alternatively, they can develop jointly funded organisations (care trusts) that are expected to become integrated providers of care. The idea is that the two authorities should merge their services so that a one-stop package of care is available to clients to prevent individuals falling into the service wasteland between the two authorities. The changes that will be introduced because of the NHS Plan are:

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- a single assessment process for health and social care because those services are available from one organisation
- the development of new, intermediate care services
- joint 'best value' inspections of the new health and social care organisations
- national guidance on home care charges
- the NHS to be responsible for registered nursing input to nursing homes.

Patel (2000) highlights that the cultural, ideological and institutional barriers that currently exist between the different public sector organisations and the independent care sector should not be allowed to prevent the NHS Plan from delivering more integrated care for NHS patients. Over the next four years, as public funding is substantially increased, it is expected that the independent sector will have a full role to play in ensuring that NHS patients benefit from this increased investment in care.

Unfortunately, according to the RHS (2000d), until the NHS manages these joint budgets, the financial constraints of local authorities are likely to continue to restrict funding for long-term care in the independent sector. A recent survey undertaken by the Association of Directors of Social Services is quoted, which highlights concern over the low levels of spending on services for older people caused by an average overspend of 2.1 per cent on local authority budgets because of the increasing number of children who require care.

Intermediate care

Holzhausen (2001), in a National Carers Association report *You Can Take Him Home Now*,

outlines how the NHS has become obsessed with 'bed blocking' and this is resulting in patients being sent home too soon from hospital. The survey highlights how hospital discharge is often poorly planned, wrongly timed and badly handled. This situation is even worse than when a similar survey was undertaken in 1998. One of the major problems that is highlighted is the lack of coordination between health and social care staff.

It is in this light that intermediate care, 'a bridge between home and hospital', should be reviewed. Intermediate care is a term introduced by the NHS Plan (DoH, 2000b). It is being established to prevent hospital beds being occupied ('bed blocked') by individuals, usually older people, who do not need acute care. According to the RHS (2001a), this is likely to radically change the health and social care market. The initiative has been energised by the findings of the National Beds Enquiry (DoH, 2000i).

Although there can be delays in hospital patients being assessed for community care, slow-acting local authorities are not always the cause of NHS 'bed blocking' (Brindle, 2000). There is a range of other potential delays, for example:

- elderly people observing their right to choose a specific care home
- a shortage of care home capacity in some parts of the country
- delays by the NHS in discharging patients.

The aim of intermediate care is to prevent avoidable admission to hospital, enhance rehabilitation and, preferably, allow people to

return to their own homes. The possibility of offering intermediate care presents a major opportunity to the independent sector for those homes that have the appropriate facilities and therapist input. It has been highlighted that, although they may be under the same roof as residents who receive means-tested funding from their local councils, individuals who are receiving intermediate care will remain as NHS patients, wherever they are treated (RHS, 2000d).

Intermediate care guidelines have been produced by the Department of Health, according to RHS (2001e). Intermediate care is defined as meeting the following criteria:

- It should target people who face lengthy stays in hospital or residential long-term care.
- It should actively provide opportunities for recovery following assessment and care planning.
- There should be an emphasis on maximising independence.
- It should have a time limit of no more than six weeks (usually one to two weeks).
- There has to be interdisciplinary working and a single assessment system.

Smith (2000) asks the question of whether residential and nursing homes can deliver effective rehabilitation to intermediate care patients when they are essentially organised to offer long-term care. He argues that few homes have a track record of enabling individuals to return to their own homes.

Care Standards Act

The Registered Homes Act (DHSS, 1984a) regulations are still in force and will continue to be used by registration and inspection units until 1 April 2002. On this date, the National Minimum Standards (DoH, 2000a, 2001f) will be utilised by regulators working for the National Care Standards Commission.

The Care Standards Act (DoH, 2000a) is leading to the establishment of a range of regulatory frameworks that cover:

- the replacement of the registration and inspection functions of social services and health authorities with a National Care Standards Commission
- the establishment of a General Social Care Council that is expected to implement new systems for registration, regulation and training of social care workers
- the introduction of a Consultancy List system that carries details of individuals who cause harm, or risk of harm, to children and vulnerable adults
- the establishment of a set of National Minimum Standards (NMS) that are to be used to modernise the current regulatory system for care services.

The final version of the NMS (DoH, 2001f) has been produced to give stronger protection for vulnerable people and to ensure greater clarity, consistency and quality of standards for providing care services. The NMS will apply to all care providers across the country. This will mean that all providers of care services will be clear about the standards that they are expected to meet in order to achieve registration as a

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provider. The NMS are generally viewed as being essential for the future of long-term care. Achieving those standards should not be a problem for good quality care providers. Unfortunately, the NMS will not be applied to NHS hospitals where a recent report entitled *Caring for Older People: A Nursing Priority* has identified 'major deficits' in the care of older people. The report claims that, whilst in hospital, older patients are neglected and denied rights to privacy and independence (DoH, Standing Nursing and Midwifery Advisory Committee, 2001). The King's Fund (2001b) highlights that a coherent system of regulation across the NHS and the independent sector would enable the public and the professions to see that they are all being judged by the same standards.

Each of the 38 standards of the Care Standards Act is based on a required outcome that opens with a clear statement of principle and then provides details of the general requirements for the standard (RHS, 2001p). The standards are placed under one of the following seven headings:

- 1 Choice of home
- 2 Health and personal care
- 3 Daily life and social activities
- 4 Complaints and protection
- 5 Environment
- 6 Staffing
- 7 Management and administration.

Health and Social Care Act

The one important aspect of the Health and Social Care Act (DoH, 2001b) is that local

authorities will no longer have the responsibility for arranging access to nursing care by a registered nurse. Rideout (2001) highlights that the definition of nursing care will constitute those actions that cannot be carried out by anyone else other than a registered nurse. In practice, there are likely to be very few tasks that cannot be covered by relatively infrequent visits from a community nurse.

Within the Health and Social Care Act (DoH, 2001b), although the Government has conceded that there will be no compulsory creation of care trusts, there are worries over the democratic accountability of these nominated bodies. There are also concerns that the health professions will dominate them (RHS, 2001). The health professions have a reputation as being paternalistic rather than inclusive and participative in their decision-making. It will be interesting to see how the joint budgets of these organizations will be identified and utilised.

Also, in response to the Royal Commission's Report on Long Term Care (DoH, 1999), the Health and Social Care Act has specified that nursing care provided in nursing homes will be fully funded from October 2001. Nursing care excludes personal care and accommodation costs, but includes time spent on 'providing, delegating or supervising care in any setting'. Unfortunately, the Act has continued the artificial divide between health and social care. It specifies that there should be means testing for personal care and a tight definition of 'nursing care' that is funded by the NHS.

The funding of nursing care by the NHS will result in a reduction in the amount of money that has to be paid by clients and their families for nursing home care. Depending on the nursing needs of an individual, it has been

calculated that the NHS could pay up to £5,000 a year towards the total costs of care (Ellicott, 2001). According to Gatenby (2000), it should mean that care homes can quote prices that exclude nursing care, so that individuals can still undertake sensible long-term care planning and budgeting. Unfortunately, because of expected delays in assessing clients' nursing needs, according to Ellicott (2001), a client will not know before entering a home how much they will be expected to pay for care. It is felt that the artificial distinction between nursing and personal care is likely to create significant administrative problems that are likely to affect the quality of care provided for individuals.

According to RHS (2001u), it will be primary care trusts or health authorities that manage both the capped budget for free nursing care (by a nursing home coordinator) and the assessment of nursing care need (by a lead nurse). This arrangement is bound to attract the usual community care criticism that the organisations that assess nursing need will also hold the budget.

It has been proposed that nursing care provided during stays of four weeks or less in a nursing home (except for intermediate care) will not be funded by the NHS (DoH, Health and Social Care Joint Unit, 2001). Also, a recent article has highlighted that the Government has decided to pay only a fraction of the nursing fees (Winnett, 2001). It is reported that every person entering a care home will be assessed and will then receive either £35, £70 or £110 per week towards their nursing care costs, depending on their assessed nursing needs. The article anticipates that few people will qualify for the maximum £100 per week. BUPA is quoted as estimating that the nursing care costs

for residents are at least £140 per week, with the costs in London and the South East of England being up to 80 per cent more.

A further problem that is identified by Winnett (2001) is the fact that individuals who are already resident in nursing homes will also have to be assessed. The systems for the nursing assessment of clients are not expected to be in place until April 2002, although payments for nursing care will be backdated to October 2001. Individuals will initially be given £50 towards the costs of nursing care, until their nursing care needs can be formally assessed. The money will be paid straight to the nursing homes and it is reported that there are fears that some unscrupulous home owners may not pass on these savings to the residents.

Fortunately for Scotland, the Scottish Parliament has taken note of 'grey power' and has broken ranks with the rest of Britain by agreeing to fund 'personal care' as well as nursing care during 2002. Cooper (2001) points out that the Scots are likely to be £6,000 better off than their English counterparts because of this welcome decision. Despite the embarrassment caused by the decision, Westminster refuses to consider its own position in terms of funding personal care, despite the industry's puzzlement over the Government's rejection of the recommendations of the Royal Commission (DoH, 1999). A recent King's Fund report (Deeming, 2001), however, highlights that two-thirds of the public believe that those suffering from long-term illnesses should not face means testing for personal care or nursing care, as originally recommended by the Royal Commission on Long-term Care. It will be interesting to see if significant numbers of older people choose to move across the border to Scotland for the better deal on care.

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Conclusion

It is obvious that the large number of overlapping government initiatives that are currently being developed and/or implemented are causing confusion within the care sector. The legislative overlap can be noted in Table 1.

The Department of Health's task in long-term care, regulation and quality of services can be expressed as the need to 'carry through work that has been promisingly started, but that remains manifestly incomplete'. The glue which could hold all of these initiatives together is the National Service Framework for Older People.

It will be interesting to note over the next few years whether the needs and interests of all

the interested parties in the independent care home market can be met by successfully managing the following problems:

- funding shortages for long-term care
- the need for close collaboration between health and social care
- ensuring that there are enough residential and nursing homes
- ensuring consistency and excellence of care service delivery
- the establishment of intermediate care facilities in all parts of the country.

Table 1 Overlapping government initiatives

	Modernising Social Services	National Service Framework for Older People	Quality Strategy for Social Care	NHS Plan	Care Standards Act	Health and Social Care Act
Coordinating health and social services	✓	✓	✓	✓		✓
Bed blockers in NHS hospitals	✓			✓		
Inflexible care service provision	✓	✓	✓		✓	✓
Consistency and standard of care	✓	✓	✓	✓	✓	✓
Care staff education and training		✓	✓		✓	
Registration and inspection					✓	

3 Accessing care home services

Typically, the entry of a client into a care home is unplanned. Often, it follows the death of a spouse, or a domestic crisis, or an episode in hospital where a full recovery has not been made. This may prove stressful for the client, especially in those parts of the country where nursing homes and residential care homes have had a bad press. Fortunately, although most care homes do not provide the quality of accommodation that one would expect from a good hotel, market forces are slowly leading to improved amenities within homes.

Joint working between health and social services

The degree to which older people will be catered for, in terms of residential and nursing home care, may well depend on the ability of local authorities and the NHS to pool budgets and coordinate their planning, as required under, for example, the NHS Plan (DoH, 2000b) and the National Service Framework for Older People (NSF) (DoH, 2001a). The DoH (2001e) emphasises that there should be no organisational or ideological barriers to the purchase and delivery of high quality health and social care to those who need it – the key test being value for money. The involvement of the independent care sector in the planning of local health care services is seen as essential for the delivery of health improvement programmes. The idea is to utilise the independent sector, not only at times of pressure, but also on a more proactive, longer-term basis.

The NSF (DoH, 2001a) has outlined standards for the local delivery of services. The standards specify that local arrangements for

implementing the NSF should involve older people and their carers, and that these plans should have been put in place by 30 June 2001. This will not be a simple process because many local health and social service departments have a long history of difficulties when the need to collaborate arises. In the meantime, though, the Government has ploughed additional funding into social services to help them with their projected overspends so that they can purchase more community care services and relieve the ongoing pressures on NHS beds.

The DoH/DETR (1999) has produced a Charter for Long-term Care. This sits alongside the NSF and specifies that local authority and health services should work together, in partnership with service users, carers, voluntary organisations and appropriate others, in order to establish local 'better care, higher standards charters'. The whole emphasis is to promote integrated working between all service providers. Despite this, the year following the publication of the Charter, *The Independent* (2000) reported that leading doctors had called the postcode lottery in elderly care a 'national disgrace' and condemned the Government's failure to act on the report by the Royal Commission on Long-term Care (DoH, 1999).

Client needs assessment

At the moment, a local authority care manager has the responsibility for ensuring that, for each client who requires residential care, he or she is properly assessed so that an appropriate placement can be made to a nursing home or residential care home (DoH, 1990). O'Kell (1995) has identified two main problems with this process – the assessment process and eligibility

criteria. These two problems will now be reviewed.

The assessment process

The great majority of individuals interviewed during this study were of the opinion that client needs assessment undertaken by care managers is not always accurate. It was highlighted that care managers are expected to assess the need for care, not the care need. Although care needs assessment is supposed to be open, accessible and challengeable, the following problems were identified by participants in this study:

- Each local authority has its own system for assessing clients' needs for community care.
- Because local authority care managers are not usually nurses, they do not always have the necessary qualifications and/or experience to coordinate client assessment and then purchase care to meet clients' assessed needs.
- Community NHS trusts are struggling to provide the required input into client needs assessment.
- When multi-agency needs assessment is achieved, there can be assessment bias demonstrated by the community nurses who are reluctant for a client to be placed in a residential home, if that client is going to require a lot of community nursing input.
- Some managers of care homes are scared to challenge the client needs assessment in case they anger the care manager and do not get any more referrals from him/her.

- Some care managers withhold vital assessment information when placing a client, for example that the client can become confused or aggressive.
- Individuals who have mild dementia can be labelled as elderly mentally infirm (EMI) clients and then placed in dementia care nursing homes when their care needs do not require this type of care.

Because there are problems in the client needs assessments being undertaken by care managers, the British Federation of Care Home Proprietors (2000) in its *Members' Code of Practice* has recommended that care homes should assess the needs of every prospective resident in order to ensure that the placement is appropriate for the client. More than half of the homes that were interviewed in this study reported that they did their own client assessment prior to accepting a client into the home. Some homes also give all residents a one-month's trial in the home to make sure that the home can meet their needs.

Residents' care needs do not stay the same throughout their stay in a care home. When a resident's care needs change significantly, this normally requires that the resident is reassessed. In this study, though, several interviewees identified that some care managers are slow or reluctant to facilitate the reassessment of care home residents, because of their heavy workloads. The NHS, Health and Social Care Joint Unit (RHS, 2001u), however, has outlined how permanent residents of homes will have their care needs assessed three months after their initial assessment for placement in a home and then every 12 months thereafter. Also, additional nursing assessments can be

requested by home owners or residents and their families.

All the homes interviewed in this study were reluctant to transfer a resident to another care facility, especially if the resident wanted to stay at the home. When a resident's care needs start to exceed those with which a care home can normally cope, a range of strategies is available to maintain the resident within the home:

- access additional care input for the resident from NHS community health services
- ask the registration and inspection unit to vary the home's registration, for example to enable them to provide palliative care or to apply for dual registration
- ask the registration and inspection unit for some flexibility, for example allowing a residential home client who requires significant amounts of nursing care to stay at the home until he or she dies
- either increase the number of care staff on duty, or agree to reduce the number of residents within the home.

Standard 2 of the 'National Service Framework for Older People' (DoH, 2001a) states that NHS and social care services should:

... treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrating commissioning arrangements and integrated provision of services, including community equipment and continence services.

One of the first targets that have been set for each locality is for a single assessment process to be established for the health and social care of

older people by April 2002 (DoH, 2000b, 2001a). This is to be backed up by a local action plan for the National Service Framework. It remains to be seen whether or not each locality will meet these targets. Past history would suggest that there are likely to be many problems in achieving the target, despite the exhortations of the Department of Health.

Both Johnson and Hoyes (1996) and Johnson *et al.* (1999) highlight the need for nationally agreed criteria for the initial and ongoing assessment of health and social care needs. The Personal Social Services Research Unit (1996) found a wide variation in the quantity and quality of information collected by different local authority systems for assessing older people's care needs. Only 24 per cent of assessment forms were used jointly by health and social services. Because older people's lives are punctuated by episodes of acute illness, assessment is important, not only at the point of entry to the home, but on a regular basis thereafter.

RHS (2001c) outlines how a universal assessment tool is advocated, based on minimum data sets. BUPA and Bristol University are undertaking a project to develop a tool for assessing the care needs of older people. The aim is to identify a UK version of the minimum data sets that were originally established in America and are now widely used in other countries such as Japan and Sweden (RHS, 2000c).

Carpenter (2001) reported on his study into the use of the Minimum Data Set Resident Assessment Instrument (MDS/RAI) and the Resource Utilisation Groups version III (RUG-III) in four nursing homes. The MDS/RAI component is a tool that has been designed to be

used by nursing staff for the assessment of residents and the development of individual care plans. Identified client problems, risk factors and strengths trigger Client Assessment Protocols that provide guidance for the assessor on best practice in developing a care plan for the triggered area. The RUG-III differentiates between the time spent on providing care for nursing home residents who are receiving 'standard' care (provided by a nurse or care support worker) and 'enhanced' care (must be provided by a nurse). This tool has undergone extensive tests for validity and reliability in different parts of the world and has always proved to be a useful instrument for explaining the variance in care time between residents. It is envisaged that the information provided by this instrument could provide the basis of a reimbursement system for the provision of nursing care to clients who are resident in care homes.

It is highlighted that the minimum data sets can provide comprehensive information on client dependency levels, required staffing levels and costs for an individual home or group of homes. This type of information is essential for managers who want to plan their home services more effectively. It would allow for a standardised link with care planning, benchmarked standards of care and care costs. These can all be incorporated into a computer package. This might then allow for home inspections to be targeted more appropriately by the use of 'alarm bells' to identify those events in practice which should not happen in a well-run home.

Because there is a need to gauge the level of nursing care that is needed by a client in a care home, this will be assessed using the Registered

Nurse Care Contribution (RNCC) tool, which is currently being developed by the Department of Health. The assessments will be undertaken by registered nurses and will determine the level of nursing care required by each individual client (DoH, Health and Social Care Joint Unit, 2001).

Three bands of nursing care are described:

- *High*: the average amount of care provided (delegated, supervised or planned) by registered nurses for those individuals who have 'complex' or 'enhanced' nursing needs.
- *Medium*: the level of care required by an individual who has 'standard' nursing needs (it is estimated that the individuals who qualify for the high band require 55 per cent more nursing care than individuals in this band).
- *Low*: the nursing care required to meet the care needs of those individuals whose needs can be met by minimal nursing input.

The RCN has also produced an assessment tool for identifying the professional nursing input required for the care of older people, including the level of supervision required by these individuals (RCN, 1997). The tool can only be used on a client by a nurse who knows that client well. In this study, the RCN assessment tool received a mixed review from the few interviewees who had heard of it and used it.

Eligibility criteria

Local authorities agree eligibility criteria for care services as a method of rationing scarce community care resources. This can result in clients being inappropriately placed in a

residential care home when their health needs require more expensive, nursing home care.

There is quite a lot of evidence to suggest that local authorities ration expensive care services by implementing local eligibility criteria that are linked to the level of funding that is available to fund those services. Since the House of Lords ruling against Gloucestershire Social Services in 1997, it has been clear that councils are not allowed to refuse to meet clients' assessed needs because of a lack of financial resources (RHS, 2001a).

A recent criticism of one county council by the Local Government Ombudsman highlighted a weakness in the local system where information collected by the social services assessment was being ignored in drawing up an appropriate care plan for a client who suffered as a consequence (RHS, 2001d).

The RHS (2001a) quotes a survey by barristers working on behalf of the RCN in 1999 who estimated that up to 90 per cent of health authorities' eligibility criteria are likely, or highly likely, to be illegal. The Department of Health (2000c), however, has recently issued guidance to local authorities on how they should set their eligibility criteria for access to care funding. Also, the Government has produced draft guidance on local authority charging policies and is currently seeking feedback on that guidance document (RHS, 2001c). If the guidance document is accepted, it will ensure that the current situation of varying eligibility criteria as a means of rationing placements in nursing and residential care homes will be replaced by a set of centrally determined rates and fees.

In addition, the Department of Health has produced a circular entitled *Continuing Care*:

NHS and Local Councils' Responsibilities (DoH, 2001g). This document provides clear guidance on the funding of long-term care. Three types of continuing care are identified:

- *Continuing NHS health care*: a package of care arranged and funded solely by the NHS. It does not include provision by the local council of any social services.
- *Continuing health and social care*: a package of care that involves services from both the NHS and local councils.
- *Continuing social care*: a package of care arranged and funded solely by the local council, which may include some nursing care where this is 'merely incidental or ancillary to the provision of accommodation' and is of a nature where it can be provided by a local council whose main responsibility is the provision of social services.

The circular also provides the following guidance:

- Care can be provided in any setting such as a care home, supported accommodation, hospice or an individual's own home.
- The timescales for the provision of care can vary from short periods to lifelong care.
- Social care is expected to use the *Fair Access to Care Services* guidance (DoH, 2001h) to ensure that there is a nationally consistent approach to establishing eligibility criteria for social care.

Therefore, Mackay (2001) outlines how social care waiting lists, delayed hospital discharges

and the discouragement of family and individual top-up payments so that a client can access a preferred care home are likely to be viewed as inappropriate and possibly illegal in the near future.

Available care services

Fortunately, the DoH (2000d) has provided guidance on how to improve the way that local authorities provide care services by publishing its Charter for Long-term Care. Improvements are expected in the following areas:

- better information about the services that local authorities and health services are expected to provide, and how these can be accessed
- clear standards of service that clients can reasonably expect from the health service and local authority
- clear guidelines for service users and carers on how to make complaints
- more coordination between health services and local authorities in the provision of services.

Despite the improvements expected from the above Charter, the DoH (2001d) outlines that there is a growing concern that older people are still not best served by local arrangements and service options. The report highlights the high numbers of inappropriate admissions of older people to residential and nursing homes, together with a lack of well-developed diversionary and rehabilitative services available within the homes. A number of barriers to good commissioning of services are identified and include:

- poor or inadequate management information
- lack of, or unwillingness to undertake, joint or multi-agency commissioning
- poor standards of client needs assessment
- under-developed alternatives to residential care
- resistance to the encouragement of independent care sector provision.

Care home provision

The National Institute for Social Work (NISW) (1997) points out that residential care for elderly people is often dementia care. Over 79 per cent of the residents interviewed in its study had dementia. The NISW was concerned at the high levels of depression and the failure to diagnose and treat the problem. It was emphasised that the increasing dependency of residential home clients meant that they needed closer monitoring and input from appropriately qualified and experienced care staff.

The Daily Telegraph (2001) reported that seven out of ten local authorities said that they could not cope with the demand for beds from elderly dementia patients, resulting in hospital beds being blocked.

There is a strong opinion that there should be alternatives to residential and nursing homes for individuals who require care. Oldman (2000) reports on a study into the care needs of clients who have similar care needs, but were placed in either a residential home or 'enhanced sheltered housing' schemes. The results showed that the individuals who were in the sheltered housing had a higher disposable income after care support costs had been paid for and they had a

greater involvement of relatives in their care.

This problem is also highlighted by the RHS (2001i) which outlines the recommendations of a study by the Relatives and Residents Association. In this study, relatives and friends who were surveyed spoke of their feelings of exclusion by care staff when they were discouraged from providing care for a relative/friend in a care home.

Local authority funding of care homes

There is growing evidence to suggest that local authority fee rates do not accurately reflect the real costs of care. A project undertaken by Age Concern (2000) highlights the fact that some old people have to move to different parts of the country because of the low level of fees paid for home care by their local authority.

The RCN *et al.* (2000) have emphasised that the current provision of health services for care home residents is haphazard and that funding for care homes for older people needs to be doubled.

However, another problem highlighted by Cooper (2001), in relation to clients having more say in the services that are provided for them, is the fact that many people cannot afford the care home that they want because the home's fees are higher than the local council's limit that it is willing to pay for care.

Paying for NHS services in care homes

One problem in the provision of health services to care homes has been highlighted in a report on a survey undertaken by a consortium of charitable organisations (RHS, 2001i). The report highlights that large numbers of older people in care homes have to pay for primary care services, for example GP visits and treatments,

which should be provided free by the NHS.

Great variations in practice are highlighted – from GPs that provide on-site surgeries at care homes for free, to GPs who charge a retainer for having a home's residents on their lists, and then charge extra for on-site clinics and visits and for treatments. Some homes pass some or all of these additional NHS charges onto the residents' fees for care. Razzell (1999) points out, however, that GPs are sometimes summoned inappropriately to care homes, especially when the care staff are under pressure because morale is low, sickness is high and agency staff who do not know the residents are drafted in.

Also, the results of this study revealed that homes in some parts of the country have to pay to borrow NHS equipment such as syringe drivers, pressure-relieving mattresses, etc. Alternatively, some care homes are denied access to NHS equipment, or are refused the training they need to use the equipment safely.

One ray of light is the announcement by the Health Minister that incontinence supplies are to be provided free to nursing home residents (RHS, 2001i). They are currently provided free only to residential homes and to clients living in their own homes.

The Department of Health has provided clear guidance on the provision of health services to residents of care home. Literally, the guidance points out that the residents are entitled to the full range of personal medical services and that they have the same rights of access to primary care as any other patient group (DoH, 2001g).

Accessing NHS community health services

According to O'Kell (1995), community NHS trusts are struggling to provide rehabilitation

and specialist health-care services to both nursing homes and residential care homes. This view was supported by some of the national organisations interviewed as part of this study. The majority of the homes in the study, however, claimed to have reasonable or good access to community nurses, although there were some local variations. Several of the homes stated that 'community nursing services are always available, if you need them'.

A few homes in the study, though, had difficulties accessing community nurses, especially if the home was in a rural area. In most areas, there were shortages of NHS community occupational therapists and physiotherapists. The reason for the shortages, according to Gillam (2001), is that, although primary care services have improved a lot over the years, they still come off second best to hospitals in terms of NHS funding.

Care homes do not have access to the same resources and specialists that are available to practitioners who work in a district general hospital. But, this study has revealed that sometimes they simply need some advice so that they can safely meet an individual client's care needs, for example in terms of: infection control, palliative care, stoma care, tissue viability, continence management, etc.

In one area of the country visited during this study, the local NHS trust had set up a multi-disciplinary Elderly Care Liaison Team to provide advice, support and training on elderly care issues to local care homes. In another part of the country, elderly care specialist nurses had been employed to carry out this liaison role plus set up local Matrons' Groups so that there was peer support for owners and matrons of care homes.

The results of this study demonstrated that a health authority registration and inspection unit can be called in to arbitrate when there are disputes between residential homes, care managers and community nursing services, for example:

- When a residential home client's care needs change resulting in him or her becoming much more dependent, but the care manager refuses to admit that the client's needs require nursing home care. This issue is likely to be much more of a problem in the future when the nursing component of care in a care home is funded by the NHS.
- When the community nursing services are having problems meeting the nursing needs of a residential home client. In one area visited as part of this study, a residential home client was redesignated as requiring nursing home care if the client needed more than two visits per week from the community nurse.

The reality of the situation is that most community health services are perceived to be under-resourced. In this study, it was pointed out by some interviewees that the residents of a care home may not be the greatest priority for the community nursing services when there are disabled and vulnerable people, living on their own, who require their services. Hopefully, the guidance provided by the Department of Health (2001g) on eligibility criteria and access to health and social care services will overcome these problems.

Conclusion

It will be interesting to find out over the next two or three years if the NHS and local authorities can 'get their act together' in order to collaborate on the planning, resourcing and delivery of the NSF and Charter for Long-term Care. This is the only way that the DoH can ensure a consistently high quality of care service provision for older people in *all* parts of the country.

Because the quality of needs assessment by care managers can be so variable, the Minimum Data Set Resident Assessment Instrument and the Resource Utilisation Groups version III assessments should be incorporated within the NMS and the necessary resources should be found so that all care homes can use them. This would then enable:

- care managers to ensure that clients have their care needs properly assessed
- individual care homes to plan and record the care provided to residents and calculate an appropriate skill mix of care staff to deliver the care

- regulators to focus more easily on care provision during registration and inspection
- the DoH and other appropriate bodies to collect valid and reliable information on care home provision in an agreed format that facilitates central decision-making.

There is evidence to suggest that both the NHS and local authorities ration expensive care services by implementing local eligibility criteria that are linked to the level of funding that is available to fund those services. This has sometimes resulted in registration and inspection unit staff becoming involved when there are disputes in the accuracy of the assessment process, the availability of care services and/or the funding for those services. It is expected that the guidance issued by the Department of Health to the NHS and local authorities on eligibility criteria should largely overcome these problems over the next year or so.

4 Recruitment of care staff

Cox (2001) highlights how public services have become the main issue in British politics. The current Government has promised that these services will be improved in its second term of office. Its vision of a 'good society' requires that the public sector, especially the health services, deliver high quality care services to all citizens.

The problem that the Government faces is that there is an overt conflict between a country that wants low taxes, yet still wishes to enjoy first-class public services. Appealing to people's concept of public service and idealism is no longer enough when there are better-paid and less demanding jobs available in the private sector.

Manpower planning

O'Kell (1995) outlined how the National Health Service Executive (NHSE) has started to include the independent health care sector in its workforce planning calculations. This has eventually resulted in a concordat being signed between the NHS and the Independent Healthcare Association (IHA) (DoH, 2000e), which includes an agreement to share information on workforce supply and demand. In this study, however, some of the national organisations and large provider organisations that were surveyed highlighted that the independent sector is not properly consulted by regional education consortia in the manpower planning and commissioning process for the education and training of care staff in the regions.

The DoH (2001c) emphasises that a holistic approach to workforce planning is needed which includes all sectors of the care market but which highlights that, no matter how good the analytic and decision-making systems are, there

will always be mismatches between supply and demand, and the aim must be to minimise those mismatches. The main areas of concern are:

- *Fragmentation of planning*: this includes insufficient recognition of the role of the non-NHS employers in workforce planning and development, and the need for coordination in health and social care workforce planning.
- *Lack of management ownership*: regional education consortia, which undertake workforce planning and the commissioning of education and training, vary significantly in their effectiveness, skills and ability. There is a need for the establishment of local workforce development confederations to aggregate the plans of the full range of local employers of care staff.
- *Training and education weaknesses*: this is highlighted by a perceived over-academicisation of professional training courses with selection criteria that emphasise academic ability over caring skills and an end product that is not always fit for purpose. Professional training courses and higher level NVQ programmes are normally offered by the higher education sector, but this is appropriate when there is an equal emphasis on learning the relevant theory and its application to practice.
- *Career structures*: there is a need for a more extensive clinical career structure so that there are opportunities for practitioners to move up the hierarchy without having to become managers.

TOPSS England (2001b) highlights that regional training forums are to be set up to analyse regional workforce data and to link with the NHS workforce development confederations.

One good piece of news is the fact that TSO Enterprises has set up a clearing-house initiative for vacancies in residential and nursing homes (RHS, 2001n). The website carries constantly updated information on available posts. Twelve local authorities are currently testing it and it is expected that a full national service will be made available to all health care organisations.

Good recruitment practice

On the surface, employing the right people for the job would appear to be an easy and straightforward matter. Employees are a valuable asset to any organisation. It takes time, effort and resources to recruit, induct, supervise, provide training for and pay the salaries of all members of staff. This investment is essential if the employees are to provide high quality care and become successful members of the care team.

The costs of not making the above investment in the recruitment and retention of care staff leads to the care facility having to make a heavy commitment of management time to deal with the problems of badly motivated staff, high sickness rates, poor quality of care, unsatisfied clients and families, and increasing numbers of complaints. This results in a care home developing a poor reputation and experiencing reduced profits, and can lead to problems when the home is inspected.

The Newcastle Joint Inspection Unit (1998) outlines good practice when setting out the

precise requirements of the job. These should be written into a detailed job description that highlights all the responsibilities and duties of the employee. In addition, the employer needs to decide on the skills that are necessary and the preferred personal qualities that are required for an individual to carry out the job description. This is outlined in a person specification.

Care needs to be taken in deciding the type of applicants and places that are to be targeted for recruitment. These can include any or all of the following:

- Internal transfer or promotion: is there a suitable person already employed by the care home?
- Word of mouth: the staff of the care home may know of a suitable applicant. This person may already have worked at the home if they are currently on the home's bank staff or they have previously been supplied from an agency.
- Job Centres provide a free nationwide recruitment service.
- Advertisements can be placed in local shop windows or in the local, national or professional press.

It is obvious that advertisements should be clear and concise. The normal expectation is that the advertisement should state the name of the care home, title of the post, the qualifications and/or experience required, whether the post is day or night duty or a mixture of the two, the hours per week, the rates of pay and the closing date for applications.

The recruitment of volunteers, trainees or students should follow the principles of good

employment practice that apply to the recruitment of permanent staff. The employer needs to be assured that these individuals are honest, trustworthy and willing to respect confidentiality. In the case of placements via an agency, clarification should be sought on the agency's methods of recruitment.

One of the ways to minimise these problems of staff shortages is to change the structure and functioning of a home so that it becomes more like a 'magnet home'. A magnet home is one that has fewer problems than its neighbours in attracting private residents and recruiting and retaining care staff. In this study, a number of factors were identified as being important in enabling a care home to move towards becoming a magnet home, for example:

- An organisational culture where the provision of high quality care is of prime importance.
- A good quality physical environment: building, decorations, available equipment, etc.
- A manager, owner, or matron who treats the care staff as valued and respected employees.
- A consistent and mature care team that demonstrates a good team spirit.

Some homes that were visited during this study utilised a range of tactics to attract care workers to their homes:

- a salary that is at, or near, the top of the range for that grade of care worker, in that part of the country
- free meals

- private health care plans as part of the employment package
- pension schemes
- the provision of inexpensive staff accommodation
- opportunities for free education and training.

Care staff requirements for care homes

In this study, out of the 19 care homes surveyed, only one home regularly used a skill/grade mix model to calculate staffing levels. The rest of the homes utilised the staffing notice specified by the local registration and inspection unit as a baseline against which to use their 'common sense' in deciding the number of staff who should be on duty at any one time.

The establishment of an appropriate mix of staff in a care home is an issue that taxes most care providers. Within a care environment, this can be achieved by the setting of an effective balance between managers or administrators, qualified nurses, care support workers and ancillary staff, so that an appropriate number of staff with the required knowledge, skills and experience are on duty at all times to ensure the delivery of high quality care. The problem is that the squeeze on profit margins currently being experienced by the independent care sector may result in a home having to cut costs in the employment of care staff.

When the NMS are implemented (DoH, 2001f), the following standards will have to be achieved by care home owners:

- The ratio of care staff to residents will be decided according to the assessed needs

of the residents, using a system for calculating staff numbers recommended by the DoH (the preferred system has not yet been identified by the DoH).

- Care staff providing personal care to residents are expected to be at least 18 years of age and the person in charge of the home is expected to be at least 21 years of age.
- A minimum of 50 per cent of care support workers (excluding the registered manager, but including agency staff) are expected to have achieved at least a Level 2 NVQ in Care (or its equivalent) by the year 2005.
- All staff are employed in accordance with the Code of Conduct – still to be produced by the General Social Care Council (GSCC) – and are to be given copies of the Code.
- The recruitment and selection process of volunteers for a home should be thorough and should include a police check.

The Newcastle Joint Inspection Unit (1998) has produced detailed guidelines on the minimum staffing levels for care homes in its area. The guidelines are similar to those used in many other parts of the country and outline the issues that affect the staffing arrangements in any care home:

- the number of floors and the number of residents on each floor
- the dependency level of the residents
- the physical location of elderly mentally infirm/ill residents above ground level
- the combination of categories of resident in the home
- the overall design of the building in relation to walking distances for care staff and the number of self-contained units
- the means of evacuation in the event of fire
- the extent of domestic or catering duties undertaken by direct care staff.

Table 2 Minimum staffing levels: residential home for elderly residents

No. of beds	8 a.m. to 2 p.m.	2 p.m. to 5 p.m.	5 p.m. to 9 p.m.	9 p.m. to 8 a.m.
1–9	2	2	2	1
10–12	2	2	2	2
13–15	3	2	2	2
16–19	3	3	3	2
20–23	4	3	3	2
24–27	4	3	3	2
28–31	4	4	3	2
32–35	5	4	4	2
36–39	5	5	4	3
40	6	5	5	3

The independent care homes sector

Table 3 Minimum staffing levels: nursing home

No. of residents	8 a.m. to 2 p.m.		2 p.m. to 5 p.m.		5 p.m. to 9 p.m.		9 p.m. to 8 a.m.	
	Qual.	Unqual.	Qual.	Unqual.	Qual.	Unqual.	Qual.	Unqual.
1–10	1	1	1	1	1	1	1	1
11–15	1	2	1	2	1	2	1	1
16–20	2	2	2	2	1	2	1	1
21–25	2	3	2	2	1	4	1	2
26–30	2	4	2	3	2	4	1	2
31–35	2	5	2	4	2	5	1	3
36–40	2	6	2	5	2	6	2	2
41–45	2	7	2	6	2	6	2	3
46–50	3	7	3	6	2	7	2	3
51–55	3	8	3	7	3	7	2	3
56–60	3	9	3	8	3	8	2	4
61–65	3	10	3	9	3	9	3	4
66–70	4	10	4	9	3	9	3	4

In this study, some homes that were surveyed chose to staff the home to the minimum levels specified in the staffing notice. In these homes, when there are staff shortages, for example because of sickness, this results in the home manager or matron having to spend a lot of time ringing round to secure the staff needed to meet the minimum levels specified in the staffing notice. Also, if the care needs of the residents require more care staff to be on duty, this can involve the matron or manager in undertaking difficult negotiations with the owners in order to secure additional care staff.

Alternatively, in some of the homes included within this study, the owners had decided to staff the home above the levels of the staffing notice. This was done, either because the care needs of the residents required more care staff, or because the home wanted to offer a higher quality of care. In these homes, when there are staff shortages and replacements cannot be found, at least the home is still above the minimum staffing levels specified in the staffing

notice. Also, in these homes, it is felt that the other care workers can more easily absorb the additional work caused by staff sickness and absence.

Although care homes are expected to recruit enough staff members to enable them to plan duty rosters well in advance, it is anticipated that, occasionally, additional care staff who are unfamiliar to the residents need to be brought in at short notice to 'make up the numbers'. The Newcastle Joint Inspection Unit (1998) provides guidance on the use of temporary, agency and bank staff by advocating that their numbers should never exceed those of the permanently employed staff on duty at any one time.

In this study, one registration and inspection unit admitted that some homes depend almost entirely on the use of bank and agency staff. This obviously has a negative effect on the quality of care that can be provided in those homes.

The majority of the homes surveyed in this study utilised a range of strategies to ensure

that staffing levels were at the required numbers for each shift. Each home included one or more of the following strategies:

- asking part-time or full-time staff to work additional shifts/hours
- using the home manager as a member of care staff
- setting up a staff bank; that is a number of care staff who are not contracted to the home, but who are willing to work at the home when there are staff shortages
- using agency staff, although, for most homes, this was a last resort.

Because staffing is the largest cost factor for any care home, Laing & Buisson (2000b) have pointed out that registration authorities tend to exercise a large amount of discretion in terms of their expectations of skill/grade mix and the staffing levels needed on each shift. Homes require some flexibility in their staffing notice when:

- occupancy rates fall
- the dependency of the clients changes significantly
- despite the home's best efforts, there are simply no care staff available to achieve the minimum levels specified in the staffing notice.

Registration and inspection units are not insensitive to the needs of home owners who need to maintain a home's viability by keeping costs down. In this study, it was found that some registration and inspection units do demonstrate flexibility in terms of enforcing the staffing notice, for example:

- allowing an experienced enrolled nurse to take charge of a shift in a nursing home
- allowing two experienced care support workers to replace a nurse for one shift, although there still needed to be a first-level nurse on duty to be in charge of the home
- allowing a registered general nurse who has completed the ENB Dementia Care course to replace a registered mental nurse in a care home that specialises in dementia care clients
- in some dual registered homes, a small number of the beds were designated as either nursing or residential care, depending on the types of clients that occupy them
- when occupancy rates are a problem, allowing a home to use a sliding scale of care staff, where staff numbers are dependent on how many residents are in the home at the time
- in exceptional circumstances, for example because of adverse weather conditions, simply allowing a home to operate at staffing levels below the staffing notice because it is impossible to bring in additional staff for a shift.

Care staff shortages

A range of issues relating to care staff shortages emerged during the study:

- In those parts of the country where there are still relatively high levels of unemployment, or where there is a ready

supply of individuals from the ethnic minorities, there appear to be few problems in recruiting care support workers.

- Homes that are located in affluent parts of the country, e.g. the South East, are experiencing problems because the property prices are prohibitive and care workers cannot afford to move to that part of the country. Also, there are reports of individuals being able to earn upwards of £10 per hour working behind a bar. In these areas, homes that are offering the minimum wage are unlikely to be successful in recruiting care support workers.
- Homes that are located in rural and isolated areas tend to have more problems with recruitment. Usually, there is no local public transport and the travelling costs result in the agencies having difficulties finding people who are willing to work in these homes.
- The staff shortages are so acute in some parts of the country that the care staff have to work long hours and this leads to burnout and low morale.
- The calibre of care staff available to both nursing and residential homes is not always of the highest quality.

Nurses

Laing & Buisson (2000b) point out that there will continue to be a reduction in the pool of young adults available for nurse training over the next few years. This is likely to cause a fierce battle in the future between the public sector

and the independent sector for the recruitment of nurses.

Carr-Brown *et al.* (2000) highlight that the NHSE has estimated that 20,000 new nurses are needed over the next three years and compare that to the Royal College of Nursing (RCN) estimate of 57,000. The article goes on to say that the Government was warned by the RCN in the early 1990s that it faced a huge shortfall of nurses by the end of the decade but, at the time, the RCN was accused of scaremongering.

The Nursing and Midwifery Staffs Negotiating Council Staff Side (DoH, 2000j) highlighted that the number of entries to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) Register over the last decade has declined by 6,000 per year, which has resulted in many care providers developing a reliance on bank and agency staff. It emphasised that the task was not simply to end years of underfunding; it was also to overcome the shortage of human resources and end years of low morale within the health-care workforce. It was pointed out that the NHS Plan (DoH, 2000b) had set a target of recruiting 20,000 more registered nurses in England alone by 2004, but that this had not taken into consideration the additional nurses required by other parts of the UK and the independent sector.

The Times (2000a) reports that there is a recruitment 'timebomb' looming in the NHS caused by up to a fifth of disaffected nurses considering leaving the service and the growing number of retiring nurses.

Buchanan (1999) also highlights the 'greying' of the nursing workforce and points out that the age profile of nurses working in nursing homes is older than that of NHS nurses and that the

pool of potential returners from which employers can recruit is declining in numbers as it ages.

The Daily Telegraph (2000) reports that there are as many as 70,000 nurses working in other professions. To overcome the NHS nursing shortages, Carr-Brown *et al.* (2000) report that an expensive range of recruitment and retention strategies are being established within the NHS:

- 1 Plans are being finalised by the Government to release £250 million to help professionals such as nurses afford starter homes in problem areas such as London and the South East.
- 2 The Health Department is to invest £120 million on:
 - increased nurse training and recruitment
 - implementing more flexible working conditions.
- 3 An initiative called 'NHS Professionals' will allow nurses the flexibility of agency working whilst allowing them to maintain NHS holidays and pension entitlements.
- 4 The provision of child-care arrangements.
- 5 By 2004, 100 hospitals will offer subsidised places at on-site nurseries.
- 6 Some NHS Trusts have resorted to signing-on fees of £1,000 or retention bonuses of £2,000.

The Nursing and Midwifery Staffs Negotiating Council Staff Side (DoH, 2000j) highlights that the current raft of human resource initiatives have yet to have a

substantial impact on staffing levels. And it points out that the record of the NHS in implementing such initiatives raises serious questions about whether the improvements will ever be delivered. If the NHS recruitment drive is successful, however, it is likely to make the independent sector recruitment problems even more acute.

A recent RCN (2000) survey of nurses in practice highlighted that better pay was the single most important factor that would encourage them to stay in the job. In fact, many nurses have a second job.

In the short term, some NHS trusts have to resort to recruiting nurses from abroad. Foreign nurses are willing to come to Great Britain because the salaries are higher than in their native countries. Usually, the recruited nurses are well qualified with a number of years' nursing experience and good English skills.

In this study, the homes and the large provider organisations that were surveyed reported that they had recruited, or were in the process of recruiting, nurses from a range of countries that included the Philippines, West Indies, India and Zimbabwe.

The Nursing and Midwifery Staffs Negotiating Council Staff Side (DoH, 2000j) points out that reliance on overseas nurses has increased dramatically in recent years as they currently represent 28 per cent of new entrants to the Register. It was emphasised that recruiting nurses from abroad is not a sustainable solution to the shortages.

In contrast, Carr-Brown *et al.* (2000) report that, although nurses are being recruited from overseas, British nurses are leaving for better-paid jobs abroad in places such as the USA and Canada.

Care support workers

Kent and Payne (2000) highlight how nobody really knows precisely how many care staff there are in social care. The current estimates are that there are about one million people working in social work and social care. One-third of them are employed by 150 local authorities and two-thirds by 25,000 independent sector providers. The King's Fund (2001a) outlines how care support workers are a workforce where the average pay rate is £5 per hour and there are high levels of staff turnover, which is only likely to get worse as the workforce becomes older and competition in the labour market becomes stiffer.

It was pointed out by many of the people interviewed as part of this study that, in many parts of the country, there are office and retail sector jobs that are offering wages to unskilled workers that are higher than those available to care support workers in the local care homes. The situation is especially difficult in those parts of the country where large retail centres have opened. In the more affluent parts of the country, the result is that homes have to offer care support workers up to £10 per hour in order to recruit and then retain them.

Back in 1995, O'Kell suggested that a register or database of non-professional care workers should be set up in order to protect the public. The Care Standards Act (DoH, 2000a) provides for the establishment of a General Social Care Council in England. This organisation will join with its counterparts from the other three home countries to establish the Social Care Workforce Registration Project (RHS, 2001c). The four councils are expected to take over the Central Council for Education and Training in Social Work's (CCETSW's) responsibilities for the

education and training of the social work and social care workforce. In addition, the councils will have new responsibilities for the regulation of the workforce.

To achieve this, a Code of Practice will be produced, a workforce register will be maintained and allegations of misconduct will be dealt with. This will require a high level of cooperation and collaboration with both public sector and independent sector employers in order to ensure that they are willing to:

- verify the identity and employment history of workers at the application stage and relay this information to the appropriate council
- ensure that their employees work to the Code of Practice and meet the continuing professional development standards
- investigate allegations of malpractice and, where necessary, inform the Council of their findings.

Another important part of the Care Standards Act (DoH, 2000a) is that the Secretary of State will establish a register (Consultancy List) of people judged to be unsuitable to work with vulnerable adults in the care sector. Everybody who took part in this study felt that this was a good idea. TOPSS England (2001a) outlines how the Consultancy List will allow employers to ensure that all their staff are vetted before employment, although regulations covering access to the register will be needed.

Conclusion

The reality is that public services are no longer attractive as a career option to many people.

There are better jobs, offering more money, available in other occupational areas, especially within the commercial sector.

In the care sector, although there is likely to be increased recruitment into the nursing profession from new recruits and returnees, because there are increasing numbers of nurses who are likely to retire or simply leave the profession over the next few years, the Government is unlikely to meet its nurse manpower targets. In fact, the shortages may get worse before they start to get better. Because the NHS is spending so much money on recruitment and retention of nurses, this is likely to make the nursing shortages even worse in the independent sector.

In terms of care support workers, until funding is available to significantly increase the fees for care homes, there is little chance that the homes can afford to pay much above the minimum wage or provide high quality training for their care staff. Therefore, in those parts of the country where there are recruitment problems, these are likely to continue.

In order to minimise the shortages of care staff, the following actions will be necessary:

- The NHS workforce development confederations will have to work collaboratively with the local authority regional training forums and the independent care sector in developing

integrated manpower planning strategies that meet the needs of all participants in the care sector.

- All employers working within the care sector will have to utilise good recruitment practice if they are to minimise their recruitment problems.

According to standard 17 of the NMS, a system for calculating the staff numbers required in care homes is to be recommended by the DoH. The sooner the DoH chooses its preferred skill/grade mix model, the better.

If the need for nurses working in the new care homes is to be reduced, this will require improved training opportunities for the care support workers working in the homes and a substantial increase in the numbers of care professionals working for the NHS community health services who can assess client needs and provide an increased amount of care within the care homes.

The planned Code of Practice, workforce registers, Consultancy List and the TSO Enterprises Clearing House Initiative, when they are available, should all be welcomed as they are likely to make the recruitment of care support workers easier and enable employers to identify those individuals who should not be working with vulnerable people.

5 Care staff retention

Staff retention is just as important as staff recruitment. It is no good recruiting a member of care staff if they are likely to leave for another job at the earliest opportunity. It makes sense that the best way to retain care staff is to make them motivated to want to stay in the job.

Motivation at work

Hertzberg's (1968) two-factor theory of motivation highlights the important elements of job motivation and job demotivation. The motivators are related to the nature of the work itself and the intrinsic rewards that flow directly from the performance of that work, for example responsibility, promotion and education opportunities. The demotivators are related to the work environment and the context of the work itself, for example organisational policy, working conditions, relationships with colleagues, salary, lack of recognition or achievement.

Both the DoH (2001c) and the RCN (2001) highlight how employee-friendly policies can benefit everyone in the caring team. In this study, additional factors were identified as motivators that enabled a care home to successfully retain care staff, for example:

- a manager, owner, or matron who is 'employee friendly' and treats the care staff as valued and respected employees
- homes that are a 'happy' place to work because there is an emphasis on good communications and teamwork
- homes that enable staff to access education and training opportunities.

Bulletpoint (2000) highlights how the best care homes can be successful in staff retention by introducing the principle of 'empowerment' where the care staff have a sense of:

- *meaning*: their work is important to them; it is more than just a job
- *self-sufficiency*: they feel as though they are in charge of their own work and have the freedom to plan how they are going to perform it
- *competence*: they are confident in their own abilities and they are not afraid to take the initiative and try something new
- *impact*: they believe that what they do and say has some influence on the way that the organisation is run.

For many people working in the care sector, caring is not going to be their lifetime career. Staff retention can be difficult in those parts of the country where it is easy to get a job with another care home and/or where there is a lot of available agency work. One of the problems identified in this study is that some care workers are known to move on to other homes for little reason, for example so that they can earn a few pence more per hour. It is suggested that, when staff enjoy their work and feel empowered, this problem can largely be overcome.

Care roles

At the moment, until the implementation of the NMS in April 2002, a nursing home is different from a residential care home in that it provides care that requires the skills of a qualified nurse (NAHA, 1985). Currently, this is defined as

where the clients require constant nursing care or one or more care procedures undertaken regularly night and day, for example administration of drugs by injection, dressings applied to wounds, management of incontinence, etc.

A residential care home, on the other hand, cannot claim to provide nursing care to prospective clients and is not expected to admit a client who requires nursing care at the time of admission. Residential care homes, however, are expected to provide both personal care and residential accommodation with board.

In this study, all the residential homes that were surveyed had residents who required some 'nursing care'. This was provided either by the community nurse or by the home staff because the care task had been delegated to them by the community nurse.

The delegation of duties by a nurse to a care support worker should be carefully considered, as highlighted by the UKCC (1996a, 1996b). The UKCC (1992a, 1992b) emphasises that care support workers should not be allowed to work beyond their level of competence and that a qualified nurse who retains the accountability for the delivery of care should supervise them.

Back in 1995, OKell revealed that, for care support workers in some parts of the country, protocols have been developed so that they can undertake some extended care roles. There are limits, though, to the care roles that care support workers can take on, as they are only expected to provide personal care, not nursing care. Here, personal care is defined as care that includes assistance with bodily functions, but 'limited to that, which could normally be provided by a competent and caring relative at home' (DHSS, 1984b).

When extended care roles are taken on by care support workers, good practice ensures that:

- the care support worker receives appropriate training in the task
- adequate and ongoing supervision is available for the care support worker
- the care support worker is confident that he or she can safely undertake the care task and is willing to take on the role
- the care support worker is certified by the home manager as being competent in undertaking the care task
- both the client and his/her relatives are happy for the care support worker to undertake the extended care role
- the registration and inspection unit is informed that care workers are to take on extended care roles.

In this study, care support workers in some of the residential and nursing homes that were visited undertook extended care roles.

Normally, they were restricted to care support workers who had achieved the Level 3 NVQ in Care and the following criteria were fulfilled:

- The local registration and inspection unit was happy that the quality of care was not being compromised.
- The home owner was happy that all of the necessary safeguards were in place.
- There was appropriate supervision available from a trained nurse in a nursing home or from a community nurse in a residential home.

The results of the study indicated a wide range of clinical and non-clinical extended care roles that were currently being undertaken by care support workers:

- minor dressings using an aseptic technique
- catheter care
- cutting diabetics' toe nails
- percutaneous enteral gastrostomy (PEG) and naso-gastric tube feeding
- administration of residents' finances
- administration of medications, including rectal valium and insulin injections
- care planning.

Care support workers, especially those who have completed an appropriate Level 3 NVQ in Care, are capable of undertaking a wide range of extended care roles. It is understandable, though, that the professional bodies have some worries in terms of the lack of accountability of care support workers and the levels of supervision that are provided.

Supervision and appraisal

Supervision and appraisal are essential for the motivation of staff and for the provision of high quality care. The NMS (DoH, 2001f) state that the registered manager is expected to ensure that all of the local arrangements for employment policies/procedures, supervision and appraisals are implemented within the home. This should include the volunteers who are expected to receive appropriate training, supervision and support, according to their designated role.

Staff supervision

Although clinical supervision is not a statutory requirement for nurses, it is strongly supported by the UKCC (1996c). It is defined as a process that brings together practitioners and skilled supervisors for the purpose of reflecting on practice. The aim is to identify solutions to problems, improve practice and increase understanding of professional issues. None of the nursing homes in this study offered formal clinical supervision opportunities to their nurses.

It is not only nurses who require supervision. The other care staff also require it, in terms of making sure that everyone has their work performance monitored so that it meets the needs of the clients and is compatible with the home's expectations. The NMS (DoH, 2001f) state that all care staff should receive formal supervision at least six times per year.

Day-to-day supervision enables the managers and senior staff to monitor the performance of the care staff and relay information or give instructions where necessary. Individual supervision sessions provide a regular opportunity for care staff to meet with senior care staff or managers. These sessions can be formal and planned in advance or they can be informal and occur when required. Alternatively, supervision can occur in groups, for example within a care team meeting. Normally, the time in these sessions is spent on reviewing and reflecting on the types and quality of care offered within the home. Also, they are an ideal opportunity to explore the possibility of incorporating evidence-based practice (Le May, 2000) within the home.

Staff appraisal

In a good care home, all staff will have an appraisal. The annual appraisal is an opportunity for the senior staff or manager to evaluate the strengths and weaknesses of the care worker over the previous 12 months and agree a set of objectives for them to achieve over the following 12 months. It is also an opportunity for the care worker to feed back to the manager on any problems they are experiencing at the home. Also, this process allows them to identify any training needs and negotiate a personal development plan to meet those needs.

However, it should be remembered that staff appraisal should not be just a one-off, annual event. A member of care staff should be entitled to an appraisal meeting with a senior care worker or manager at least once every three months. These meetings provide an opportunity to review the care worker's progress in meeting the negotiated objectives and in achieving the care worker's personal development plan, as agreed at the formal annual appraisal.

Individual appraisal sessions should be planned and conducted in privacy, without interruption. All appraisal sessions should be documented. There should be a clear policy outlining the appraisal process and who has access to appraisal documents.

Only a few of the care homes surveyed in this study had implemented a formal appraisal scheme.

Personal development opportunities for care staff

O'Kell (1995) found few personal development opportunities for care staff employed in nursing

homes and residential care homes. The few opportunities that were available focused on task-centred subjects such as manual handling, health and safety, etc. (usually referred to as statutory study days).

The great majority of homes surveyed in this study provided statutory study days for all care staff. These study days can be provided in-house or bought in from an external provider, although the quality of in-house provision can be rather variable. Unfortunately, in some care homes, it was found that care staff could be very reluctant to attend the statutory training days unless they are offered some inducement. Therefore, in some of the homes, they retained the staff certificates of attendance at statutory study days so that they could not take them with them if they decided to move to another home. Also, some homes required care staff to pay back a proportion of their training fees if they left the home within 12 months of receiving training.

In this study, there was great variability across care homes in terms of the amount of resources that homes were willing, or able, to put into staff training. At one end of the scale, staff had all course fees and expenses paid and were allowed to undertake the course during work's time. At the other end of the scale, some homes paid nothing towards course fees or expenses and expected staff to do the courses in their own time, even the statutory study days.

The King's Fund (2001a) highlights how two-thirds of the workforce does not hold a relevant qualification and that there are inadequate education and training opportunities for care support workers.

Two issues that might overcome some of the problems of enabling independent care sector

staff to participate in education and training activities were identified by participants in this study. The first is that the independent sector should be allowed access to all NHS and social services libraries. The second is that, if a range of high quality distance learning materials were made available to the independent sector, this might help to reduce its staff training costs.

The DoH (2000g), in the new Quality Strategy for Social Care, has indicated a full commitment to staff development and training through the introduction of lifelong learning. One of the issues that is on the agenda is the stimulation of training activity in the independent care sector. Evans (1999) outlines how developing the capacity and willingness of the individual practitioner to learn is the foundation for client-centred care.

Johnson *et al.* (1999) concluded from the results of their study that the greatest gains in achieving improvements in the quality of long-term care can only come through improving the skills of the care staff and, therefore, training is needed for all levels of care home staff.

A range of learning opportunities was identified as being needed by the independent care sector. These included the following subjects: dementia care, managing challenging behaviour, palliative care, rehabilitation, handling complaints, suicide awareness, risk management, care planning, etc.

In the past, some registration and inspection units offered training to the care homes. Unfortunately, nowadays, they are much too busy to offer this service.

TOPSS England (2001a) has proposed that continuous professional development (CPD) requirements will be introduced for those individuals registered with the Social Care

Councils. It is expected that the CPD requirements will be related to the registration category and may vary for those in different parts of the register. The NMS (DoH, 2001f), however, has specified that each member of care staff should receive a minimum of three days' paid training per year (including in-house training) and should have a personal training and development profile.

Induction training

Induction training is absolutely essential for all new staff, even when they are experienced and qualified. The NMS (DoH, 2001f) specify that all members of care staff should receive induction training to the National Training Organisation (NTO) specification within six weeks of appointment to post. The concept of induction, however, can mean different things to different employing organisations. It can vary from a comprehensive programme of learning during the first six months of the care support worker's employment down to a short learning programme covering the 'essential' basic skills and knowledge, which is completed within a week of starting their employment with the organisation.

Because there is little consistency in induction programmes around the country, a set of national induction standards linked to the Level 2 NVQ in Care have been developed. They are based on identified best induction practice and specify that the new care support worker must have completed the programme before:

- they can work unsupervised, out of the 'line of sight' of a fully inducted worker who takes responsibility for the new worker's practice

- he or she has been employed for a total of six weeks.

The new induction standards have been designed so that they can be incorporated within already-delivered induction training programmes, whether they are taught in house, bought in, accessed externally, or delivered by distance learning materials. The five draft induction standards are:

- Understand the principles of care.
- Understand the organisation and the worker role.
- Understand the experiences and particular needs of the service user group(s).
- Maintain safety at work.
- Understand the effects of the service setting on service provision.

It is envisaged that care workers new to the job should be able to see the completion of the induction programme as being the first step on the career ladder. After induction training, the NMS (DoH, 2001f) specify that all care staff should receive foundation training to NTO specifications within the first six months of appointment. The foundation programme should follow on smoothly after the induction programme. It is anticipated that the foundation programme should enable practitioners to achieve accreditation against a Level 2 or 3 NVQ in Care. The five draft foundation standards are:

- Understand how to apply the value base of care.
- Communicate effectively.

- Develop as a worker.
- Recognise and respond to abuse and neglect.
- Understand the experiences and particular needs of the individuals using the service.

Registered managers

During this study, it was discovered that registration and inspection units were inconsistent in their requirements for registered managers. At one end of the scale, the registered manager simply needed at least two years' experience at a senior level working with the client group. At the other end of the scale, the registered manager was expected to have a professional qualification or a Level 4 NVQ in Care, or their equivalent, together with the two years' relevant experience. It is anticipated that the General Social Care Council (GSCC) will identify registered managers as a priority group for registration.

The NMS (DoH, 2001f) specify that the registered manager should have at least two years' experience in a senior management position during the last five years and, by 2005, will have achieved a Level 4 NVQ in Management and Care or its equivalent. Alternatively, the registered manager, where nursing care is provided within the home, should be a first-level registered nurse and have a relevant management qualification by 2005.

ARC (2001) highlights that, in order to achieve some consistency in the competences of home management, a set of 23 national occupational standards for registered managers have been identified.

It is expected that these standards will be accepted by TOPSS and discussions are being undertaken with the Qualifications and Curriculum Authority (QCA) and the awarding bodies so that they can be used as the basis for a Level 4 NVQ for registered managers.

In addition to the NVQ, registered managers will be expected to achieve the following Level 4 personal competences as part of the NVQ:

- acting assertively
- acting strategically
- behaving ethically
- building teams
- communicating effectively
- focusing on results
- managing oneself
- searching for information
- thinking and taking decisions.

Care support workers

The NMS (DoH, 2001f) specify that a minimum of 50 per cent of care support workers (excluding the registered manager and nurses, but including agency staff) should have achieved at least a Level 2 NVQ in Care by the year 2005. According to the Centre for Policy on Ageing (2001), only 10 per cent of care homes, at the time of its study, reached that minimum standard. This survey, which collected data from 418 care homes, estimates that only 20 per cent of care support workers have a Level 2 NVQ in Care and that in 12 per cent of care homes, there are no care support workers who have completed an NVQ in Care. A further

finding from this study is that nearly a third of care homes offer their care staff no basic training such as induction or foundation courses and 43 per cent of homes provide no staff training in manual handling.

In this study, the majority of homes surveyed, encouraged and supported their care support workers to complete a Level 2 NVQ in Care. Some care homes were also willing to support appropriate care support workers in undertaking a Level 3, or even Level 4 NVQ in Care. A range of problems was identified with the NVQ in Care programmes:

- Once a care support worker has completed an NVQ in Care, they tend to seek posts in other homes that don't provide much staff training, but offer higher rates of pay.
- Local apprenticeship schemes provide funding for the under-25s. There is less funding available to pay the training costs of the over-25s.
- The assessment process is very time consuming, both for candidates and assessors.
- When peripatetic assessors are used, the quality, reliability and validity of assessment tend to be reduced.
- Several nursing homes highlighted that the NVQs in Care at Levels 3 and 4 are inappropriate for nursing homes where there are nurses available to take on the more complex care tasks.

Action on Elder Abuse (2000) highlighted that the NMS related to staff training are going to be very expensive to implement nationally. It

hoped that the Department of Health was not going to place this burden solely on the shoulders of cash-strapped care home owners, which would lead to even more home closures.

Back in 1995, O’Kell predicted that there would be the development of skills-based courses for the training of care support workers to take on extended care roles as this would be ‘a more economic buy for the cost conscious care manager’. Since then, there has been a restructuring of the NVQs in Care awards so that individuals who have completed the Level 3 award may well be capable of undertaking a range of extended care roles. Also, the Joseph Rowntree Foundation has established a Certificate in Care that is being linked to a Level 4 NVQ in Care. The JRF Certificate in Care is now available at two universities in Britain (Sunderland and Lincoln) and is also offered by several large care provider organisations, for example BUPA, Shaw Homes. A number of other universities and organisations are showing an interest in offering this qualification.

Qualified nurses

In order to maintain his/her registration as a nurse, each practitioner has to undertake a minimum of five days (or its equivalent) of study activity every three years (UKCC, 1997, 2001). Any type of formal or informal, structured or unstructured learning activity is appropriate as long as it is relevant to practice and as long as the practitioner can identify the learning that has been achieved.

The continuous personal and professional development opportunities of nurses working in the independent sector are no less important than those of nurses working in the public

sector. In this study, it was proposed by several interviewees that independent care sector nurses should have access to the same courses that are available to NHS nurses. This would appear to be a sensible strategy when you take into consideration the increasing need of nurse training schools for high quality, non-hospital placements for their students. It would not be unreasonable for a home to expect (free) access to English Nursing Board (ENB) courses in return for the provision of student placements.

Back in 1996, Johnson and Hoyes outlined the need for gerontological nurse specialists who could work as established staff in care homes or be based in support agencies, allowing the flexible use of their specialist nursing skills. The RCN *et al.* (2000) have advocated for a specialist gerontological input to be available in every care home, either from a nurse employed by the home, or from an NHS community nurse.

Conclusion

There is no doubt that the provision of care to the residents of care homes, at times, can be rather stressful. A good home manager will ensure that the causes of stress for care workers are kept to a minimum and that team motivation is maintained.

In the new care homes, where it is expected that very little care will be designated as ‘nursing care’, it is likely that extended care roles for care support workers will be encouraged by home managers and primary care groups. The need for extended care roles for care support workers will be even more important when there are no nurses employed by a home, and/or where there is a limit to the

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amount of health care support that can be provided to individual residents by NHS community nurses. In this study, it was found that the types of extended care roles undertaken by care support workers are dependent on three main factors:

- the acceptance of care support workers undertaking extended care roles by registration and inspection units
- the promotion of specific, extended care roles for care support workers by home managers
- the willingness of homes and members of the primary care team to provide the necessary training and supervision to care support workers undertaking extended care roles.

The NMS have specified a range of issues that have to be addressed by care homes in relation to staff supervision and training. Many home owners will feel that they have neither the time nor the resources to properly meet the

training standards, even though they have until 2005 to meet some of them.

In terms of access to training opportunities, even if care homes can stimulate their care staff to undertake further study, outside help is going to be required so that innovative solutions can be found to the problems of involving the independent sector in local training needs analysis and in overcoming the problems of expensive course fees, limited access to academic libraries, etc.

The new occupational standards that have been developed for the induction and foundation courses, registered manager award, etc. will require a review of the NVQ in Care awards so that they can be integrated within the NVQ framework, as well as being stand-alone awards.

Finally, a local review of available gerontological skills will be needed in each district to see how best to facilitate gerontological nurse specialist input into all care homes.

6 Registration and inspection

Back in 1996, it was Johnson and Hoyes who suggested that a self-financing national office for standards of care to oversee the setting of national standards and the registration and inspection of all services was required. Therefore, the great majority of the independent care sector have welcomed the Government's announcement of moving towards a 'level playing field' with the Care Standards Act (DoH, 2000a), which is effective from April 2002. This Act will establish wholesale reform of the registration and inspection of nursing homes and residential care homes:

- Setting up the National Care Standards Commission (NCSC) to undertake the registration and inspection function of all care homes (including Part III accommodation).
- The establishment of a single care home; the definition of a care home is one that provides accommodation plus nursing or personal care.
- Consulting on the final format of the National Minimum Standards (NMS) that will form the basis for registration and inspection.

Home inspection

Until the NMS are implemented in 2002 (DoH, 2001f), the legislation governing the registration and inspection of all nursing homes and residential care homes is still the Registered Homes Act (DHSS, 1984a). Although some standards within the Registered Homes Act are quite specific, others are open to interpretation of what is 'adequate'. This has resulted in

registration authorities setting their own local standards for certain areas of care (O'Kell, 1995). According to Anne Parker (Chair of the NCSC), though, this has not necessarily been a bad thing. This is because the very vagueness of the Registered Homes Act standards has allowed registration and inspection officers to 'talk up' quality in homes (RHS, 2001g).

The RCN (1994) has also described how the current system for registering and inspecting nursing homes is inadequate because of the great variation in registration and inspection practices across the country. In this study, the majority of the large and national organisations that were interviewed highlighted that there is a high level of inconsistency around the country in terms of the way that the Registered Homes Act standards are interpreted and implemented by inspectors.

In practice, Laing & Buisson (2000b) point out that health authorities and local authorities are in a powerful position when homes are seeking initial registration. This results in homes which, in order to achieve speedy registration, have acceded to locally specified requirements that the registering authority is not entitled to impose. After registration, the balance of power shifts to the homes. Although the registration authorities have the ultimate sanction of deregistering a home, this rarely happens because it has proven to be a difficult legal process and there can be difficulties in finding alternative accommodation for residents. Therefore, homes have to offer very poor quality care in order for them to be deregistered.

Jefferson (2000) highlights that inspectors have been criticised in the past for concentrating too much on inputs (quality of the living environment and care staff levels) and outputs

(number of diversion activities and quality of care plans), rather than on outcomes (actual experiences of clients in homes). Unfortunately, the NMS have not changed this emphasis.

The establishment of the NCSC in April 2000 as part of the Care Standards Act (DoH, 2000a) has been needed to ensure that the new regulatory services that are being established overcome the current registration and inspection problems and inconsistencies.

However, according to Jefferson (2000, 2001), what is needed is a system that replaces outmoded and inappropriate registration and inspection practices and procedures, whilst preserving the best parts of the old system which include:

- 1 fostering and developing 'best practice'
- 2 protecting vulnerable people from being neglected, exploited and abused by preventing the most unscrupulous providers from offering services
- 3 retaining the professional knowledge and experience of current inspectors:
 - knowing when to be flexible
 - maintaining links with local communities.

Jefferson (2001) also highlights those aspects of the old registration system that he hopes will disappear:

- the stereotype of the registration officer being inflexible and unfriendly (in this study, only one registration and inspection unit was described thus)
- professional rivalries and misunderstandings between different registration and inspection authorities

- the influence of senior managers on the effectiveness of a registration and inspection unit.

RHS (2001p) points out that, when the new standards are implemented, it will no longer be possible for registered managers to complain that their inspector (regulator) is setting personal standards, or that local authority homes are required to achieve less than the rest of the care market, or that clients and/or their relatives are making unrealistic demands of the services on offer. The standards are 'clear, visible and unequivocal'. The new breed of regulators who will commence their roles in 2002 have been provided with a sensible manual to guide them in their duties.

Wright (2000) reports that it is likely that lay inspectors will be retained within the new system of registration and inspection, even though there is great disparity across the country in how they are used and remunerated (or not) for taking part in the inspection process. One disincentive to using lay assessors that has been identified is the lack of administrative support for registration officers who have significant work pressure but have to negotiate their own arrangement with lay assessors.

The problem of the changing care needs of clients in care homes has resulted in an increasing number of homes becoming dually registered. This is a process in which a health authority and a local authority, either separately or together, register a home as both a nursing home and a residential care home. Dual registration has been designed to allow the widest possible range of care to be provided within an individual home. This process is required so that, when a client's care needs

change, that client does not have to be moved to another home. The additional benefit for a care home owner is that it enables the home to maintain its occupancy levels.

With the introduction of care homes in 2002, there will be an expectation that each home will simply have to employ the correct numbers and types of care staff who, in conjunction with the available NHS community health services, can meet the assessed care needs of the residents. According to O’Kell (1995), however, problems can occur because of the huge differences in the levels of NHS community health services that are available in different localities.

According to Wing (2000), inspectors are going to have to be aware of the Human Rights Act (Home Office, 1998). This Act states that every act or decision made by a public authority must be compatible with the European Convention on Human Rights. An example of a potential problem might be where an urgent closure is required. However necessary the closure, because it can have long-term implications for the care of an individual or may even result in death, this could provoke a legitimate human rights challenge. It will no longer be sufficient to argue that the registration authority acted reasonably. The burden is on the authority to justify how the actions that have been taken are not a breach of human rights. This situation may cause regulators to be very cautious in their decisions and, therefore, may result in vulnerable people not being properly protected. This again could put the authorities in breach of the Act because they have not intervened. Wing (2000) states that lawyers acting on behalf of care providers have intimated that they will use the Act to challenge regulators in the exercise of enforcement.

Inspectors (regulators) beware!

Wright (2001) outlines the pioneering work being undertaken by Pembrokeshire County Council in creating standards for inspection units. Its work has highlighted the wide variations in current practice of registration authorities. This has led to it recommending that a common approach to the production and publication of publicly accessible inspection reports is needed. It is busy producing a good practice guide and suggests a range of performance indicators that include a percentage of draft reports:

- produced within 28 days of inspections taking place
- finalised and published within 63 days of inspection.

Resourcing of registration and inspection units

Despite being under-funded, under-resourced and under pressure, health authority and local authority registration and inspection units have coped well over the years, although not always consistently, as previously mentioned, with local and central expectations of adopting new ways of working and meeting performance targets (Jefferson, 2000). The latest data that are available from the DoH (2000h) highlight that, in the year 1999/2000, the statutory targets for inspection were met for virtually all categories of establishment.

The DoH (2000h) also highlights that there were 120 vacant posts out of 1,340 whole-time equivalents in local authority registration and inspection units, and ten vacancies out of 245 whole-time equivalents in health authority

registration and inspection units. In this study, the numbers of inspectors available in each registration and inspection unit was very variable. They varied from the very large local authority teams with a dozen or more inspectors, down to the singleton health authority inspector covering a whole county by her/himself.

A further issue is that the fees charged by the local authority and joint registration and inspection units account for only 45 per cent of their running costs, whilst the fees charged by the health authority registration and inspection units account for 80 per cent of their costs.

The NCSC has had to agree that the Government's insistence on registration and inspection being self-funding by collecting fees charged to providers is now only a long-term goal. Anne Parker, the first Chair of the National Care Standards Commission, has admitted that registration and inspection 'is a long way off being self-financing' and has outlined how she will be looking for significant economies of scale in terms of local registration and inspection arrangements (RHS, 2001g). Additional funding will be required from central Government to make up for the loss of subsidies that were provided by health authorities and local authorities to their inspection units (RHS, 2000e). If not, then the regulation of care homes could be rationed to the resources that are available.

RHS (2001g) points out that the intention is to provide the NCSC with new premises, new IT systems and reorganised working procedures to go with its revamped image. According to the NCSC (2001), lay assessors will be an important part of the plan. These resources come at a price

and it would be unjust and impractical to pass these costs down in their entirety to providers and service users, who have already shown themselves to be very reluctant to pay more.

In Scotland, Hill and Gibb (2001) highlight that a Policy Position Paper has been produced which sets out the proposed target of a minimum of one inspection per year for each home. Considerable reservations have been expressed because this reduces the minimum number of two inspections per year (one announced and one unannounced) that are specified at the moment by the Registered Homes Act (DHSS, 1984a) and are expected to be adopted next year by the NCSC.

Training for inspectors

A further development is the construction of a set of national occupational standards for registration and inspection officers (DoH/SSI, 2001a). TOPSS England and Health Work UK have developed the standards after wide consultation. The standards outline the complex task of undertaking registration and inspection, as specified in the Care Standards Act (DoH, 2000a) under its regulations and associated codes of practice. According to the DoH/SSI (2001b), the national occupational standards are expected to:

- describe good practice in registration and inspection
- provide a benchmark against which to judge the performance of inspectors (regulators)
- provide the basis for training and qualifications.

There are four core standards:

- evaluate and process applications for registration
- plan and implement the inspection of regulated services
- investigate issues, concerns and complaints
- secure compliance with legislation through negotiation and enforcement procedures.

These are accompanied by two support standards:

- contribute to the development of regulatory authority, policy and practice
- take responsibility for own business performance and the continuing professional development of self and others.

In preparation for the implementation of the National Minimum Standards, RHS (2000c) highlights how TOPSS, CCETSW and the Open University are currently working together to set up a training project for inspectors in registration and inspection units. CCETSW has agreed to become the awarding body for the qualification based on these standards during the interim period until the Government's consultation on CCETSW awards has been completed (DoH/SSI, 2001b). RHS (2001m) outlines how the Open University has provided a draft national curriculum to CCETSW so that it can be launched in September 2002 and have its first graduates complete the course in 2004. Inspectors transferring to, or joining, the National Care Standards Commission will have

access to a conversion pack that is, currently, under development.

One important point made by the DoH/SSI (2001a) is that the new regulators are expected to maintain their nursing or social work registration with the relevant professional body, where appropriate, and keep themselves updated so that they can promote good practice in registered homes.

The work base of inspectors is likely to be an important issue for the future. Many inspectors are worried about the potential isolation if they are expected to work from home (RHS, 2001b). Fortunately, the NCSC appears to have conceded that regulators will be given more choice over their working arrangements than was originally envisaged.

Conclusion

Registration and inspection is, currently, in a state of flux. Care home owners are having to prepare for the implementation of the NMS by working towards the achievement of those standards. At the same time, many of the inspectors working for registration and inspection units are applying for posts as regulators within the NCSC and working towards the achievement of the national occupational standards that have been specified for regulators.

It is going to take a while before the regional and local offices of the NCSC are established. In 2002, when these offices become operative, it is going to be interesting to see how well they are going to be resourced and whether or not they can avoid the allegations of 'inconsistency' that are currently being levelled at registration and inspection units.

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A further important point to note is that, because the NMS are no better than the Registered Homes Act standards in terms of concentrating on structure and process standards, consideration may need to be given

to linking the NMS to the results of the Minimum Data Set Resident Assessment Instrument that is likely to be used by care homes, so that the outcomes of care can be incorporated into the inspection process.

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