NURSING HOME CARE IN KENT

A Review by a Select Committee appointed by the Social Care and Community Health Policy Overview Committee

Parts I and II

Chairman: Mr M Angell

February 2002

FORWARD

On behalf of the Select Committee I am pleased to attach the final report on Nursing Home Care in Kent. The review has been conducted in accordance with the terms of reference and taking into account the policy on Active Care 2000, the Joint Review Report 2001 and the Public Service Agreement.

In presenting this report I strongly recommend that the County Council leads on a study of the "Role of the Nursing Home in the Community". Certain measures recommended in the report would undoubtedly improve the quality of life for elderly patients and go a long way to supporting the need for more stepdown/intermediate care beds: at the same time addressing in part the problems of delayed discharge.

A clear objective now exists for a community wide approach to health. I think that this is now emerging in the interface between the Policy Overview Committee and the work of the NHS Scrutiny Committee. Several common themes are emerging from the work of both Committees. It is therefore essential that these are recognised and taken forward in the context of the present and imminent changes to the healthcare economy in Kent.

Finally my thanks to the Committee Members and all who gave evidence and have been involved in the production of this report.

Mr M J Angell
Chairman, Select Committee

Members Version SEVEN

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A box containing the background materials has been placed in the Members' Lounge

NURSING CARE TOPIC REVIEW - EXECUTIVE SUMMARY

This topic review was chosen by cross party agreement in light of the perceived deterioration in the volume of available nursing home places for Kent CC funded individuals within the our County. Concerns surrounded the actual loss of homes (and beds) together with a marked decline in the amount of remaining beds actually accessible to Kent's publicly funded clients, due to a rising need for 3rd party top ups and the anecdotal perception that providers viewed Kent CC as the purchaser of last resort. During the lifetime of the Select Committee a special Department of Health grant became available and enabled the weekly rates to providers to be raised but it was too early to assess the impact of this.

The terms of reference of the Select Committee were:

To consider the capacity of, and trends in, the Kent Nursing Home sector, with particular reference to the projected needs of public sector purchasers and the influence of central government on supply.

The Select Committee, chaired by Mr Angell, first met on October 2 and concluded the evidence gathering on November 30. The membership comprised Mr M J Angell, Mrs A D Allen, Mr J A Davies and Mr M V Snelling (for the Conservative Group), Mrs J E Butcher and Mrs M Newell (for the Labour Group) and Mrs M E Featherstone (the Liberal Democrat spokesperson).

There were 9 evidence gathering meetings involving 19 witnesses: involving a diagonal slice of staff within the Directorate and from a broad range of external stakeholders. In addition individual or small groups of Members undertook visits to 6 nursing homes and conducted semi-structured interviews with each manager. To arrive at their findings and recommendations the Select Committee met on Dec 6 and 17. Subsequent development of the text and refinements to the recommendations were achieved through e-mail consultations.

The main body of the report is divided in to 5 chapters and the recommendations to the County Council are:

FUTURE DEVELOPMENT

Recommendation 1.1 That the "Building Capacity and Partnership in Care" national concordat be recognised as an opportunity to develop a new relationship between the County Council, the Primary Care Trusts (PCTs) and social care providers.

Recommendation 1.2 Use the Building Capacity development arrangements to recognise that individual providers may need business advice to safely embark on diversification.

Recommendation 1.3 a) A wider role for some nursing homes should be examined by the National Care Standards Commission (NCSC), local authority and health service commissioners in conjunction with the industry. These would vary with local circumstance but might include:

- a hub-and-spoke model where i) domiciliary nursing services are provided from a nursing home base, ii) day care in the nursing home is provided for those living independently;

- diversion to the nursing home instead of hospital, sanctioned by either the casualty department or GP or paramedics;

- step down/ intermediate care with therapists and equipment to maximise the individual's potential for independent living;

b) these specific proposals should be seen as part of an integrated community approach to social care, health provision and supported housing

Recommendation 1.4 The County Council should lobby for the NCSC to authorise suitably qualified and experienced nurses employed in nursing homes to be able to undertake the range of procedures they would be authorised to undertake if employed in a hospital.

Recommendation 1.5 Eligibility criteria for single people be reviewed by the Social Services Directorate to re-test whether the right balance between quality of life and personal safety is met taking into account that institutional settings cannot provide a risk free environment.

Recommendation 1.6 The Social Services Directorate review the care management assessment process and eligibility criteria and give consideration to potentially considering frail older couples as mutual givers and receivers of care.

Recommendation 1.7 The County Council and providers are recommended to consider, through the Building Capacity machinery, the scope for development of a data base to enable real time vacancies to be accessible by care managers; this may be considered from a regional perspective to incentivise providers and minimise cost to the KCC.

Recommendation 1.8 The County Council contracting processes should recognise that fee levels affordable by the authority appear insufficient to produce a viable business if entirely reliant on KCC clients. There would be merit in negotiating with individual providers a financially safe proportion or number of beds that may be used for KCC clients; a home with a vacancy within that quota would give priority to KCC placements.

Recommendation 1.9 Central government is recommended to consider establishing a bespoke loan support scheme to help good nursing homes access the capital needed to survive and thrive.

Recommendation 1.10 The County Council adopts or, where necessary, campaigns for developer contributions to be made for social care needs including nursing home provision.

Recommendation 1.11 The County Council Cabinet give further consideration to promoting nursing home developments through property disposals.

Recommendation 1.12 The County Council should encourage the 12 district councils to individually adopt an exceptions policy allowing nursing home development on greenbelt land where there is an insufficient supply of available places for local people.

COSTS

Recommendation 2.1 The County Council should lobby for the consequential costs to social services and health due to the large population of self-funders and other LA residents to be met through grant or formula funding mechanisms.

Recommendation 2.2 (a) The Social Services Directorate should look at trends in demand and supply of nursing care across London, the resulting picture enabling a KCC response *to* be drawn up, including re-examination of the KCC contract procurement strategy and informed lobbying of national policy makers. (b) The Building Capacity machinery should include a regional forum where providers and the range of purchasers can seek a coherence in planning and commissioning services within Kent.

Recommendation 2.3 The present contractual gross payment and third party payment arrangements assist homes and should be continued.

Recommendation 2.4 Consideration be given to an attendance allowance take-up campaign for older people in the community, jointly run with appropriate partner bodies, as this will result in an expanded Standard Spending Assessment for Personal Social Services in Kent.

TRAINING AND DEVELOPMENT

Recommendation 3.1 Promotion of training should be through the existing consortium but given a much higher profile quickly if providers are to achieve NCSC targets by 2005; communication with homes on the training available must be improved.

Recommendation 3.2 A sustained campaign to ensure the replenishment of the qualified nurse workforce should be commenced by central government as a matter of urgency

Recommendation 3.3 Career paths within nursing home employment for both care and nursing staff need to be established and developed *and* central government consider means of raising the status of care work

Recommendation 3.4 The current lobbying of central government to end the perverse funding formula for training is endorsed. Just as importantly there is also a need for a substantial rise in the sums available.

DISCHARGE PLANNING

Recommendation 4.1 Discharge planning should be commenced from the point of admission to "design out" the inherent delays. The pilot underway in East Kent is welcome; there should be comparisons made with other LAs' initiatives and Kent then adopt (or adapt) the most efficient on a county-wide basis. Similar comparisons should discern best practice for achieving speedy discharge whilst complying with the Choice of Accommodation Directions.

Recommendation 4.2 The County Council support the NHS Plan as a catalyst for the development of intermediate care.

Recommendation 4.3 The Social Services Directorate in conjunction with district councils, health bodies and housing associations fully explore the scope for developing intensively supported sheltered housing accommodation.

Recommendation 4.4 It be noted that i) health service criteria for the top band of "free" nursing care are very close to those for continuing care and the latter shall be reviewed ii) there could be resource issues for Kent CC if the threshold was raised iii) the National Health Service Overview and Scrutiny Committee be recommended to consider this issue.

Recommendation 4.5 The NHS should make patients and their relatives fully aware of their rights to challenge discharge decisions, particularly when nursing home care is proposed for high dependency cases, and this should be a performance measurement for local Patient Advisory and Liaison Services.

OVERARCHING ISSUE

Recommendation 5.1 An inter-active web-site should be explored that might: i) enable speedy and direct communication to and from - and between - providers, ii) enable all providers to access training opportunities and funding, thus raising the visibility of the Consortium (see recommendation 3.1) and iii) be developed as the data base suggested (see recommendation 1.7).

NURSING CARE TOPIC REVIEW - MAIN REPORT

INTRODUCTION

SCENE SETTING

(i) The context to this report is the responsibilities placed on local government under the National Health Service and Community Care Act 1990, the resources made available to discharge them and the changing environment in which they are to be delivered. In this report the terms "client", "user" and "patient" are used interchangeably

Exhibit 1: The place of nursing homes in the community care continuum:

<table>
<tr><td colspan="5">Local Authority Social Services</td><td colspan="2">< > HA</td></tr>
<tr><td colspan="4">Low intensity -> high intensity care package relating to assessed dependency, risk/suitability of environment</td><td>Personal care from staff. Any limited nursing requirements met by DN</td><td colspan="2">Nursing and personal care provided by staff</td></tr>
<tr><td colspan="4">Continued independent living</td><td>Residential Care Home</td><td colspan="2">Nursing Home</td></tr>
<tr><td colspan="2">Existing family home</td><td colspan="2">Move to suitable/ sheltered accommodation</td><td></td><td></td><td></td></tr>
<tr><td>Small adaptations and aids</td><td>Major adaptations</td><td colspan="3"></td><td></td><td></td></tr>
<tr><td colspan="5">Funded by Local Authority with client contributions</td><td colspan="2">< > Free</td></tr>
</table>

Continuing care boundary

(ii) Nationally, resources have been expanded in domiciliary care enabling many who in the 1980's would have required residential care to be successfully supported in their own home: a policy and service success. However, community care may well have been structurally under-funded from its *launch* in April 1993: "Local authority interests claimed from the inception of the 1993 reforms that central government funding of community care was inadequate" (Laing & Buisson 2001) From that base, year on year additions have been *considered* inadequate resulting in belt tightening: meaning stricter eligibility criteria.

> "During the latter part of the financial year 1994/5, there were increasing reports of local authorities having over committed their community care budgets and having responded by raising eligibility criteria and reducing or even halting independent sector placements" (Laing & Buisson 1994).

(iii) Nationally, for these reasons, some who would have received a social service in the early 90's would now, in similar circumstances, not qualify for any, some with some substantial home care packages would now receive less, some eligible for and preferring residential care (to domiciliary support) would now not have the choice and - significant to this review - some previously assessed as requiring nursing care would now, instead, be assessed as eligible for residential care. This one-step-down has, in conjunction with the development of domiciliary services, significantly reduced the demand for both nursing and residential care. For some years the developing over supply had the happy consequence of allowing cash strapped councils to hold down fee increases. In 1996 Laing & Buisson noted that:

"Some commentators have expressed the view that the outlook for care home fees is bleak from the perspective of care home operators" but "it is difficult to see how most local authorities could pursue a policy of keeping fee inflation below RPI for a prolonged period without seriously threatening the financial viability of a substantial proportion of care home operators…".

More recent changes to the market have indeed, for some parts of the country, reversed the situation…..

Exhibit 2: The gradual change in care home buoyancy affected residential homes first and then nursing homes - as may be gleaned from these comments in Laing & Buisson's annual reports:

"… the era of very rapid growth of the care home sector, fuelled by ready availability of income support funding, has now come to an end" (1994 edition)

During 1995 there was little change in overall care bed numbers across all sectors

The private residential home sector actually registered a small reduction in net capacity in 1995, for the first time since the beginning of the private residential boom in the mid 1970s…

The private nursing home sector continues to be the main focus for capacity growth.

(1996 edition)

The long period of uninterrupted growth in independent care home capacity, which began in the 1970s, came to an end in 1997

(2001 edition)

(iv) The above impressions are underscored by the blunt facts of contraction in the Kent nursing and residential care market - measured by both number of homes and beds. Figures supplied by the two health authorities show a nursing home bed reduction for older people (including terminal care) in the five years to April 2001:

- from 2354 beds to 2117 for West Kent (incl. Medway), the loss of 10.07%
- from 2189 beds to 1408 for East Kent, the loss of 35.68%.

(v) Moreover, the Department of Health implicitly recognised the national nature of the problem by commissioning the PSSRU at the University of Kent at Canterbury to research the 'Rate, Causes and Consequences' of home closures during the spring of 2001. The Select Committee is grateful to the DoH and the PSSRU for making available the findings of that report ahead of expected publication in February. It is hoped that when in the public domain, the national significance as interpreted by central government and the local significance, as interpreted by KCC will be complementary.

DEMOGRAPHIC CONTEXT

(vi) While shifts in supply and demand over barely a decade are important - causing this Select Committee to be created - there is a much longer term context of population trends. While the numbers of people reaching the age of 85 or 90 might be thought to be predictable, there are enormous difficulties in estimating future need for community care services and the cost to local and health authorities and users of providing those services. Work by the Personal Social Services Research Unit on demands for long term care suggests an increase in the numbers aged 85 and over of 88% between 1996 and 2031; if the numbers rise by 1% per year faster than that 'base case' assumption the increase in those aged 85+ would be 166%; in consequence:

> "Expenditure on long-term care would rise to £28.6 billion in 2031 rather than £24.3 billion under the base case"

which in percentage terms means an increase between 1996 and 2031 of 148% (base case) or 192% (if higher population growth). The PSSRU model "represents an attempt to consider in more detail than previous British studies the relationship between factors affecting the need for care, such as dependency and household type, and the provision of long-term care services" Using the model the numbers of people in nursing care and how much this would cost public funders depends on, inter alia, inflation in the care sector and how many users would qualify for public support, as savings thresholds are affected by the rates of owner occupation and affluence.

(vii) What might reasonably be said is that over recent decades long term hospital care for older people has diminished substantially whilst people have increasingly lived longer. Therefore whether as self-funders or as publicly supported clients (subject to charges based on means), more people will be contributing to the cost of their care.

(viii) That having been said, a key but unanswered question is whether in future people will require care support for the same proportion of their lengthier lives - meaning an average longer number of months/years of assisted living - or the same duration as now - which would, in comparison, markedly keep down the future health and social care bill.

> "Uncertainty about future numbers of dependent elderly people means that policy-makers need to plan for an uncertain level of demand for long term care" (Comas-Herrera (2000))

It is also very difficult to anticipate the policy and technological developments that will provide alternatives to institutional care.

(ix) These uncertainties make long term projections of future nursing home demand hard to gauge. Overall though, the Select Committee heard no prognosis that the sector ought to be in long term decline.

(x) This Select Committee report also looks at the close relationship between nursing home capacity and hospital in-patient stays. As well as the unfortunate consequences of delayed discharge for patients, there may be scope to avoid hospital admissions taking place at all. One experienced professional told a Member that in their estimate 40% of older people admitted to hospital between November and April do not need to be there.

CHAPTER 1: FUTURE DEVELOPMENT

FROM PURCHASER:PROVIDER *SPLIT* TO *PARTNERSHIP*

1.1 From the 1992 run up to the current community care arrangements Kent CC has taken some pride in the sophistication of its contractual relationships with care providers. Contracts for older persons' residential and nursing care were let in 1993 and, in revised form, from 1999. A consistent feature has been a clear divide between the purchaser and provider roles, which had the merit of clearly demonstrating probity. The financial strictures on the County Council as purchaser, the reduction in the overall capacity of providers and increasing unwillingness of those that remain to accept KCC clients have indicated a need to re-think how the business is done.

1.2 Kent's proximity to the capital with its lack of care home capacity combined with the ability of London Boroughs to pay more for Kent located beds creates particular problems for KCC by exaggerating the same problems faced elsewhere in the country. The PSSRU national research found net contraction in all regions in nursing homes though the extent and causes varied significantly.

> Ex-home owners gave in rank order these as the decisive factor in closure: cost implications of care standards, Local Authority prices not covering costs, drop in demand for publicly funded places, future Local Authority fees not expected to cover costs and the relationship with the I&R unit.
>
> I&R views of area factors in Nursing Home closures (ranked) were: recruitment of nursing staff, Local Authority pricing policies, care standards, wage rates, recruitment of basic care staff, Local Authority use of residential beds for high dependency clients and high property values.
>
> Examples of provider views about investment in care standards were:

- "Inadequate fees for a regulated service within which standards are being demanded to ever greater levels is an obvious recipe for trading failure" and

- "unless they were prepared to pay a proper fee and you were very sure you were going to have a continuing contract at a proper price, you couldn't take on a large debt like that and service it"

Exhibit 3: What were the problems in Kent as related to the Select Committee?

1. Why homes give up

- Developers are actively encouraging operators to sell up
- The standards required by 2007 may require large scale capital expenditure
- Operators may have difficulty obtaining loans as banks ask i) will the home be viable with 80% single rooms; ii) if yes, will the extra investment be sound?
- A large number of operators are around retirement age and the above factors encourage 'selling up' not 'going on' or 'selling on'…..
- For some, profits were reportedly so low as to exclude the semi-retirement option for owners of 'going on' but with a manager

- Home losses vary: 6 out of 8 homes at Folkestone, 65% of places in T/Wells since 1995, only 2 in 5 years at Dartford

2. Why homes become unviable

- KCC clients maybe cross-subsidised by self funders and other LAs' clients who generate greater income than KCC clients
- Too many KCC clients can capsize the income base
- The use of agency staff may trigger a downward spiral as outgoings increase but the fee base is static

2 (a) The problems of finance

- Apparently modest improvements in door widths etc can be very expensive because of knock on work (eg to relocate electrics) when repeated throughout the home
- The 80% single room standard will reduce older homes occupancy totals and in itself make some homes unviable
- Banks are aware of these issues and will/may decline to lend
- Homes largely reliant on KCC clients may have insufficient net profit to allow/encourage re-investment
- Similarly, for older operators contemplating semi-retirement insufficient profit may preclude employment of a manager and cause a sell up.
- The sector would like a continuing dialogue with KCC as purchasers eg giving at least year long indications of usage and partnership in planning

2 (b) The problems of staffing

- Many care home nurses are approaching retirement age with insufficient younger nurse to replace them
- In some areas nursing vacancies mean i) bed vacancies to meet I&R ratios ii) or agency nurses triggered finance problems
- For care staff wage rates in retail are often higher
- Fee income is insufficient for homes to compete for staff
- The minimum age of 18 and the increasing need to study make it hard to gain new entrants to caring employment
- A more qualified workforce will in itself not produce more nursing home beds
- Two witnesses with knowledge of workforce issues had differing views on whether Govt. initiatives to win back nurses to the NHS were siphoning existing staff from homes

3. Why there are insufficient places for KCC clients

- Self-funders from Kent & elsewhere and other LA clients generate higher income and are preferred
- High eligibility criteria make KCC clients more highly dependent than self-funders or other LAs with more generous funding having lower criteria
- The above are a double whammy leaving KCC as purchaser of last resort
- For homes not dependent on KCC clients, delayed hospital assessments mean a vacant nursing home bed might be lost to a self funder or other LA client
- The reduction in supply has created a sellers' market in west Kent
- With no central system for notifying vacancies it is not untypical for care managers to make 20, 30 or 40 calls to locate a bed and they may miss out on soon-snapped-up vacancies (also see below)

4. Why there are vacancies

- For homes on the edge an extra KCC client (representing low fee income) may make a continued vacancy more attractive
- Similarly, one marginal client may trigger more staffing costs than income because of the I&R ratios
- The widening need for top-ups prevents placement of those without a (willing) third party
- For homes largely dependent on KCC clients delayed hospital assessments defer moves to vacant nursing home beds
- With no central system for notifying vacancies it is not untypical for care managers to make 20, 30 or 40 calls to locate a bed but may miss out on long standing vacancies (flip side of same point under 3)

5. Why the present situation is less bad than it could be

- Generally carers are not demanding
- Proprietors are reluctant to evict (eg where a depleted self-funder's fees drop to KCC levels) however some do evict
- Payment of gross fees by KCC is generally preferable to net fees because provider risk is reduced
- The closure of homes probably means those that remain have less staffing problems
- Bringing those homes below band price up to that level will have enhanced their viability
- The rise in fee increases funded through Building Capacity grant will enhance viability in eastern Kent and may make KCC clients more attractive to providers in western Kent
- There may be a temporary lull whilst providers assess the impact of free nursing care

6. At the hospitals

- The bed blocking problems are all year but worse still in winter
- As well as nursing & residential shortages, blocking is also partly caused by problems in the domiciliary sector preventing intense home care services
- There may always have been bed blocking but the continuous reduction in bed capacity has magnified the impact
- There were suggestions that full recovery potential is lost because bed blocking facilities do not have the range of skills/services to maximise recuperation
- It has thus become obvious that the bed blocking problem is due to a number of causes

NB - bed blocking is an important issue for the National Health Service and social care agencies in Kent and extends beyond nursing home availability to include: availability of NHS staff and care managers to undertake assessments, delays in NHS transfers, self funders awaiting choice of placement, plus the availability of residential and domiciliary provision.

1.3 In light of the evidence, what shone through about the regional variations within Kent is the simple financial issue. There are empty beds in East Kent because home owners cannot afford to take KCC placements at the rate paid by the authority. Without the prospect of more cash and with little opportunity to cut overheads, many homes have been closing. The situation in West Kent is different but still boiled down to cash. Places tend to be filled by London Borough nominations because they can afford to pay more. Overlaid is the temptation for smaller home owners to sell up where they are in a property development hot spot, especially when people cannot foresee a decent rate of return carrying on the business.

1.4 At a national level the concerns prompted the dialogue leading to the concordat "Building Capacity and Confidence In Care" which heralds a shift toward more partnership working, with purchasers and providers seen as co-operative stakeholders in the organisation and delivery of social care. One reported example of a collaborative response involves Sheffield, Doncaster and Rotherham, where the three councils acting in partnership with the health community and representatives of the independent social care sector would jointly engage consultants to advise on issues arising from the new concordat. Tasks include determination of a fair fee structure based on the quality and sustainability of the service provided and a longer term need for commissioning for long term care for older people.

1.5 Here in Kent the Select Committee heard a strong desire from some providers for a closer and open relationship with Social Services and the requirements of "Building Capacity" create the opportunity for this to be realised. One Member, reflecting the views of the whole Select Committee commented: "We cannot stress enough that, as the largest purchaser in the county, KCC wishes to maintain a relationship of trust and good communication with providers. This would be beneficial to both parties as we are aware that many homes would not be viable without KCC funded clients - and those individuals could not be cared for without the continued availability of the homes" .

Recommendation 1.1 That the "Building Capacity and Partnership in Care" national concordat be recognised as an opportunity to develop a new relationship between the County Council, the Primary Care Trusts (PCTs) and social care providers.

1.6 The Select Committee were aware and regularly reminded that the P&V sector comprises several thousand beds but is actually made up of many small (and fewer medium sized) businesses. Broader horizons as perceived by confident entrepreneurs can equally feel like fearful steps in the dark by others - confidence building is therefore essential.

Recommendation 1.2 Use the Building Capacity development arrangements to recognise that individual providers may need business advice to safely embark on diversification.

INNOVATION FOR IN-PATIENT REDUCTION

1.7 Of the home operators/managers talked to by the Select Committee there were varying levels of confidence about the future of individual nursing homes. Yet a consistent feature - irrespective of the level of optimism or pessimism - was the very clear and commonly held view that nursing homes had a wider role to play: these are endorsed and set out in the recommendation below. Given the rather depressing reasons for instigating the topic review, this struck Members as visionary, enthusiastic and practical. As well as a better deal for frail older people there are real prospects of helping businesses survive and thrive. The repeatedly stated obstacle was that nurses were not allowed to use *in the home* the qualifications and skills that they *could* use if (also) working in a hospital eg intravenous anti-biotics, drips.

1.8 The recommendation below would also reduce demand on hospital beds by reducing lengths of stay or obviating the need for admission. Furthermore, persons already resident in nursing homes could be spared the need to transfer to hospital.

1.9 The Select Committee agree that a hospital ward is not an appropriate place for individuals to make life changing decisions ie about a permanent care home place instead of returning home. The proposals in recommendation 1.3 also offer a better location and for the decision to be taken after having a full chance to re-acquire independent living skills.

Recommendation 1.3 a) A wider role for some nursing homes should be examined by the National Care Standards Commission (NCSC), local authority and health service commissioners in conjunction with the industry. These would vary with local circumstance but might include:

- a hub-and-spoke model where i) domiciliary nursing services are provided from a nursing home base, ii) day care in the nursing home is provided for those living independently,

- diversion to the nursing home instead of hospital, sanctioned by either the casualty department or GP or paramedics;

- step down/ intermediate care with therapists and equipment to maximise the individual's potential for independent living,

b) these specific proposals should be seen as part of an integrated community approach to social care, health provision and supported housing

1.10 The right to provide these services and undertake procedure would have to be earned; a robust process of authorisation and monitoring for individual homes and staff would be required to ensure excellence.

Recommendation 1.4 The County Council should lobby for the NCSC to authorise suitably qualified and experienced nurses employed in nursing homes to be able to undertake the range of procedures they would be authorised to undertake if employed in a hospital.

Exhibit 4: Question: might there be real potential for diversion from acute beds?

As mentioned in Setting the Scene, one experienced professional had told a Member that in their estimate 40% of older people admitted to hospital between November and April do not need to be there. One detailed study (Coast J) in 1992/3 "identified 19.7 % of admissions for whom there was potential for treatment outside the acute hospital". A GP panel "reduced this potential to between 9.8% and 15% of emergency admissions. However as McDonagh (2000) comments "The reason for this difference was due to taking into account the alternative services available in the area…. This may mean that 20% were in fact inappropriately located in an acute bed, but at that point in time there was no where else for half these patients to go". The main alternatives were GP bed or out patient appointment within 24 hours and not nursing home care. For the future, the NHS Plan's stress on the development of intermediate care should mean that the alternatives will increasingly be available. Moreover, IF the Select Committee's suggestions about a wider range of procedures being undertaken in nursing homes *were* to be implemented then use of the latter as an alternative to hospital *may* increase the proportion of patients who can be safely diverted.

1.11 One of several excellent witness sessions was with Alisoun Milne, from the Tizard Centre at the University of Kent at Canterbury, who had recently completed work on older carers for Help the Aged. During the dialogue a concern emerged that eligibility criteria often weight a need for institutional care for individuals living alone (as opposed to sharing accommodation with a spouse/partner or other carer). The logic was that higher risk attached to someone living at home unable to call ready assistance in case of accident; the person was seen as being at less risk if in a residential or nursing care home. Ms Milne's comment was that in reality the individual was, instead, often swapping one set of risks for the risk of a reduced quality of life in a care home. A better option to maximise quality of life for some would be to remain at home with good care packages and other steps to minimise the risk.

Members had some sympathy for the views expressed but little opportunity to consider the matter in detail: they would like the Directorate to give further consideration to the issue

Recommendation 1.5 Eligibility criteria for single people be reviewed by the Social Services Directorate to re-test whether the right balance between quality of life and personal safety is met taking into account that institutional settings cannot provide a risk free environment.

1.12 Ms Milne also raised the issue of how older couples are viewed by social services. Usually one partner was seen as the client and the other as the carer. This is based on long standing practice and accords with the NHS and Community Care Act and re-inforced by the Carers Act. An exception it should be said is where both partners are separately seen as meeting eligibility criteria. Ms Milne's point was that for frail older people there is not a clear split of role between disabled person and carer. Partly that is because the less dependent person is carrying out tasks which are very taxing for their stage in life.

> "On average, older carers supporting a spouse provide 65 hours of care per week; this is higher than any other group of carers. These older carers also offer higher levels of personal and physical care than other carers. This care is often interdependent in nature and the carer/cared for roles are often distinguishable from each other"

1.13 She had recommended that couples be assessed as a unit with their carer/cared for needs considered jointly. Again Members empathised with the views expressed but had little opportunity to consider the matter in detail and, in consequence, would like the Directorate to give further consideration to the issue. Although legislation must be seen to be complied with, the purpose of the 1993 community care arrangements is to promote flexibility and good outcomes.

Recommendation 1.6 The Social Services Directorate review the care management assessment process and eligibility criteria and give consideration to potentially considering frail older couples as mutual givers and receivers of care.

BOOSTING AVAILABILITY, PROTECTING VIABILITY

1.14 Care managers told the Select Committee that in parts of Kent up to 30 to 40 phone calls could be made in order to identify a care home vacancy. This might be a combination of homes having no vacancies or being unwilling to accept a KCC client when the vacancy might quickly be taken by either a self funder or another LA paying above the KCC fee rate. This had been an increasing trend with the situation being described as worse than 5 or 2 years ago. Additionally a greater number of contracted homes required a third party top up than prior to the 1999 contract re-let thereby reducing the number of homes available in practice for those without a willing third party. Naturally there is a very gradual turn over in residents but no means of knowing where, across dozens of premises, these arose on a daily basis - other than by phoning. Home operators in eastern Kent shared the same frustration. In an interview between Mr Don Scott Faulkner of the Registered Nursing Home Association and the research officer it was noted:

> "Communication problems: there was no easy means for a vacancy to be notified to the care management teams. Mr Scott Faulkner believed some kind

of central point in KCC where vacancies could be registered, but then accessible to all care managers, would be very helpful - similar to tourist information centres, having knowledge of bed and breakfast vacancies"

1.15 Social Services management were not optimistic that a data-base would provide a solution as there was no incentive for providers to routinely use it. However the "Building Capacity" concordat is predicated on a changed relationship between purchasers and providers. Commissioners are exhorted to have in place "an understanding of how information about demand can be matched with up-to-date information about supply. For example, by the electronic capture of information about providers' spare capacity"; providers "should ensure" that they "Take a more proactive approach to alerting commissioners to spare capacity they may wish to use - for example, by setting up on-line 'vacancy catalogues'". Given this, it would not be appropriate to discount the feasibility of a data base. It may be that homes could be keener if a system covered the London boroughs and other likely purchasers - which would dilute the cost to Kent CC. While that would not create more beds for Kent clients it would still be a significant Best Value improvement if care managers knew where the limited vacancies existed.

Recommendation 1.7 The County Council and providers are recommended to consider, through the Building Capacity machinery, the scope for development of a data base to enable real time vacancies to be accessible by care managers; this may be considered from a regional perspective to incentivise providers and minimise cost to the KCC.

1.16 Some home managers told visiting Members that a waiting list was maintained and anecdotally references were made to the varying attitudes of *other* homes to accepting KCC supported clients. It was reported that the low fee levels paid and/or the heavy dependency associated with KCC supported clients apparently produced *some* very negative attitudes in western Kent. The Select Committee deeply regret that. Hopefully the £2.1m "Building Capacity" grant, which has enabled fee levels to be increased by £47.79 (in eastern Kent) and & 69.70 (western and central Kent) per week for new nursing home residents will significantly improve the attractiveness of Kent CC as a purchaser. The new placement weekly figures of £420 (eastern) and £450 (west/central) are significantly close to the weekly fee increases suggested for Kent by the LSE model of demand and supply, as described to the Select Committee on November 30, 2001 .

1.17 A related but more understandable issue is about financial viability of homes - and more so for eastern Kent. Almost a third of places have been lost in 5 years. Reduced demand produced over supply and thus provides a partial explanation for businesses exiting the market. The area produces fewer self funders and - due to distance - fewer London Borough placements. Therefore a higher proportion of residents are likely to be KCC funded, with the associated lower KCC fee rates.

1.18 Across Kent the home owners/managers referred to a viable mix of residents. In eastern Kent a home representative with 40% KCC and 60% other residents was asked what would happen if the ratio were reversed? The answer was the home would close. Similarly a north Kent home with 30% KCC and 70% other gave an identical answer to the same question.

1.19 It is not in the County Council's interests to capsize a home's viability by having too many KCC placements. In the spirit of openness suggested by the Building Capacity concordat there could be merit in the contracting process including an individual proportion of beds for KCC use. That quota would serve the dual role as a 'cap' by protecting the

viability of a home and 'reference point' to discourage the negative gate keeping attitudes referred to. Where a home was under its agreed number of KCC clients, a first refusal might operate in favour of the County Council; however there would not be any expectation that the home should turn away any self-funder or another Local Authority's client if no suitable Kent client was not imminently in need of the bed.

Recommendation 1.8 The County Council contracting processes should recognise that fee levels affordable by the authority appear insufficient to produce a viable business if entirely reliant on KCC clients. There would be merit in negotiating with individual providers a financially safe proportion or number of beds that may be used for KCC clients; a home with a vacancy within that quota would give priority to KCC placements.

ENCOURAGING *OLD* AND *NEW* NURSING HOMES

1.20 The Scene Setting (at paragraph (iv) of the Introduction) showed that over the last 5 years over 1 in 10 beds had been lost in West Kent (including Medway) and 3 in 10 lost in East Kent. For the South East just under 7% of homes had closed in the 12 months to March 2001. The PSSRU research on the national picture for both nursing and residential stated:

> "The overall rate of home closure, 5 per cent, was very similar to the rate reported for 1999 - 2000 nationally. National data for the previous years suggested that the rate of closure was increasing dramatically. The evidence here suggests that the rate of closure is levelling off, although if it continued at this rate there could be serious consequences (emphasis added) for overall supply as in some areas the number of registrations is far from keeping pace".

1.21 It is possible that this paints an optimistic picture. Anecdotal evidence from witnesses suggests two factors that may have further negative effects. Firstly the propensity to continue in business: it was suggested that some operators have deferred a decision to exit the market until they have assessed the impact of free nursing care. As the policy intention is that the beneficiary should be the resident, by the reduction in his/her fees by the amount of money paid by the NHS, the realisation of this by providers may prove a disappointment. The only exception would be if providers used the change as a pretext for fee increases. Secondly the ability to continue in business: it was suggested that (as at October 2001) many providers had not fully assessed the capital costs of the National Minimum Standards required by 2007, nor the willingness (or otherwise) of banks to lend to enable the works to take place. On a more positive note the fee increases funded through the Building Capacity grant may enhance the viability of East Kent homes which are dependent on KCC funded clients.

1.22 Both William Laing and Mr Snelling explained to the Select Committee that banks would not lend more than 70% of the capital requirement, leaving the putative operator to put up the remainder. Moreover, two trends are discernible which increasingly discourage new developments: firstly a gradual rise in the minimum size of nursing home (by bed numbers) considered necessary for business viability. Even in 1994 Laing & Buisson noted:

> "Development is a significant source of scale economies, derived from reducing marginal construction costs and from spreading large items of equipment like kitchens and laundries over more beds… Because many single home owners are constrained by personal capital, however, they may not be able to exploit these economies of scale" thus

> "The average size of all private nursing homes opening between 1992 and 1993 increased to 40 beds from the previous year's 38 beds, and 28 beds in 1988-9. Those opened by major providers during the year to mid-1993 averaged 63 beds".

1.23 It seems to the Select Committee that a number of good existing homes may be forced out of business, or unable to expand their business, because they cannot meet the cash contribution or available collateral criteria of lending bankers. To assist those smaller homes who *are* able to demonstrate viability and sound business planning in either improving or extending their present property (or establishing a second or further home) central government should consider establishing a loan support scheme, akin to the existing Small Firms Loan Guarantee Scheme, but specifically to the nursing home sector.

Recommendation 1.9 Central government is recommended to consider establishing a bespoke loan support scheme to help good nursing homes access the capital needed to survive and thrive.

1.24 Secondly, rising property prices - which have already been noted as a significant reason for existing operators to exit the market - also operate as a barrier to creating new nursing homes. Taking these factors together, if the typical current cost of a new build home is £2 ½ m to £3m, a 30% contribution will be an unobtainable sum for most new businesses.

1.25 The Select Committee believe the best route to ensure an adequate supply of nursing home places and facilitating new businesses would be for a change in public policy. Developers of new housing have long been expected to make contributions to local infrastructure where existing schools or roads are under pressure. In future developer contributions should also be made for social care purposes and particularly nursing home provision. Whilst contributions to date have been for publicly funded amenities (education and highways), nursing homes are built by private sector. A mechanism would be needed to hold the contributions made, this might be a ring fenced fund held by the County Council - the size of the authority should enable the best rate of return to be achieved and thus enhance the fund. The fund would be used to reduce the 30% capital that prevents some entrepreneurs from setting up in business. In return a discounted weekly fee rate might be negotiated for KCC funded clients. When considering the need and scale of developer contributions two factors will be essential: firstly, the overall future demand for nursing places as the local population ages and secondly, the present and future London effect which reduces the amount of nursing home beds available to Kent residents (both self and publicly funded). This change in public policy may be achievable using well being powers but, if not, the County Council should lobby central government both directly and through the Local Government Association to secure the change.

Recommendation 1.10 The County Council adopts or, where necessary, campaigns for developer contributions to be made for social care needs including nursing home provision.

1.26 Land value also creates enormous competition for available plots. One current operator who wished to establish another, new nursing home explained that financial backing was in place, due to their proven track record, but the problem was finding a suitable parcel of land in the local area which was not already snapped up by housing developers. The potentially helpful role that the County Council might play is as an occasional seller of land. It might be that notification of impending sale could be made to trade associations and other places where nursing home (potential) entrepreneurs would become aware. A bid through the normal process would be made and - as present - the land sold to the highest bidder. On this model smaller (potential) businesses would have time to prepare and, through a valuer,

make the best assessment of the bid price to make. A radical variant model would be for the County Council to actively promote nursing home development by selectively placing covenants on appropriately sized plots. The advice provided to the Select Committee was that this could be done as the property policy of the authority cannot be divorced from the overall wider policies, objectives and statutory duties upon it. The "best price" obtainable would be the land value in light of the covenants imposed.

Recommendation 1.11 The County Council Cabinet give further consideration to promoting nursing home developments through property disposals.

1.27 In those areas where there is a widespread shortage of development land, yet also a demonstrable local need for more nursing home places, one further mechanism might be considered to enable land to be made available for new nursing homes to be built. The County Council should explore with the planning departments of the district councils the scope for an "exceptions" policy within their Local Plans. This would allow the limited release of small parcel(s) of greenbelt land for this purpose. The policies and principles governing this could be similar to that applying to the current "exceptions" policies for affordable housing. This might have two beneficial effects: making land *available* and making the development *affordable* - the latter would be achieved because the market value of the plot would be around a midway point between that of agricultural land but, crucially, less than land approved for housing development.

Recommendation 1.12 The County Council should encourage the 12 district councils to individually adopt an exceptions policy allowing nursing home development on greenbelt land where there is an insufficient supply of available places for local people.

CHAPTER 2: COSTS

KENT'S SPECIAL CIRCUMSTANCES

2.1 There proved to be remarkable similarities between the findings of the 2000 Looked After Children (hereinafter LAC) topic review and what the Select Committee heard in respect of nursing care. Kent is a substantial net importer of older people (as with LAC); superficially the fees payable by the placing authorities cover the full costs of the placement (ditto). The County Council as lead agency is responsible undertaking Adult Protection investigations for all homes sited within the county boundary (as with LAC). Additionally where homes are closed through cancellation of registration "the local authority within whose area the service is located should co-ordinate the assessment and placement of future/alternative service users receiving a service from the registered provider" (sic) (LAC(2001)31, confirming this remains the case after April 2002). The sheer scale of the social care sector in Kent means this carries a significant cost - not faced by the LAs with the least developed care home sector making most use of out-of-area placements. For the local NHS the inward migration of older people to Kent care homes causes an additional demand for the range of health services (as LAC do for education and health).

Recommendation 2.1 The County Council should lobby for the consequential costs to social services and health due to the large population of self-funders and other LA residents to be met through grant or formula funding mechanisms.

2.2 The unavoidable reality is that Kent is a destination for older persons placed by London boroughs, other southern Social Services Departments - and self funders. Once more the analogy with LAC is apparent.

2.3 Most Kent witnesses referred to the use of Kent nursing homes by London Boroughs. These placements were said to have two inter-linked effects i) pushing up operators expectations of fee levels ii) making local homes unavailable to local people as providers choose the better funded London clients. In light of contracting capacity in Kent and the financial strictures on KCC these effects were seen as harmful. The general message from witnesses was that London authorities were able (through higher SSA) and (apparently) willing to pay considerably more than KCC could afford. Figures provided by Laing & Buisson did indicate a very wide range in SSA funding levels.

2.4 There is a lack of local provision forcing the relocation of individuals away from their families and established local networks ie militating against maintenance of contact with family and friends. The real answer must lie in encouraging in-borough London provision - and the KCC should consider advocating this. Some of the mechanisms suggested under Encouraging Old and New Nursing Homes may be appropriate to parts of the Metropolis. In the immediate future though the priority is to co-operate with other purchasers to influentially affect both purchasers' and providers' behaviours for the purpose of "stabilising the market, in the interests of the KCC" (to quote Mr Snelling)

Recommendation 2.2 (a) The Social Services Directorate should look at trends in demand and supply of nursing care across London, the resulting picture enabling a KCC response *to* be drawn up, including re-examination of the KCC contract procurement strategy and informed lobbying of national policy makers. (b) The Building Capacity machinery should

include a regional forum where providers and the range of purchasers can seek a coherence in planning and commissioning services within Kent.

KEEPING THE POSITIVES

2.5 Amongst the generally bleak reasons for Kent to be perceived as purchaser of last preference, a positive factor referred to more than once was the County Council's practice of paying gross fees; a majority of local authorities pay net fees leaving the home operator to collect the client's assessed contribution - which creates paperwork and can lead to cash flow problems. Similar arrangements avoid the operator having to collect "third party" payments. This has the disadvantages of the County Council having to collect client and third party contributions as well as bear cash flow costs. Members consider that the advantages to the many small businesses outweigh the costs to the county's largest local authority, therefore current arrangements should be maintained.

Recommendation 2.3 The present contractual gross payment and third party payment arrangements assist homes and should be continued.

INDIRECT BUDGET ENHANCEMENT

2.6 The financing of British local government gives few levers to balance supply and demand for public services. Eligibility criteria are the key variable mechanisms available to match needs to available resources for Social Services between and within financial years. The Standard Spending Assessment is the formula to determine central funding and is usually seen as a "given" over which a local authority has no influence. Yet some of the drivers of SSA include indicators of deprivation and benefit receipt. Increasing the number of residents aged 65 and over receiving Attendance Allowance (or Disability Living Allowance) would subsequently also result in KCC receiving a higher SSA for the elderly residential element of the personal social services block, which might then be passed on to the base budget. KCC might *also* benefit as those in receipt of domiciliary care services who receive Attendance Allowance pay a proportion as part of the assessed contribution. Consideration should therefore be given to the County Benefits Unit, in conjunction with district councils and welfare rights organisations, undertaking an older persons benefits take up campaign for the dual purpose of i) ensuring those entitled receive the benefits Parliament intended they should have and ii) increasing the county's SSA - with the merit of increasing central government's funding of KCC responsibilities.

Recommendation 2.4 Consideration be given to an attendance allowance take-up campaign for older people in the community, jointly run with appropriate partner bodies, as this will result in an expanded Standard Spending Assessment for Personal Social Services in Kent.

CHAPTER 3: TRAINING AND DEVELOPMENT

WORK FORCE ISSUES

3.1 Almost all the home owners/managers met during the review conveyed the same messages. For care staff these were, in sequence: 1. Care staff could earn a higher hourly rate in hypermarkets. 2. The fee base did not allow higher wages to be paid in order to compete. 3. Existing staff saw care work as a vocation and tended to stay. 4. 16 and 17 years were not allowed to be employed to provide personal care and, having left school and worked in retail for one to two years were very unlikely to transfer to emotionally and physically demanding work for less pay. 5. A further deterrent was that no work related study was required to work in a hypermarket whereas the Care Standards Act effectively required it for those entering social care.

3.2 In the national minimum standards for care homes for older people, standard 28.1 requires that "A minimum ratio of 50% trained members of care staff (NVQ level 2 or equivalent) is achieved by 2005, excluding the registered manager and/or care manager, and in homes providing nursing, excluding those members of the care staff who are registered nurses".

3.3 Provider pessimism about the achievability of a 50% qualified (non-nursing) care work force by 2005 may become a reason for some to exit and the County Council and our health partners have a strong interest in facilitating training capacity. As the sector comprises very large numbers of small to medium businesses, training needs to be delivered flexibly, according to content, style of teaching and audience numbers eg a large home may employ sufficient numbers to make an "inward" trainer economic, smaller homes may need to send staff to a shared/pooled event. To adapt the equal opportunities adage: to treat businesses equally does not mean treating them all the same. Plainly the responsibility for securing a trained work force rests with the employing business but the help available must be equitably accessible.

3.4 Most of the owners/managers and the Registered Nursing Homes Association expressed a degree of frustration about accessing information from the Training Organisation for Personal Social Services and the Kent Social Care Consortium. In discussion between the research officer and Mr F Nichols, KCC's Professional & Social Care Training Manager, it was explained that the Consortium is a newly formed body brought together to enable effective bidding for training funds. The Learning and Skills Council is now responsible for the range of post-16 training - and has very considerable sums to spend. Other avenues to funding include the European Social Fund, for which a bid has been made.

3.5 Though Mr Nichols chairs the Consortium he stressed that it was P&V driven and KCC saw its roles as one provider and facilitator. The successful model he cited was Rural Consultancy Incorporated which, through the employment of two training officers, had enabled training to be funded and organised for the farming community which, like social care, also consists of hundreds of businesses. When told of the Select Committee's concern that there might be insufficient administrative capacity to spend the money garnered in Mr Nichols did comment that:

> "It is the case that all of the members of the Consortium have day jobs" and "It would be very helpful to have one - or two - people to do the 'doing' of project management: it could be considered 'invest to save".

3.6 The Select Committee agree: the cost of enhanced administrative capacity would be small but could make a sizeable contribution to achieving the target of 50% of care staff possessing NVQ Level II by 2005.

3.7 Equability needs to extend beyond the characteristics of homes and also apply to the workforce. Much of the TOPPS funding is available only to those staff below the age of 26. Given the profile of the nursing (and residential) home care work force this does not make sense as i) a large scale programme is needed if the 50% target is to be met by 2005 ii) a large proportion of the care staff are female iii) they cannot have commenced employment until attaining the age of 18 iv) many will have been on maternity leave in their early twenties v) older new entrants to care work should be encouraged and no discouragement placed in their way vi) such age boundaries do not appear to be replicated in the NHS.

3.8 In addition to achieving the plateau of a 50% qualified care workforce by 2005, there is a concurrent need for continuous top up training to maintain best practice and promote innovation.

Recommendation 3.1 Promotion of training should be through the existing consortium but given a much higher profile quickly if providers are to achieve NCSC targets by 2005; communication with the homes on the training available must be improved.

3.9 There is a growing problem about the availability of qualified nurses. The United Kingdom Central Council has estimated that 40% of nurses on the register are due to retire over the next ten years. It may be that the demographic issue is partly hidden in East Kent because the contraction, represented by the loss of a third of beds, will have caused a number of redundant but still active nurses to chase a diminishing number of jobs.

3.10 It might have been thought that some employed in the nursing home sector might have been attracted back to the NHS as a consequence of the high profile recruitment drive, the evidence from the visits made to homes did not show this to be a significant problem. There seems to be a widespread and strong ethos of a long term carer-user relationship which the rapid throughput of hospital in-patients in the modern NHS denies staff and which retains loyalty to the nursing home sector, despite the pay and career limitations. This is not likely to be sustainable given the strong career orientation of younger workers in Britain.

3.11 It was clear that the Government's campaign was to attract people into NHS employment as opposed to the nursing profession. To defuse the demographic time bomb the Department of Health will need to promote nursing to school leavers and young adults as a vocation to be performed in a range of employment settings. This needs to be started soon and done consistently over a number of years if damaging levels of staff shortages, eg as schools are increasingly affected by teacher vacancies, are not to be replicated in health and social care.

Recommendation 3.2 A sustained campaign to ensure the replenishment of the qualified nurse workforce should be commenced by central government as a matter of urgency

3.12 Central government is also the only driver capable of tackling the fundamental issues affecting the availability and quality of care staff. The King's Fund report "Future Imperfect" looked at the whole care sector (rather than just nursing care) and commented:

> "The recruitment and retention of staff in care and support services is a major and growing challenge that demands imaginative and innovative solutions if

crisis is to be avoided … Improved pay and conditions must be at the heart of the approach, and other ways of raising the status of care workers will be key. A radical change is needed in the value attached to care work, which continues to be denigrated as unskilled work that anyone can do".

3.13 There is a need for career pathways to be created for present and future nurses (as with care staff) to ensure personal development and staff loyalty - and to prevent younger recruits to the nursing vocation seeing the NHS as the sole route to enhanced status. Career pathways for nurses and care staff might include grade and pay differentials, allocation of responsibility and associated professional recognition, access to training and development. Although external agencies and funding are factors much can be achieved by homes now - and this is essentially an integral part of management. Members undertaking home visits and hearing evidence were struck by the repeated references to good management making the difference: retention of a stable staff group, ensuring business survival when nearby competitors had failed.

3.14 In light of the evidence the Select Committee would also wish to see an end to the oil and water divide between the nursing and care staff. Some of the managers seen were seeking to have some of their care staff qualified to NVQ Level 3 which they saw as representing competence and status. The Select Committee believe that an intermediate qualification, pitched around the equivalent level of the former SEN grade, could form a bridge between care and nursing status which would:

- incentivise current care staff by offering a ladder of training and career progression with the potential to achieve qualified nurse status
- assist recruitment of new care staff for the same reason - which also raises the image and attractiveness of care home employment, and
- assist recruitment to nursing by creating a grow-your-own entry to the profession

3.15 A further proposal (building on evidence given by Mr R Coe on November 12, 2001) which may be worthy of fuller investigation was that a new qualification - Basic Nursing and Social Care to Older People - should be created and jointly accredited by health and social services national training bodies. It would cover all the skills in procedures common to the client group but it did not need to cover all the skills required of those working in acute services. This was on the basis that around 80% of nursing needs for older people fall into a small number of categories eg skin integrity, swallowing, medication. It was suggested that people trained specifically in these areas may be better skilled than current RGNs. The attractions would be a new and cost effective work force, the offer of career progression for care workers and raise the profile and status of care work.

3.16 Consideration of both these proposals will need the involvement of many stakeholders, including the Department of Health, the National Care Standards Commission, and training bodies eg the United Kingdom Central Council and TOPSS.

Recommendation 3.3 Career paths within nursing home employment for both care and nursing staff need to be established and developed *and* central government consider means of raising the status of care work.

3.17 Central government expects Social Services Departments to assist with P&V sector training. However the calculation of grant is based on the size of the in-house work force rather than the total size of the social care sector. This benefits LAs with large provider units and small P&V industries. Kent is, in contrast, penalised by having a very large P&V sector

against which in-house provision is very small. The Select Committee heard that representations had been made to the DoH.

Recommendation 3.4 The current lobbying of central government to end the perverse funding formula for training is endorsed. Just as importantly there is also a need for a substantial rise in the sums available.

CHAPTER 4: DISCHARGE PLANNING

4.1 Delayed discharge of hospital patients has two major consequences. It keeps an individual in a location no longer best placed to meet their needs to recuperate and to regain their independent living skills. It also denies the bed to a patient awaiting treatment. Central government has put substantial resources into the lengths of and time spent on waiting lists, yet delayed discharges can seriously undermine targets for operations. Much of this report is about protecting and expanding local nursing home capacity *and accessibility* for Kent clients. The reduction in capacity plus, west of Ashford, the disinclination of providers to take KCC clients has led to significant problems of delayed discharge. At the time of writing it is hoped that the increased weekly fee rates for new clients (funded from the £2.1 m "Building Capacity" grant) will expand the range of homes available for those with access to a third party top up.

4.2 However from the various witnesses there appear to be a number of earlier stages which can delay the discharge of a person. The first is that in some hospitals a Social Services assessment is only arranged after the decision that the patient is medically fit for discharge. It was instanced that it could be five days (increasingly up to ten in south east Kent) before the assessment then took place. Secondly, if Social Services expenditure was required eg for nursing or residential care there would be a gap whilst the manager's approval was obtained.

4.3 Third, the patient (or family) would be given the homes brochure and asked to identify a suitable home. Finding a vacancy in West Kent for a KCC client might be difficult - especially where there was no willing third party - and the client's name might (fourthly) be added to a chosen home's/homes' waiting list. Finding vacancies in East Kent would be less of a problem because of less competition from self funders and other public purchasers for places. None the less it was put to the Select Committee that one reason for vacant places in East Kent was that from two to three weeks could pass between a putative resident being considered medically fit in hospital and their arrival in a nursing home because of the above stages. Against virtually fixed costs these vacant days represented lost income. It is also the case that if there are no step-down beds for people in acute beds to transfer to, there is a longer delay before the acute bed becomes free because of the time taken to identify a suitable home.

4.4 A very different perspective was given by nursing home managers; in the words of one "there should be planning for discharge from the date of admission". This would include doing an outline joint assessment enabling funding to be agreed. She believed that a person in charge of a ward could be 90% certain whether a person would or would not be able to return directly home. If an individual's recovery proved more successful so that they could be discharged home direct then the assessment would be revised accordingly. The experienced nurses' ability to predict outcomes meant the early assessment activity would be a worthwhile use of time. It was acknowledged that relatives needed to be reassured that their loved one would be given their chance to secure a maximum recovery.

4.5 The Committee were pleased to hear that a pilot to re-engineer discharge processes in East Kent was underway. Positive steps should also be taken to ascertain what works best from other local authorities.

4.6 A related issue also perceived to contribute to delayed discharge was the Choice of Accommodation Directions and conveyed almost a client veto on any home other than their first choice - even when there was a long waiting list. The Select Committee were provided

with copies of the letter which sought to encourage patients to consider another nominated home until their first choice became available. However the actual wording of the Directions and associated guidance are actually quite narrow; the long standing policy of the County Council under the Directions was drafted at a time of better funding, more homes and wider choice has been much more generous than the statutory minimum. In the altered circumstances that prompted this topic review it is in KCC's interests - and equally those of the health trusts - to have a policy closer to the legal minimum requirements.

Recommendation 4.1 Discharge planning should be commenced from the point of admission to "design out" the inherent delays. The pilot underway in East Kent is welcome; there should be comparisons made with other LAs' initiatives and Kent then adopt (or adapt) the most efficient on a county-wide basis. Similar comparisons should discern best practice for achieving speedy discharge whilst complying with the Choice of Accommodation Directions.

4.7 The NHS Plan stresses the importance of developing a range of intermediate care by 2004. This entirely accords with Members' findings at the conclusion of the Select Committee's evidence gathering. This has informed earlier recommendations about new roles for nursing homes: both for post-hospital care and to avoid hospital admissions. Intermediate care incorporates step down care and active rehabilitation and a variety of settings; just as nursing homes might be appropriate for some, for others without nursing needs the setting might be a residential care home or through intense home support. The significant point is that nurses and care managers undertaking discharge planning should, by 2004, have a wider range of options available to most appropriately meet the individual's needs. As a priority, older patients of all hospital trusts in Kent should have access to good quality step down care - this is most pressing in those parts of the county where nursing home places are in short supply for Kent residents.

Exhibit 5: Links to the NHS Plan.

"By 2004 we will end widespread bed blocking. All parts of the country will have new intermediate care services which will be underpinned by new arrangements to ensure more seamless care for patients. We will introduce new standards to ensure every patient has a discharge plan including an assessment of their care needs, developed from the beginning of their hospital admission. Together these measures mean that patients should not have their discharge from hospital delayed because they are awaiting assessment, support at home (adaptation, equipment or package of care), or suitable intermediate or other NHS care.

Recommendation 4.2 The County Council supports the NHS Plan as a catalyst for the development of intermediate care.

4.8 The Select Committee would wish to see a full exploration of intensely supported sheltered housing as a further option to be available for frail older people. It seemed that there were a number of people who could live independently but where the intensity, range and - crucially - the rapid availability of services were not viable when geographically dispersed. The development of small to medium sized facilities could provide the critical mass whilst the resident retained their own front door, which is the valued symbol of independence. Social care, district nurse, GP and aspects of home from hospital would be available and able to respond flexibly and reliably through the economies of scale. Rehabilitation and therapy would be available primarily to maximise independence following an illness or accident which may have been the trigger event for the individual's move from their previous home - either directly or after a spell in hospital. It seems to the Select Committee this innovation might offer the twin benefits of continued independent living for a

number of frail older people and also assist the County Council to achieve its Public Service Agreement target of reducing the number of placements in nursing and residential care homes.

Recommendation 4.3 The Social Services Directorate in conjunction with district councils, health bodies and housing associations fully explore the scope for developing intensively supported sheltered housing accommodation.

4.9 At the initial scene setting meeting on October 2nd 2001, senior management's outline of the major issues included the introduction (the previous day) of free nursing care for self funders. Free in this context means reimbursement of the assessed nursing element of care, leaving personal care, bed and board to be paid for by self funders or local authority. Cross party KCC representations had been made to Whitehall on the proposed arrangements for publicly funded clients - the implementation date was subsequently deferred. An immediate issue is that the highest of the three assessments bands for free nursing appears very close to the local Health Authorities' current threshold for continuing care (which is totally free). The Committee heard that a local criteria review is to follow in consequence. As any boundary redrawing may result in new obligations on the County Council for very highly dependent people, vigilance and the possible willingness to make robust representations are warranted.

Recommendation 4.4 It be noted that i) health service criteria for the top band of "free" nursing care are very close to those for continuing care and the latter are to be reviewed ii) there could be resource issues for Kent CC if the threshold was raised iii) the National Health Service Overview and Scrutiny Committee be recommended to consider this issue.

4.10 Should a patient want to challenge a medical decision that they are fit for discharge ie they no longer need NHS in-patient care they, or a person acting on their behalf, have a right to request that the decision be reviewed by an independent panel. This might usually apply on a hospital ward when the patient would normally expect to either return home or, if inappropriate, move temporarily or permanently to residential or nursing care. The patient would be arguing that they need further medical attention in the hospital. However, a variant issue is whether the individual should continue to be the responsibility of the NHS because he or she meets the criteria for "continuing care" provided on a hospital ward or, more usually, in a nursing home.

4.11 Agreed continued stays in hospital do not usually generate disputes because no change is involved and the care remains free; similarly, agreed 100% health funding in a nursing home retains NHS responsibility for the patient and obviates the issue of charges. It might well be thought that some very poorly hospital patients, on being told that they are fit for discharge but in need of very intensive nursing care, may well consider that they also should qualify to be the 'continuing care' responsibility of the NHS - and thus continue to receive free care either in hospital or by having the full fees in a nursing home paid by the NHS. There was no evidence provided to the Select Committee that the review machinery was used to any extent. This is primarily an issue of patient rights but also determines whether funding responsibility for the nursing home place falls to the County Council (as raised in the previous recommendation). Nationally those opposed to the abolition of Community Health Councils have recently questioned whether the new hospital based "Patients Advocacy and Liaison Services" (PALS) will have sufficient operational independence to give patients messages which are inconvenient to the Trust or wider health economy. PALS should be willing and unfettered in advising patients to exercise the right to challenge discharge decisions and evidence of this should be a measure of the system's robustness or weakness.

Recommendation 4.5 The NHS should make patients and their relatives fully aware of their rights to challenge discharge decisions, particularly when nursing home care is proposed for high dependency cases, and this should be a performance measurement for local Patient Advisory Liaison Services.

CHAPTER 5: OVERARCHING ISSUE

ONE STEP, THREE GAINS

5.1 A number of the issues discussed in this report indicated that communication was the key to better working for the various players eg care managers currently having to make numerous phone calls to identify a nursing home vacancy and providers being unaware of how to access training for staff. In addition there is the need to fully give effect to the aspirations for partnership working, contained in the Building Capacity concordat.

Recommendation 5.1 An inter-active web-site should be explored that might: i) enable speedy and direct communication to and from - and between - providers, ii) enable all providers to access training opportunities and funding, thus raising the visibility of the Consortium (see recommendation 3.1) and iii) be developed as the data base suggested (see recommendation 1.7).

GLOSSARY OF TERMS

Note some do not appear in the text but do appear in supporting evidence

ACTION PLAN an agreed plan setting the targets of listed tasks to be carried out.

AGENCY any organisation, statutory or private, which provides social care, health care, or housing services in the community.

ASSESSMENT (Needs Assessment) the process of defining needs and determining the eligibility for assistance. It is a continuing process which should involve the service user, carers, and all organisations involved in the provision of care for that person.

BED BLOCKING (Blocked Bed) see "delayed discharge"

BLOCK CONTRACT is a contract which guarantees a given volume of business for the provider.

CARE HOME From April 2002 this term will replace the current categories of nursing home and residential care home; the distinction will largely remain in practice.

CARER any person looking after a relative or friend who, because of disability, illness or the effects of old age, cannot manage at home without help.

CARE MANAGEMENT a process which involves identifying a person's needs (see "assessment"), drawing up a care plan and arranging provision of the services required. Services may be purchased from social services, health or the independent (private or voluntary) sector.

CARE MANAGER the member of staff (usually, but not always, from Social Services) responsible for assessment, producing a care package and monitoring and adjusting, as necessary, care arrangements. Nursing home placements of Local Authority-funded clients are jointly assessed with an NHS nurse

CARE PACKAGE (**package of care**) a combination of services arranged by a Care Manager to meet the needs of an individual.

CARE TRUST a Care Trust will be formed when a local council transfers some of its functions to a local NHS Trust partner, enabling the securing and/or delivery of related services by one body. Primary objectives of setting up a Care Trust are to provide a more seamless and integrated service to users/patients and carers.

COMMISSIONING the means by which the local authority and health authority plan, organise and purchase services for people.

COMMUNITY CARE a way of providing services to people to help them to stay in their own homes for as long as they are able, or in other homely settings in the community eg a nursing or residential care home.

COMMUNITY CARE PLAN a strategic 3 year plan for services for older/elderly people and for adults with a physical disability and/or sensory impairment, learning disability or with mental health needs . Required by statute, jointly planned with key agencies including the private sector. The Plan sets out principles and policies governing service provision, and is open to public consultation.

COMMUNITY HEALTH SERVICES health provided for people living in the community (as opposed to hospital care).

CONTINUING CARE an extended period of NHS funded health care which is usually arranged by teams led by specialist consultants. Continuing health care is for people with chronic or disabling illness who meet agreed local criteria and may be provided in hospitals, hospices, nursing homes or in patients' own homes.

CONTRACT a specific, legally binding agreement between two or more parties, one of whom is purchasing a service or product, the other supplying it. This agreement will describe the nature of the service to be provided, including the resources to be used, standard to be achieved, quality assurance methods to be applied, and the quantity and price of service.

DAY CARE is usually offered at a day centre or in a day hospital. It offers care for a dependent adult during the day most usually to provide a social life for older people living alone or to give carers a break. Day care is usually *funded* by the statutory sector. Age Concern is a major *provider* in Kent

DECOMMISSIONING the process of planning and managing a reduction in service activity in line with commissioning objectives.

DELAYED DISCHARGE a bed occupied by a patient who in the consultant's opinion no longer requires the services provided for that bed, but who cannot be discharged or transferred to more suitable accommodation.

DEMENTIA progressive impairment of a person's mental processes.

DEMOGRAPHY the study of the make-up of the population, including changes in size, age distribution and movement between the areas.

DOMICILIARY CARE help and services provided in a person's own home to improve their quality of life and enable them to maintain their independence. This can include home care, meals on wheels, and visits by the occupational therapist and/or district nurse.

ELDERLY MENTALLY INFIRM (EMI) older person(s) with mental frailty eg due to dementia

ELIGIBILITY CRITERIA the 'rules' which determine whether a person is entitled to a particular service e.g. Care Management. The criteria are used so that those with the greatest needs are given priority.

ETHNIC MINORITY COMMUNITIES relates to all sub-groups of the population not indigenous to the UK whose cultural traditions and values derived, at least in part, from their countries of origin.

HEALTH IMPROVEMENT PROGRAMME a three year health improvement plan, which provides the framework within which all local NHS bodies will operate.

HOLISTIC an approach which takes all factors into account - a complete overview.

HOUSING ASSOCIATIONS non-profit making organisations which provide a range of accommodation to rent or buy in the community.

HOME CARE is a Social Services Department's most extensive service. Since community care, home care has increasingly provided personal care; whilst housework and other domestic tasks have become marginalised. It has also developed into a more intensive support service targeted at more dependent people at risk of admission to residential or nursing care.

INDEPENDENT SECTOR a range of non-statutory organisations involved in social and health care provision, including both private and voluntary/charitable organisations.

JOINT COMMISSIONING where more than one statutory agency join together to commission or purchase new or existing services.

JOINT FUNDING a funding arrangement which includes two or more funders.

LINKED SERVICE CENTRE a Kent County Council residential home for older people also providing a range of community services such as day centres.

LOCAL HOUSING AUTHORITY District or Borough Councils which have a responsibility for housing.

MARKET MANAGEMENT using contracting and other processes to influence the supply of services to achieve strategic commissioning objectives.

MULTI-DISCIPLINARY (Multi Agency) the involvement of people from different agencies or professions, combining their their specialist skills and knowledge to work towards a common goal.

NATIONAL CARE STANDARDS COMMISSION (NCSC) From April 2002 this statutory body will subsume the present registration and inspection units run by health authorities (re nursing homes) and local authorities (re residential care homes).

NHS TRUST An NHS Trust is an autonomous provider of one or more the following health care services: acute or sub-acute care, community health services or patient transport.

NURSING HOME a home which has a registered nurse on the premises at all times, registered and inspected by the Health Authority.

PACKAGE OF CARE see "care package"

PALLIATIVE CARE care provided to people who are chronically or terminally ill, in order to relieve symptoms of pain.

PERSONAL CARE is care which involves support with bathing, washing, dressing, going to the toilet, help with getting in and out of bed, walking and getting up and down stairs.

PRIMARY CARE care provided through the traditional family practitioner services i.e. general practice services, pharmacists, optometrists and dentists.

PRIMARY CARE TRUSTS bring together all the GP practices and their staff in a geographical patch (eg serving around 100,000 people) to provide the range of primary care services and to commission other services.

PRIMARY HEALTH CARE TEAM includes the general practitioner, district nurse, health visitor, practice nurse and others who work from or in a GP practice or health centre.

PROVIDERS any person, group or organisation supplying a community care service.

PURCHASER organisations or people who control resources and use them to purchase services which meet an individual's needs.

REFERRAL a request for action may be initiated by an individual or by e.g. their GP.

REHABILITATION help for a person who has a disability or loss of function to aid their recovery and achieve maximum potential.

RESIDENTIAL CARE HOME a home which provides accommodation with board and personal care, registered and inspected by Kent County Council. (See "Care Home" and National Care Standards Commission")

RESPITE CARE may take several forms, e.g. a short stay in residential care or care in the home to give carers a break from their usual caring activities.

RING FENCING the setting aide of funding for a particular purpose, usually to protect the service or prevent use of those funds outside the specified purpose, but occasionally to prevent other sources of income from subsidising the ring-fenced money.

SERVICE AGENCY AGREEMENT an agreement between Social Services and a voluntary sector organisation for the provision of services. Disagreements are settled by negotiation, since such agreements are not intended to go to law.

SERVICE LEVEL AGREEMENT exists between two parties where there is no intention to go to law. Disputes are settled by negotiation; Service Level Agreements exists between different parts of the County Council since the county cannot take itself to court.

SENSORY IMPAIRMENT a loss or absence of ability to see or hear. The term does not necessarily signify complete loss.

SERVICE USER anyone using services provided by Social Services. Other terms frequently used are 'clients', 'customers', 'consumers' or, in the NHS, 'patients'.

SITTING AND OTHER TYPES OF HOME CARE RELIEF SERVICES provide alternative care for a disabled person at home, enabling the carer to take a break. Such schemes overlap with the provision of the Crossroads Care Attendant Scheme which combine a care function with respite on a regular and more intensive basis. In some areas night sitting services are also available. Voluntary sector providers tend to provide sitting services.

SOCIAL SERVICES INSPECTORATE (SSI) a section of the Department of Health responsible for monitoring the performance of local authority social services departments.

SPECIAL NEEDS HOUSING (see **"supported housing**").

SPECIAL TRANSITIONAL GRANT (STG) a grant awarded by Government to local authorities to fund the new community care arrangements arising from the NHS and Community Care Act 1990 absorbed in phases into the SSA. Ended from 1999.

SPECIFICATION a document which lays down the essential elements of a service which a purchaser requires of a provider. The specification will describe the elements of the services required, and will include details of quality, quantity and how these will be monitored.

SPOT PURCHASE refers to the purchase of services for individual clients. Spot purchase contracts represent a flexible response to individual need. Spot purchasing may carry a higher cost per unit if it is not governed by a contract agreeing price.

STANDARD SPENDING ASSESSMENT a formula to share out the amount of central government funds for various local authority activities.

STATUTORY SECTOR ORGANISATIONS local authorities, health authorities, NHS Trusts, District Councils, central Government and similar bodies created by statute law.

SUPPORTED HOUSING (also referred to as Special Needs Housing) describes homes for those who require additional care, support and shared housing. These range from self-contained homes with visiting care staff, to residential homes where care is part of the tenancy agreement.

USERS (see **"Service Users"**)

USER GROUPS is the phrase to describe support groups made up of people with a range of disabilities which are self-supporting or facilitated by a voluntary organisation. The term may be used in other contexts to refer to client or care groups in general.

VOLUNTARY SECTOR a range of non-statutory organisations which include self-help groups, consumer forums, umbrella organisations, users and carers groups, lobbying groups as well as organisation providing services for certain groups of people. Voluntary sector organisations may employ volunteers, paid staff or both and are usually controlled by an unpaid management committee or trustees. Funding may be received from a variety of sources including grants, donations, fund-raising, legacies and sponsorship.

WHOLE SYSTEM PLANNING the process of strategic planning and commissioning across a range of services and organisational boundaries. It acknowledges and deals with the fact that changes in one part of the system, whether housing, health or social care, are likely to have an impact on the other parts.

NURSING CARE EVIDENCE GATHERING MEETINGS

DATE	ASPECT	PERSON(S) ATTENDING
2 October 2001	SHQ Management	Mr P Gilroy Mr O Mills Miss C Highwood Mrs P Huntingford Mr M Ayre
11 October 2001	Health & Social Care Consultancy - National Trends In Nursing Care Market	Mr W Laing
24 October 2001	(1) Training and Workforce Issues (2) Capacity around Tunbridge Wells and Ashford	Mr F Nichols Ms C Cogdell Ms Y Phillips
25 October 2001	Registered Nursing Homes Association	Mr D Scott-Faulkner Mrs N Morgan
5 November 2001	(1) Capacity in North West Kent	Mrs T Hinton
	(2) National Care Homes Association	Mrs N Ahmed
12 November 2001	(1) Capacity in East Kent (2) Capacity in Mid Kent	Mr R Coe Mr B Hudson
15 November	SHQ Management	Mr O Mills
28 November 2001	(1) Older Carers and Care Services (2) East/West Kent Health Authorities	Ms A Milne Ms L Sinnock Mr M Walters
30 November 2001	(1) National Research on Closures (2) Age Concern England	Dr A Netten Mr S Lowe