Registered Nursing Home Association

Conference Report:

HIGHLIGHTS FROM CHESTER 2004

Survival of the fittest - meeting the challenge of change

Opening the RNHA's annual conference in Chester, National Chair Rosemary Strange said the title of the event - *Survival of the Fittest - Meeting the Challenge of Change* - epitomised how nursing homes were striving to cope with increasing demands.

Said Rosemary (pictured left with Derek Whittaker): "It is to our mutual benefit to be able to work with colleagues, through our association, to raise standards and speak up for the independent nursing home sector. It is on occasions like this annual conference that we have the opportunity to network and catch up."

Later during the proceedings, RNHA Vice President Derek Whittaker who, unknown to himself was about to receive a lifetime achievement award, presented Rosemary with a gift on behalf the association as a mark of appreciation for her hard work and commitment during her three years in office.

Debating the future of long-term care - *nursing homes must adapt to market conditions*

Launching a conference debate on the future of long-term care, RNHA Vice Chairman Ian Turner (pictured right) looked ahead three or four years to assess likely changes in the size and scope of the market.

Reductions in the volume of social services funded care were possible, he thought. Other potential 'threats' included competition from domiciliary care, extra care housing and cheaper residential care.

But whilst government policy envisaged a higher proportion of those who need care being looked after at home, the pressures to clear hospital beds provided new opportunities for nursing home providers who were flexible enough to offer the right mix of services.

On workforce issues, Ian predicted that the labour market would continue to be 'tight', with fierce competition for suitable staff from the NHS, social services and other sectors of the economy.

More generally, on the business challenges and opportunities ahead, he said: "If you are a nursing home owner, you need to consider whether you need to reposition yourself in order to take advantage of changes in the demand for health and social care.

During the following debate, several RNHA members stressed the need for the nursing home sector to adapt to the direction of

continued on page 2

Derek Whittaker receives RNHA's first-ever *lifetime achievement award*

The RNHA used the recent Chester conference as an occasion to present its first-ever 'Lifetime Achievement Award' to Derek Whittaker, a former Chairman and current Senior Vice-President of the association.

Derek Whittaker is one of the RNHA's longest serving members, having joined the association some thirty years ago.

He was elected to the RNHA National Council in 1982 and has served on its governing body ever since, becoming Vice Chairman in 1992 and Chairman in 1994.

Following his four-year term as chairman, Derek was appointed RNHA Vice-President in 1998.

Making the presentation to Derek, outgoing national chair Rosemary Strange said it was right to recognise his sterling work for the nursing home sector over such a long period of time. She described him as a 'tower of strength' who had consistently given his time and energy to ensure that the voice of nursing homes was heard.

continued from front page

Debating the future of long-term care

travel within the NHS. Future opportunities might lie more with NHS purchasers than with social services.

One member argued strongly that the association should lobby hard for the implementation of a single assessment process which, if carried out properly, would reveal that there were currently many individuals receiving residential care who really needed nursing care.

In determining a future strategy for nursing homes, some members stressed the need to take account of local conditions. There were major differences, they argued, between homes with 90 per cent of self-funding patients and those with 90 per cent of publicly funded patients.

Concluding the debate, Ian Turner said local authorities needed to develop a strategic vision of what services they wanted to purchase in the future. "They need a total understanding of the care system in their own area," he said.

He also called for a greater effort to promote caring as a valuable profession and a worthwhile career. He added: "Registering care assistants would enhance their status and make them feel that they are appreciated."

Essence of Care project highlights good practice in nursing homes

William Anderson, Canterbury and Coastal PCT

There is a lot of good work going on in residential nursing care. This sincerely held view was expressed at the conference by a nurse employed in the NHS rather than by the independent sector.

William Anderson, Joint Development Manager for Older People with Canterbury and Coastal Primary Care Trust, highlighted a number of examples of good practice as he described the outcome of a 12-week *Essence of Care* pilot project in south east Kent.

Up to 51 local care homes were invited to get involved in a scheme designed to promote innovation and put patients at the heart of the care agenda.

It was, as Mr Anderson put it, an opportunity for managers and staff to review current standards and assess what older people need and want.

At the end of the project, it was recommended that:

- Care homes should have a documentation policy/procedure covering all aspects of record-keeping that is understood and used by *all* members of staff.
- There should be a policy on confidentiality that is understood and used by *all* members of staff.
- Care homes should review all policies and procedures in place.

"Assessment is the cornerstone of good practice in care homes," said Mr Anderson.

"But our study found that nurses weren't writing down what they were doing. It is essential to keep good records based on individual care plans that are person-centred."

Maintenance of privacy and dignity was also highlighted as a crucial component of good quality care. "Knocking on the door and waiting for an invitation from a resident to enter should be our approach," said Mr Anderson.

Understanding the impact of *Agenda for Change*

Tony Boswell, Royal College of Nursing

Nursing homes in the independent sector need to understand the impact on the nursing and other health professions that will result from the implementation of the *Agenda for Change* within the NHS.

This major new initiative that has been negotiated between the NHS and trade unions representing NHS staff, including nurses, involves a new evaluation of posts against an agreed set of criteria based on knowledge, skill and responsibility. New pay bands and terms and conditions of service will then be applied.

Tony Boswell, representing the Royal College of Nursing, said there was an intention to roll out the *Agenda for Change* to the independent sector. This, he said, made it imperative that nursing homes should familiarise themselves with what was happening.

He added: "One of the outcomes of this process may be equal pay for nurses in the NHS and the nursing home sector. This, in turn, could reduce nursing homes' problems in recruitment and retention of key staff."

However, RNHA members listening to Mr Boswell's presentation challenged this assertion, stressing that nursing homes had to operate within the resources available to them and would not be able to match NHS salaries without a corresponding increase in their fee income for publicly funded patients.

On a positive note, the conference applauded Mr Boswell when he reported that the RCN was lobbying hard to ensure that, in future, nursing homes would be inspected by individuals with nursing qualifications rather than by social workers.

The challenge of commissioning

Nigel Walker, Department of Health Change Agent Team

National guidance to be issued in September 2004 aims to make the commissioning of social care fairer and less bureaucratic, the conference was told by Nigel Walker from the Department of Health's Change Agent Team.

Describing the bureaucracy currently faced by nursing homes as 'huge', Mr Walker said there was a need for health and social services to develop long-term partnerships with the providers of social care. Those partnerships must serve the interests of the people who use services and should be based on trust between commissioners and providers.

He said: "I believe there has to be a real mix of care and a range of options for service users to choose from. I have no doubt that nursing home care will feature among those options."

Emphasising the importance of quality and standards, Mr Walker reminded delegates that a *Learning and Improvement Network* had been established earlier this year to identify and share examples of good practice in commissioning and to promote a 'whole system approach to capacity planning'.

"We need to have honesty and a critical analysis of what works and what doesn't work," he said. "You should have the information necessary to enable you to put tenders together and deliver good services."

He added: "The Government's intention is to put the people who use services in the driving seat. That means making services more flexible to respond to individuals' needs and preferences."

On the thorny issue of contact - or lack of it - between commissioners and providers, Mr Walker stressed that it was no longer acceptable for local authorities or primary care trusts to say they were not ready to talk to independent care providers.

"We want all the key stakeholders, including providers and service users, to sit round the table," he said. "Local networks must also include regulatory bodies, while professional organisations such as the RNHA should have an influence over policy."

Mr Walker pointed to a number of key issues emerging from the work of the *Learning and Improvement Network* to date. They included the need to:

- improve population needs assessment;
- strengthen joint commissioning between primary care trusts and social services;
- improve commissioners' understanding of the market;
- identify and disseminate good practice.

Looking ahead, Mr Walker predicted greater segmentation of the market, with more and more providers becoming specialised in the care they offer. This would require workforce planning to ensure that the sector attracted and retained people with the right skills.

Care homes are *not* past their sell-by date

William Laing, Laing and Buisson

New incentives are needed to encourage a further expansion of capacity in the nursing home sector, according to one of Britain's leading analysts of the independent care sector.

William Laing, from the highly respected Laing & Buisson organisation, opened by taking issue with Health Minister Stephen Ladyman. Said William: "The Minister seems to think that care homes are past their sell-by date. I disagree. Our ageing population and demographic forecasts suggest a growing level of needs well into the future."

Using an age-standardised index of care home demand, Mr Laing pointed to a steady decline in places since 1993. "We're almost back now to the position the sector was in during 1981," he said. "Today, there are around 100,000 fewer people in care homes than there would have been if the 1993 rate of demand still applied."

Recent Government population projections, he said, pointed to a rise in the number of people in care homes over the next thirty years, even assuming that the level of demand for residential care remained the same as it is now.

Turning to the issue of 'fees', Mr Laing argued that local authorities had used their purchasing power since 1993 to drive down the real value of fees paid for publicly funded patients. But, he added, there were signs of a 'bounce back' in the past two or three years. Market forces were now beginning to apply.

On the question of profitability, Mr Laing stressed that there were no really good statistics, although there were some indicators that things were improving. The healthy target, he said, should be a profit of £6,500 per bed before tax and depreciation.

Referring to a previous Joseph Rowntree Foundation report which recommended a fair price for care, Mr Laing said it had probably been a mistake to come up with one set of figures for England, particularly when London operating costs were 20 per cent higher than in the rest of the country.

Revised figures for 2004/05 now made a clear distinction between relatively low cost conditions in some regions and the high cost environment of London. At the same time, the figures now suggest a floor and a ceiling for both the regions and for London.

Local circumstances had to be taken into account, said Mr Laing. That is why a fair price for care would vary from one part of the country to another. Local wage rates and land prices were key factors.

The new figures have been calculated on the basis of the efficiency level expected from a 40 to 50-bed home. The upper ceiling in each band assumes the amount of capital investment needed to construct a brand new home. But, Mr Laing argued, a nursing home which meets all the physical standards laid down in the Care Standards Act should not receive the ceiling rate of fees unless it meets all other quality standards.

Assessing current market conditions in the sector, Mr Laing said that investors were willing to pay 7.25 x profits for care homes and were looking for a 14 per cent per annum return on capital.

"The sector is still perceived as 'risky'," he said. "But if nursing homes were able to move towards five to ten year block contracting with local authorities, the expected return on capital could be reduced to 10 per cent per annum."

Looking ahead, Mr Laing said the key determinants of the likely future scale of nursing home care provision were:

- healthy and non-healthy life expectancy (both are going up);
- society's willingness to offer informal care (family ties are still a factor);
- the government's willingness to provide formal care (likely to diminish over time);
- consumer preferences.

He concluded: "In the debate about domiciliary versus residential care, I believe that for the foreseeable future more of everything is likely to be needed."

A FAIR PRICE FOR CARE: REVISED RECOMMENDED RATES

Weekly rate for nursing home care provided to older people and those with dementia

£420 to £497 per week in a 'low cost' provincial location

£543 to £620 per week in London

Protecting vulnerable adults from abuse

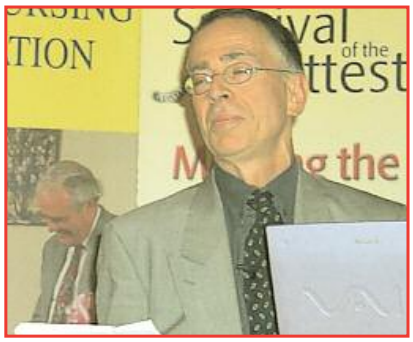
Raymond Warburton, Pollicy Lead on Vulnerable Adults, Department of Health

"Elder abuse is a scar on society. The vast majority of care providers are repulsed by it." These powerful words formed the opening sentences of a presentation by Raymond Warburton, Policy Lead on Vulnerable Adults for the Department of Health, who went on to describe many recent and impending initiatives designed to protect this section of the population from abuse by their carers.

Good employment practice consists of a whole range of measures to ensure that older people in care are not put at risk, he told the conference. Such measures include:

- confirming the identity of potential employees;
- holding rigorous but fair interviews;
- securing references;
- undertaking CRB checks;
- applying for POVA checks;
- ensuring appropriate supervision of staff;
- encouraging 'whistle-blowing' to expose poor practice.

Reminding his audience that POVA checks would come into force from 26th July 2004, Mr Warburton said care professionals who had previously harmed people in their care would be put on the POVA list.



Individuals who would need to go through a POVA check were those applying for positions that would bring them into regular contact with vulnerable adults. This could mean that domestic and administrative staff might need to be checked, as well as nurses and designated care staff.

"Nursing home operators will be under a statutory duty to undertake POVA checks, where relevant, on new staff," said Mr Warburton.

"However, existing staff are not affected by POVA, unless an individual is transferred from a post that is not covered by the scheme to one that is covered."

From 26th July, conditional offers of employment within nursing homes will be subject to the outcome of both CRB and POVA checks. Anyone put on the POVA list will automatically be banned from working with vulnerable adults.

Keeping within the law on new POVA staff checks

Such was RNHA members' level of interest in POVA that the association's Chief Executive Officer, Frank Ursell, decided to devote a special session of the Chester conference to a detailed discussion of the practical implications for nursing homes.

In particular, he focused on ensuring that members understood the definitions of some of the terms being used in the POVA protocol.

From 26th July, new staff likely to come into regular contact with patients will have to undergo POVA checks to ensure that no older person is at risk of harm from them.

What is meant by 'regular contact'? As Frank explained, it is those staff who will have contact which recurs at short, uniform intervals. 'Harm' means ill treatment or impairment of health.

Frank also highlighted the link between CRB and POVA checks. Currently, as he pointed out, nursing homes are allowed to appoint staff conditionally before the outcome of the CRB check is known. This is crucial for nursing homes needing to recruit additional staff or replace existing ones who have left, as CRB checks can take anything up to about seven weeks to complete.

However, from 26th July nursing homes can only take on a member of staff prior to the outcome of a CRB check if they have undertaken what is known as a *POVA first* check, which should be dealt with within a matter of a few days in most instances.

The duty on nursing homes to carry out POVA checks in all appropriate cases is statutory. For individuals who are on the POVA list, it is an offence to apply for a post that involves the care of vulnerable adults.

Said Frank: "Those nursing homes which avail themselves of the CRB service provided by the RNHA should indicate on the forms they complete whether or not they want a *POVA first* check to be made. We will then make sure it is undertaken immediately and will email the result back to the nursing home as soon as possible.

"Assuming a successful outcome, it means you will probably be able to start your new member of staff within a week or so, although this is still subject to the eventual outcome of the CRB check."

He also advised RNHA members to ensure that POVA checks have already been carried out by any agencies via whom they recruit new staff. "You need watertight contracts with those agencies to make sure you are covered legally," he stressed.

New opportunities for nursing homes in primary care

Dr James Kingland, National Association of Primary Care

In April 2004, this country saw the most significant change in general medical practice since the establishment of the NHS in 1948, Dr James Kingland told the conference.

Up to now, GPs have been paid on the basis of their activity levels rather than on the quality of service provided. But, he stressed, the new system has put quality at the top of the agenda, with reduced bureaucracy and an emphasis on meeting standards rather than counting numbers of procedures.

New methods of delivering primary care services are being tested, he said. Primary care trusts are now employing some GPs directly, while some general practices have become nurse-led. The GP monopoly is disappearing although, as he pointed out, doctors are still the only people who can directly provide medical care.

Against this backdrop of structural change in primary care, Dr Kingland predicted that five years from now only about 75 per cent of general medical services would be provided as they are now. Some services, he said, would be provided on contract by independent sector organisations.

So how could nursing homes get involved in this 'revolution'? Those which are sufficiently flexible and entrepreneurial could, he argued, become providers of a range of services to the NHS, including:

- services designed to help deliver quality targets set in the *National Service Framework for Older People*;
- enhanced or specialist services for older people;
- intermediate and respite care.

Overcoming the pitfalls of overseas recruitment

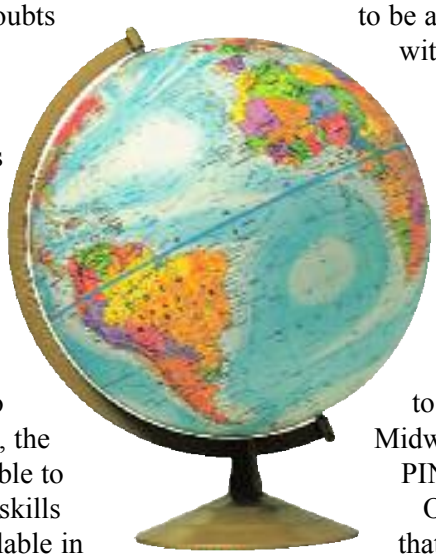
Frank Ursell, Chief Executive Officer, RNHA

Given the degree to which some nursing homes are now having to rely increasingly on recruiting nurses from overseas, and in the light of some of the problems being encountered, the RNHA decided to use its Chester conference to highlight the necessary procedures.

Chief Executive Officer, Frank Ursell, said the recruitment of overseas staff into the UK was a very 'process-driven' task.

Applications for work permits (for those from outside the European Economic Area and other designated countries) have to be completed on the correct forms. It is an offence to employ anyone who has no right to be in the UK. It is also essential to stay within the restrictions specified in work permit documentation.

Addressing the issue of senior care assistants, Frank said that until October 2001 it had not been possible to recruit them into the UK because of official doubts about the need for people at this skill level.



Whilst senior carers can now be brought in under certain circumstances, there is still a dilemma about defining the role they are intended to fulfil. To obtain a work permit, the employer has to be able to demonstrate that the skills required are not available in the local labour market.

Frank issued his own health warning about recruitment overseas when he said: "Most of the trouble our members experience comes from having inadvertently dealt with some of the less savoury overseas agents upon whom they rely in the country of origin. It is better to use one of the agents on the Department of Health's approved list. They have to have at least two references in order to be able to do business with you."

When a qualified nurse is being recruited from abroad, Frank stressed the importance of ensuring that the individual concerned applies to the Nursing and Midwifery Council for a PIN.

On entering the UK, that individual must first undertake a period of supervised practice at an establishment authorised for this purpose by a provider of nurse training.

More user-friendly community equipment service

Mike Clarke, Integrated Community Equipment Service

More streamlined, user-friendly community equipment services are being introduced nationwide, with a single point of contact and fewer steps for the ordering of essential items.

A vision of an integrated service responding more efficiently to the needs of users was painted at the conference by Mike Clarke, the National Lead for Care Homes from the Integrated Community Equipment Service (ICES).

By December 2004, he said, all needs assessments should start within 48 hours of a referral and be completed within four weeks. Seventy per cent of referrals should be dealt with within two weeks. And by the same date, all community equipment should be provided within seven working days of a decision that a specific item is required.

He added: "By 2006, there should be 500,000 more pieces of equipment available."

Respecting the dignity of dementia patients

Dr Graham Stokes, Head of Mental Health, BUPA

It is a fallacy to think that dementia can be dealt with almost entirely in the community, Consultant Psychologist Dr Graham Stokes told the conference.

Dr Stokes, who is Head of Mental Health for BUPA Homes, said there was no single condition called 'dementia'. Rather, it covered a spectrum of conditions involving a progressively growing degree of dependency.

"We don't want people with dementia to feel that coming into a care home is the end for them," he said. "We need to add value to their lives and to provide them with whatever they cannot get outside."

He added: "We must aim to deliver functional improvements, to provide a safe living environment and, as seen through their own eyes, to give patients a life that is worth living."

Describing a 'person-centred' model of care, Dr Stokes said that too many care plans were pre-occupied with dressing, washing and toilet arrangements. "That's all very well, but when does life start?" he asked. "There is a danger that we focus too much on the disability and the problems it brings and that we don't see the person.

"For example, we expect people with dementia to do things that we ourselves would never do, like sitting in a chair for hour after hour. When they get up and move around, we call it 'wandering'. And when we try to get them to sit down again and they resist, we say they are 'violent'."

Dr Stokes argued passionately for a careful assessment to be made of individuals' likes and dislikes, so that the appropriate care plan could be tailored to their specific needs and preferences. What do they like to eat? What can't they tolerate? Do they prefer their door open?

"If we don't really know what our patients are like as people," he said, "we can mistake their behaviour as symptomatic of their condition when it is simply a remnant of their normal pre-dementia behaviour. What we must realise is that those of us who do not have dementia share more with dementia patients than separates us. Respecting their dignity is very important." Finally, Dr Stokes reminded his audience that dementia is sporadic and does not run in families. It is not a disease of old age, he argued. It is a phenomenon of the ageing process which can even affect people from their 30s onwards.

Quality through the eyes of service users

Dame Denise Platt, Chair, Commission for Social Care Inspection

Dame Denise Platt, Chair of the new Commission for Social Care Inspection (CSCI), began by paying tribute to the skilled workers in social care who 'make a major contribution to the welfare of our communities'.

Referring to the organisation she now leads, Dame Denise said CSCI had been created to provide a single point of focus for social care performance and quality. "We are committed to using the experiences of those who use social care services as our starting point," she said.

Bringing everything together in one place would, she thought, result in a more rational and integrated approach. "We want to support innovative practice," she said. "We have also listened to users of services and have taken account of what they want."

Stressing once again that CSCI would be driven by the needs of service users, she said a MORI poll had shown that people valued independence, choice, empowerment, dignity, respect, flexibility, consistency, competence,

courtesy and safety. They want the same control, choice and freedom in their lives as other citizens.

"We will judge services by how they reflect these factors," she told RNHA members. "We will assess progress towards independent living, even if an individual is within an institutional environment. We expect people to be given not just a menu of choices about their care but to have an influence on the content of the menu."

So what does user-focused inspection mean in practice? "Inspection should be proportionate to risk," said Dame Denise. "We will be asking ourselves whether the services offered to people are appropriate. We have also started developing case-tracking in order to look at services from the users' perspective."

Turning to the needs of care providers, Dame Denise pledged that CSCI would try to reduce the paperwork they have to deal with. "We are looking at the number of times you have to give us the same information," she said. "We are exploring the potential for self-assessment. We are reviewing the way inspection reports are written and how we tell you whether you are meeting standards. We will work on the presumption that you encourage and act upon complaints."

Dame Denise also promised to involve nursing home providers in reviewing the way CSCI works. "We want our discussions with the sector to be based on meeting people's needs better," she said, "not on the semantics of regulations. A modern regulatory regime needs all the partners to work together."

Dame Denise said that, later this year, CSCI would appoint a senior nursing adviser to make sure that the agency is up to date on nursing issues.

Around the conference exhibition

For more information about the RNHA, please contact:
Frank Ursell, Chief Executive Officer, RNHA, 15 Highfield Road, Edgbaston, Birmingham B15 3DU Tel: 0121-454 2511

Visit our web site:
www.rnha.co.uk