Care in the balance

EVALUATING THE QUALITY AND COST OF
RESIDENTIAL AND NURSING HOME CARE FOR OLDER PEOPLE

Accounts
Commission
for Scotland

How to use this report

In the main body of the report we have used 'home' as a generic term. Where the distinction is important, we have used the term 'nursing home' or 'residential care home' as appropriate.

For ease of comparison each home has been assigned a unique number with a suffix indicating its sector: **'c'** represents a council home; **'v'** represents a voluntary sector home; **'p'** represents a private residential care home; **'pnh'** represents a private nursing home. The council and voluntary sector homes are all residential care homes. These numbers and suffixes are used in all relevant graphs.

Interesting and good practice examples are highlighted throughout the text. These are not intended to be prescriptive but, depending on local circumstances, providers may wish to adopt or adapt some of these approaches.

For the purposes of testing our survey methodology we spoke to:

• 318 residents in residential care homes
• 47 relatives of people in nursing homes.

The differences in satisfaction between residents and relatives should be treated with considerable caution.

CONTENTS

Introduction

Community care for older people is one of the major services provided by Scottish councils. Currently, councils spend over 65% of the total community care budget on services for older people - around £500 million. At present, most of this money is spent on residential and nursing home care - estimated at £290 million in 1996-97[1].

Exhibit 1: Councils' expenditure on services for older people

57% of total expenditure on services for older people is spent on residential and nursing home care
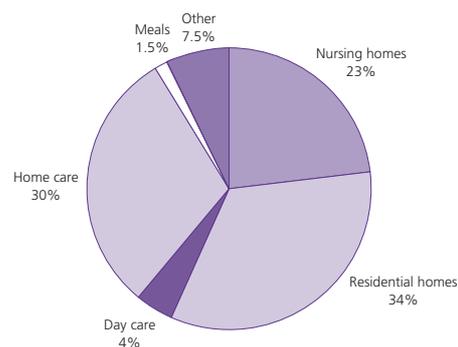
Source: CiPFA, 1996-97 actuals.

Approximately 34,000 older people live in residential or nursing homes in Scotland, usually after they have become unable to cope on their own. The way in which these homes are managed and run directly affects the quality of residents' lives. There is much that can be done to improve their effectiveness without necessarily requiring significant extra money to be spent.

The demand for community care for older people is likely to continue to increase over the next decade, both because of changes in social policy and because people are living longer due to improvements in public health and medical advances. The number of older people over 65 in Scotland is projected to rise to 858,000 in the first twelve years of the next century, an increase of 72,000. The most significant increase will be in those over 85 years old[2].

Against this background, there has been a steady reduction in the number of long stay NHS beds for older people and a clarification of NHS responsibilities for the continuing care of patients[3]. In the ten years from 1987 to 1997 nearly 3000 long stay NHS beds for older people (excluding beds for people with dementia) were closed[4]. There has been a consequent transfer of responsibility for the care of older people from the NHS to councils. The Government is currently considering ways of enabling more people to remain at home rather than having to move into residential or nursing homes[5].

There is already a strong mixed economy for residential and nursing home care for older people. In 1997 there were just over 16,500 residential care places in Scotland, of which 47% were council-run; 25% were provided by the voluntary sector; and 28% by the private sector. There were also 23,000 private nursing home places[6].

Exhibit 2: The changing pattern of provision in residential and nursing home care

The biggest growth has been in the private nursing home sector, with an increase of just under 6,500 places since 1993. Council residential care places have fallen by nearly 1,500 places over the same period.

Number of places (000s)

Year

Council residential
Voluntary residential
Private residential
Private nursing home
NHS long stay care of elderly beds
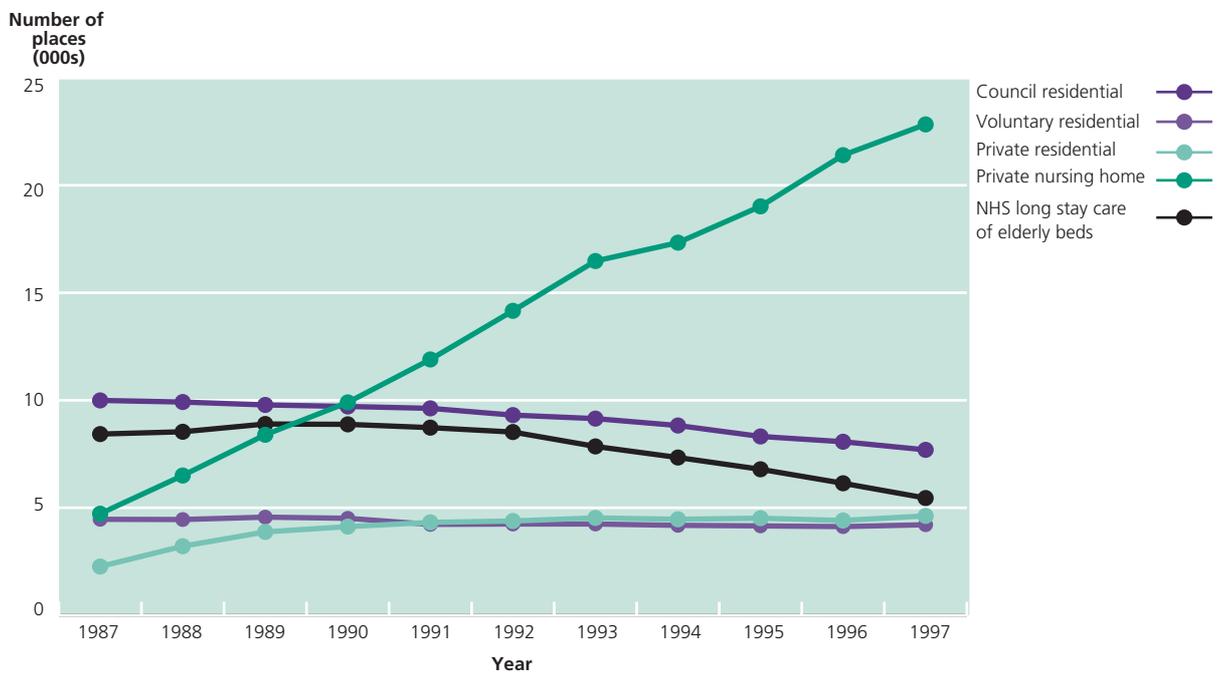
Source: Scottish Office, Community care, Scotland, 1997.

Best value

The challenge facing councils is to ensure the provision of high quality and affordable care for older people in our society. This balancing of cost and quality is at the heart of the Government's best value agenda for councils. Best value requires councils to:

• achieve continuous improvement in services, by comparing the performance of different providers
• assess quality from the perspectives of those who receive and pay for services
• develop services which are cost effective
• be openly accountable to local communities for decisions made and services provided.

These principles apply whether councils provide services directly or commission them from providers in the private and voluntary sectors. The onus is on councils to demonstrate that their decisions on expenditure are based on full and accurate information on the level of local needs, and on the quality and cost of services to meet those needs.

Achieving best value is not simple. It requires constant balancing of cost and quality, and there is no single 'right' combination. Simply measuring costs on a consistent basis can be difficult, but assessing quality is much more challenging. Quality in residential and nursing homes means different things to different people, and is made up of a range of elements: the staff providing care, the choice residents have about their way of life, and the home itself and its environment.

We have assessed the quality of residential and nursing homes in terms of the extent to which they:

- respect a person's individuality, dignity and privacy
- encourage the maintenance of independence and choice
- retain links with local communities
- provide staffing levels which enable these aims to be achieved
- provide good standards of accommodation.

We have worked with 39 homes drawn from councils, voluntary and private organisations to develop a group of indicators of cost and quality. All the homes volunteered to take part in the study and we are very grateful for their assistance. Full details of the homes participating in the study are given in appendix 1.

Concern has been expressed about the differences in costs and quality between sectors. The aim of this report is to provide tools which can be applied across all sectors to assist best value reviews. These reviews will need to be explicit about the quality of the service and how much it costs.

We hope that the report will also be of interest to members of the public, particularly older people and their families.

This report begins with the most important factor affecting the quality of care in residential and nursing homes: the staff. It moves on to examine other aspects of the quality of care, exploring how much freedom residents have to make choices about their way of life, and the quality of the building and its environment. It analyses the cost of providing these services, and considers the links between cost and quality. We have placed particular emphasis in the final section on two groups of factors:

- those which contribute to high costs without improving quality
- those where quality can be improved without significantly increasing costs.

There is a great deal of variation in the cost and quality of residential and nursing home care. This report makes it clear that there is scope in many homes to make savings which will not affect quality, or to improve quality at little cost. This will help to ensure both that existing residents receive the best possible quality of care, and that the available resources go as far as possible in meeting the rising demand for care for older people.

The Commission will publish a complementary report, on the commissioning of services for older people, later this year. This will address the wider issue of how councils, in liaison with other planning partners, are developing a broad spectrum of services - from home care through supported housing to residential and nursing home care - to meet the needs of their elderly populations. It will also consider other issues such as the funding of places, user choice, contracting, and the use of partnership working to develop quality services.

Staffing and quality of care

Staff are the most important aspect of residential and nursing home care, with residents and their families being very clear about the importance they attach to staff. Staff are also the biggest element of the cost of care (about 80% in our study). In line with this figure, Laing and Buisson have estimated that, for a typical 50-place nursing home, wages account for three-quarters of total costs[7].

It is obviously difficult to assess the quality and effectiveness of staff; we have used a range of indicators to try to build up a rounded picture. These are summarised in appendix 4.

The role of the manager

The manager is the single most important person in determining the culture of the home and influencing the way in which it is run to meet the needs of residents. Good managers understand the purpose of residential and nursing home care and promote a positive image of their service. They are also skilled in:

- assessing and meeting individual residents' needs including an assessment of risk
- balancing the needs of individual residents with the well-being of the group as a whole
- staff management
- financial management
- leadership and delegation
- the provision of care
- developing and maintaining links with the local community for the benefit of residents.

"… the need for leadership in institutions is of the greatest importance in achieving satisfaction among residents, relatives and staff."
Ebrahim

The qualities of an effective manager are well
documented and there are many good guides and references in this field[8]. We have
focused on three important factors which mark out an effective manager:

- making time to manage
- supporting and developing staff
- building links with local communities.

Managers need time to manage and the most effectively run homes are those where:

- the manager's role is clearly defined, with *protected* management time
- the manager is readily available throughout the day for residents, their families, care managers, and other agencies and professionals
- administrative support is provided.

In a number of homes there was some confusion amongst managers about their role.
Some managers routinely include themselves on the rota as part of the care team. This
is either because of relatively poor staffing levels, or from a perception that this is the
best way to keep in touch with what is happening in the home. Managers may need to
be flexible and cover for absent colleagues, and indeed this gives an opportunity to
evaluate care practices at different times. However, it is not an effective use of a
manager's time *routinely* to cover care sessions on the rota. The manager needs to be
available at times when residents, families and other care professionals know they can
be contacted, but working on a rota system makes this more difficult. The situation
may be different in small private homes, where owners work long hours and often
cover a mix of management, administrative and caring tasks themselves.

There is a large amount of necessary paperwork associated with running a home, yet a
number of homes have no administrative support available (exhibit 3). Some
managers estimate that they spend up to 50% of their time on administrative tasks,
which could be delegated to an administrative assistant. This is not a good use of their
time.

Local judgements need to be made about the appropriate level of administrative
support. For some homes a better use of information technology could also help.
Homes which provide a mix of services, including respite care, will need to take account
of the extra demands this entails.

All the nursing homes and some residential care homes have administrative support.
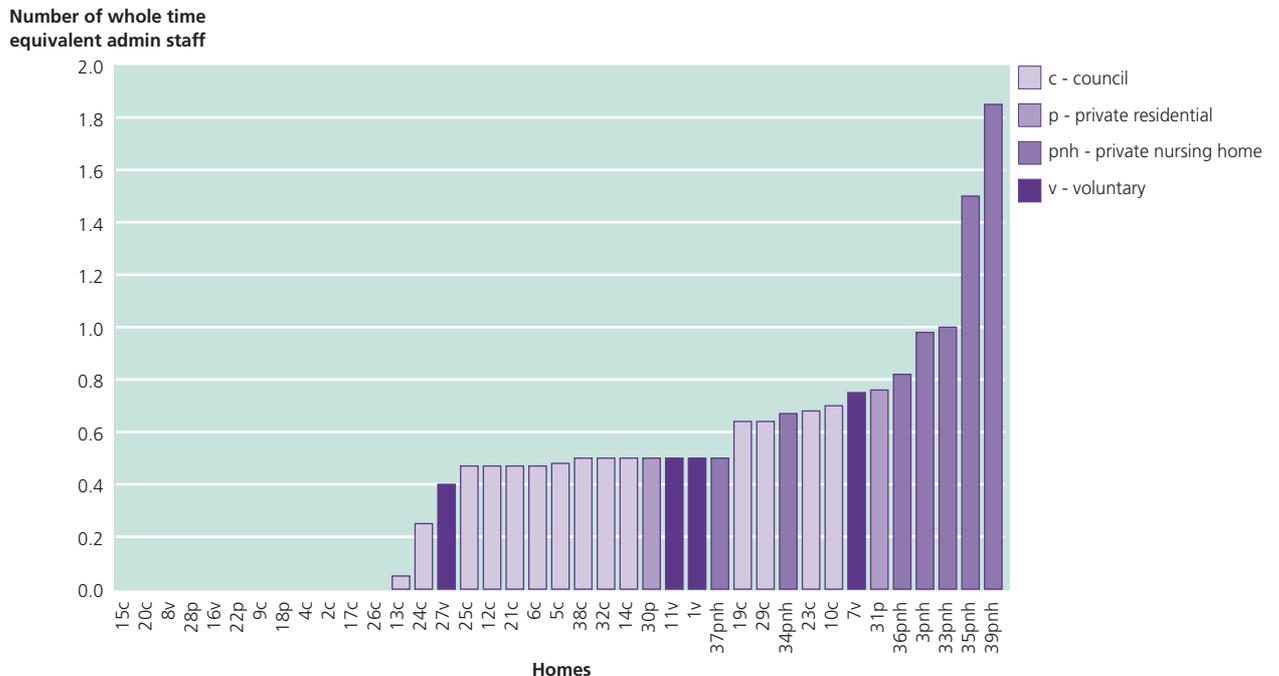
**Number of whole time
equivalent admin staff**

Legend:
- c - council
- p - private residential
- pnh - private nursing home
- v - voluntary

Homes

Another key factor in a manager's effectiveness is the ability to support, motivate and supervise staff. This is very closely related to the extent to which the home manager:

- sets and reinforces service values
- fosters a learning culture
- involves staff in decisions
- values staff and makes best use of their skills
- constructively supervises work and offers support
- provides good induction for new staff.

These issues are developed later in this chapter under '*Qualifications and training*' and in the next chapter '*Service quality*'.

Each home is part of a local community, and continued links with people outside the home are important to residents. The best managers seek to develop and build social and professional connections for the benefit of residents. For example, some managers encourage the use of local facilities such as membership of libraries, attendance at local churches (often with volunteer support), attendance at social events, and trips to local pubs. This requires good organisational skills and, more importantly, it needs a vision of the importance of providing as normal a life as possible.

Management structures

The management structure of the home is important to both quality and cost. It is difficult to make comparisons between sectors, since there is a wide disparity in job titles and tasks, and salary cannot be taken as a proxy for levels of responsibility. In addition, nursing homes are more likely to be modelled on hospital structures, which have distinctive nursing hierarchies based on grade and function.

We have focused here on comparisons between council-run homes, which have relatively uniform staffing structures and job descriptions. In spite of this broad similarity, there are important variations. Most council homes have relatively flat management structures, but some have up to four tiers of senior staff (exhibit 4).

Exhibit 4: Management structures in council homes

Most of the council homes have relatively flat structures. A few, however, have hierarchical structures that are not justified by size or complexity of service.
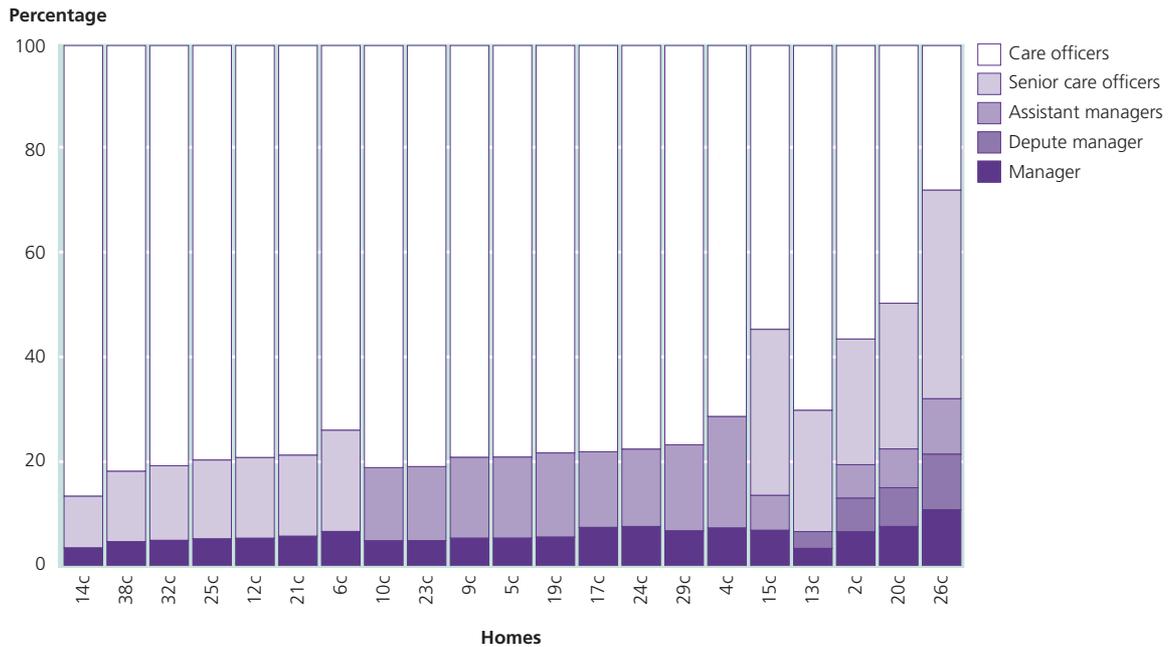
Not surprisingly, those homes with three to four tiers of management are among the most expensive overall. Their structure is difficult to justify when compared to other homes that are run efficiently with much flatter structures. For example, home 14c, which is a 48-place home with a complex mix of services, is run efficiently by one manager and three team leaders. Each team leader has clear responsibilities and is actively supported in the job through regular supervision and a positive training programme. There is also a small group of experienced care officers who can 'act up' when required. Overall, the staffing structure of this home maximises the number of front-line staff in line with Government policy[9].

Staff restructuring is not an easy option, but a number of councils have already removed unnecessary management tiers and others can learn from their experiences. In the short term, taking out tiers can result in low staff morale and does not release immediate savings. Nevertheless, it is a necessary step for those councils with several tiers of management in their homes, which wish to retain their in-house provision and demonstrate that they offer best value on cost.

Some councils, recognising the overlap between some care and domestic tasks, are actively:

· involving domestic staff in care staff teams
· running training events on care issues for all staff
· developing specific training programmes for domestic staff on values and caring in residential settings.

A few councils have taken out a tier of management in their homes and re-invested the money in creating a 'care assistant' grade which spans domestic and care roles in the home. Such exercises cannot be done in isolation but need to be carried out as part of a review of all tasks, responsibilities and skills in the home. This should ensure that quality does not suffer as staff should undertake only those tasks for which they are appropriately trained and experienced. These reviews offer the chance to rationalise tasks within the home and provide more front line staff.

Staff restructuring

A review of ten residential care homes for older people in one council identified a range of issues in relation to the standard of the accommodation, staffing levels and costs. The council took the view that, if it was to continue as a provider of residential care, it required to improve substantially the standard of the accommodation, increase staffing to at least registration levels, and reduce unit costs to a competitive level.

Implementing the review has involved the removal of two tiers of management, a restructuring of care staffing with the introduction of a care assistant grade, and the transfer of catering and cleaning staff from the DSO into the social work service. Costs have been substantially reduced by the closure of two homes. The staff restructuring which has taken place in the remaining eight homes has generated a significant saving which the council is committing to a programme of adaptation and refurbishment.

The council has achieved standards in its own residential homes which match those of good local private and voluntary providers.

Whatever the management structure, homes should have sound governance arrangements in place. Staff should be encouraged to highlight concerns about care practices to a manager in the home who has the necessary authority to deal with the problem. Regular inspections of homes by the Registration and Inspection teams is also a valuable external safeguard. The Commission's recent performance indicators show an increase in the number of visits these teams make.

There should also be adequate systems in place for checking the references of all staff as a way of minimising the risk of abuse.

Promoting the rights of the individual

One council has a Clients' Rights Officer (CRO). Her role is to act as an advocate for individual social work clients. If residents feel that their rights are not being respected, but they do not want to go through the formal complaints procedure, they can contact the CRO. She works with them and the home to resolve the issue. If staff have concerns about care practices impinging on the rights of individuals, but are worried about raising these in the home, they can also alert the CRO. She may then work with the local inspection team to examine their concerns.

Care staff

Staffing ratios

The number of care staff available is important to the quality of care provided. We have examined this in a number of ways, but the key indicator is the ratio of residents to staff. This ratio needs to be used with other indicators, such as the quality of care planning, resident feedback and the levels of staff interaction with residents, to build up a more complete picture. It is clear from what residents say, however, that the number of care staff on duty, and their willingness to assist, are amongst the most important factors in their daily lives.

We examined staffing levels in two ways: the permanent establishment (expressed in whole time equivalents, or WTE) (exhibit 5), and the number of staff on duty at particular times of day. For the most part these approaches gave a consistent picture. In some cases there were more staff on duty than the staffing establishment suggested. This was due to either:

- a relatively heavy use of relief or bank staff
- effective rota management.

The best managers are adept at ensuring that rotas are managed to provide more staff at the busiest times of day, such as when residents are getting up in the morning and at mealtimes. The use of relief staff is an important issue. Fluctuations in occupancy levels can be difficult to manage. As a way of minimising financial risk, some providers use bank staff to contain staff costs. Bank staff are employed to supplement normal staffing levels when the home is relatively full, and not used when occupancy levels drop. However, this may affect the continuity of care for residents.

In some homes there were fewer staff on duty than the staffing establishment suggested. This was largely due to high levels of sickness absence.

Good resident to care staff ratios are found in all sectors. However, some council homes have poorer ratios than found in the independent sector. With the exception of designated dementia units, there does not appear to be a close association between the dependency levels of residents and the number of staff. Councils' different registration requirements for staffing levels may partly explain the variation seen in exhibit 5.

Exhibit 5: Resident to care staff ratios

There is more variation in the council sector than in the independent sector.
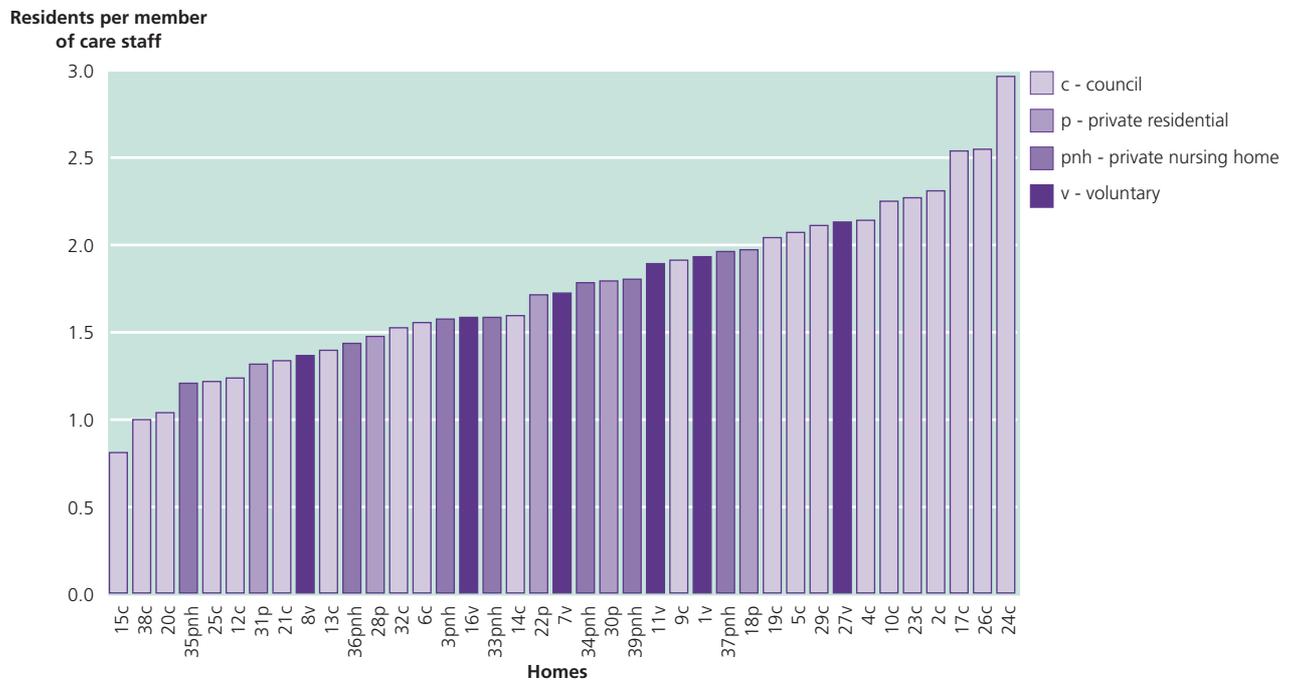
Note: In nursing homes nurses and care assistants are counted as care staff.

Staff costs are the major factor in explaining overall cost differences. The council homes, and to a lesser extent the voluntary sector homes, with the best resident to staff ratios are the most expensive within their sectors. Conversely, those homes with

amongst the poorest resident to staff ratios are the cheapest. This direct relationship between cost and staffing levels is not so strongly evident in the private sector. Here, pay rates tend to be lower than in the council sector and are more likely to vary as they are not tied to national pay scales.

Although all the homes meet their local registration and inspection staffing standards, our findings suggest that some of these standards may be too low. There is no doubt that some residents have their choices limited by a shortage of staff to support them.

> **Managing the rota**
>
> In addition to having people on the rota to cover each wing of the home, home 32c has a floating member of staff. At the beginning of the shift this person is allocated to the part of the home where the needs are greatest for that shift. For example, if a resident needs to be accompanied to an outpatient appointment by her key worker, the floating staff member could cover. Or, if a resident requires more intensive support for an activity this can be accommodated.
>
> The manager in this home also reviews the rota each Friday for the coming week so that adjustments can be made for known events.

Use of part time staff
The use of part time staff is widespread in residential and nursing homes, offering flexibility to both staff and managers. Part time staff are often willing to work extra hours, which allows the home to cover annual leave, sickness absence and training days with the minimum of disruption to residents. These staff will be familiar with residents and with the home, where agency staff may not know the residents and will need more active supervision. In fact, none of the homes use agency staff, preferring instead to build up their own bank of relief staff. There is also a cost advantage to using part time staff for cover:

- part time staff may not necessarily be entitled to overtime rates
- agencies make an administrative charge for staff
- employers' National Insurance contributions may be lower.

However, a balance needs to be struck. Too many part time and relief staff may have a negative effect on residents and other staff, and involve additional costs:

- the number of people caring for residents increases, causing distress to some residents
- training costs may increase.

An examination of the percentage of staff who work less than twenty hours a week shows wide variation between homes (exhibit 6). It is not possible to be prescriptive about the optimum proportion of part time staff. Each home will have its own operational requirements, and the local labour market may affect this. Indeed, many good care workers may only want to work part time. Nevertheless, having a large percentage of part time staff could affect quality. Our survey of residents revealed that some residents do not like having to relate to a large number of part time staff. It is important, therefore, to seek feedback on the effects on residents in individual homes.

A quarter of the homes make significant use of staff working less than 20 hours a week.

Percentage of staff working < 20 hours per week

Homes

Legend:
- c - council
- p - private residential
- pnh - private nursing home
- v - voluntary
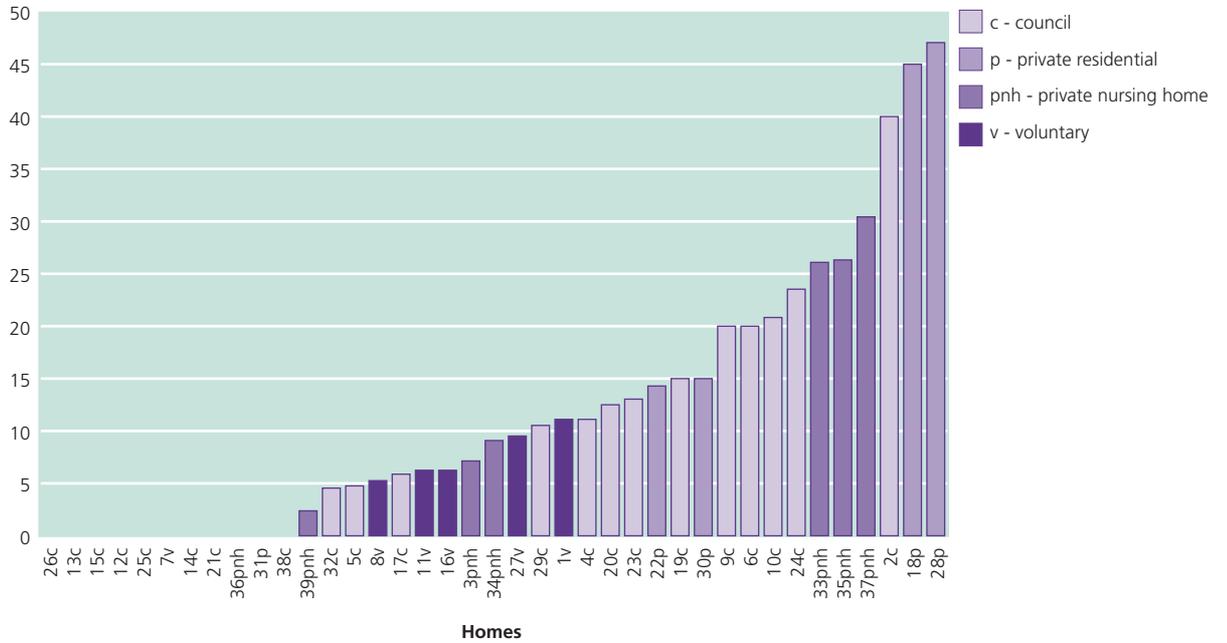
Flexible use of contracts

One council, with a standard working week of 39 hours, has started recruiting staff on 35-hour contracts. The aim is to provide each council home with some flexibility in managing sickness absence and holidays, while limiting the number of individual staff members caring for residents.

Sickness absence

Sickness absence can have a direct effect on both continuity of care and costs. Council staff on short term sick leave receive full pay. Other providers can choose whether to augment the minimum statutory sick pay (£3.20 an hour after the first three days). The costs associated with sickness absence may also include the time taken to arrange alternative cover, and to manage and integrate staff who are not as familiar with the residents or the home as the regular team.

Nationally the rate of sickness absence for all employees is 4.2%, although the figure for managers and administrators is 3%[10]. Sickness absence also tends to be higher among women than men[11]; the majority of residential and nursing home staff are women.

The homes have a wide variation in managers' sickness rates (exhibits 7 & 8). Most of this absence relates to long term sickness rather than absences of a few days. This long term sickness results in an overall average of 6.11% compared to the national figure of 3%.

Exhibit 7: Sickness absence among managers

The rate of absence varies from 0% to nearly 60%.

Percentage of working year lost

Legend:
- c - council
- p - private residential
- pnh - private nursing home
- v - voluntary
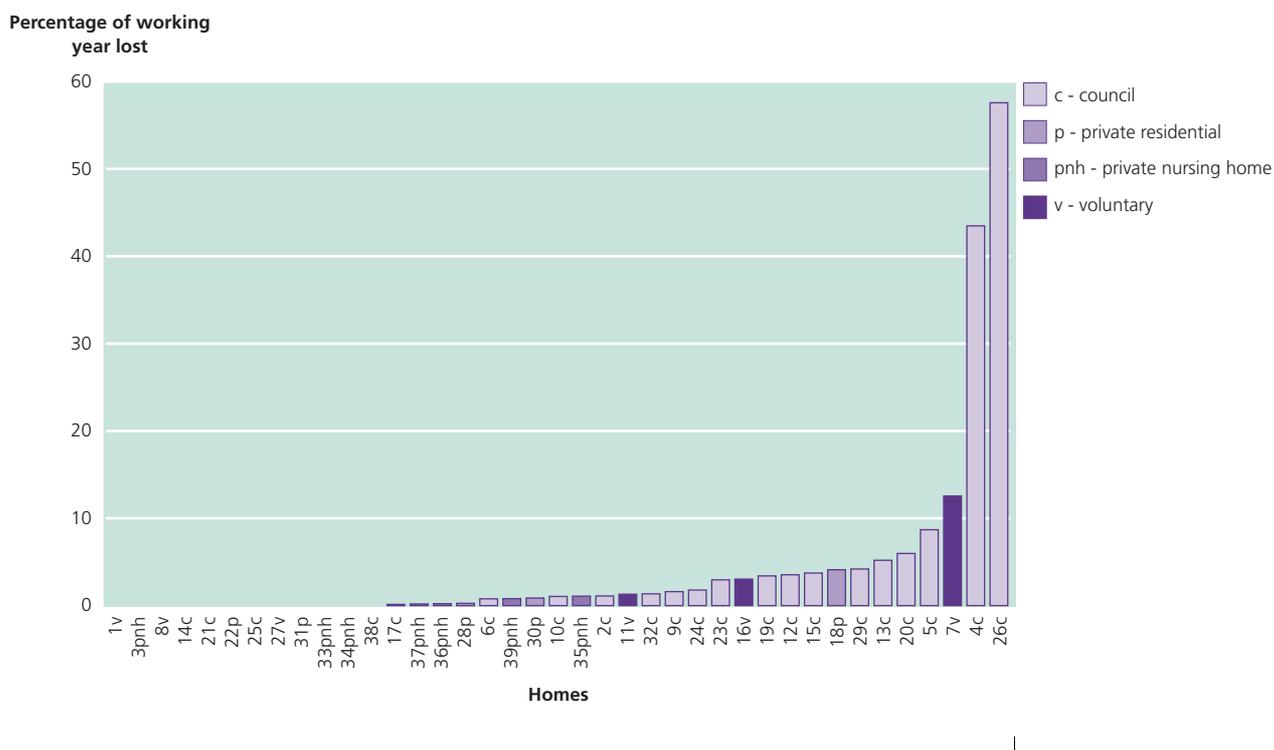
Homes

Exhibit 8: Sickness absence among managers in different sectors

Overall, absence is higher in council homes.

| Type of home	Range %	Average within the sector %
Council residential	0 - 57.6	9.0
Voluntary residential	0 - 12.6	2.5
Private residential	0 - 4.1	1.1
Private nursing	0 - 1.1	0.4

Note: Percentages rounded to 1 decimal place

"They should increase staffing levels - there is always someone ill or on holiday. There are too many off at the same time."
Resident

Absence is generally higher among care staff than among managers (exhibits 9 & 10). The average for the homes as a whole is 6.6%, compared with the national average of 4.2% (manual and non-manual).

Exhibit 9: Sickness absence among care staff

The rate of absence varies from just under 1% to nearly 16%.

Percentage of working year lost

c - council
p - private residential
pnh - private nursing home
v - voluntary

Homes
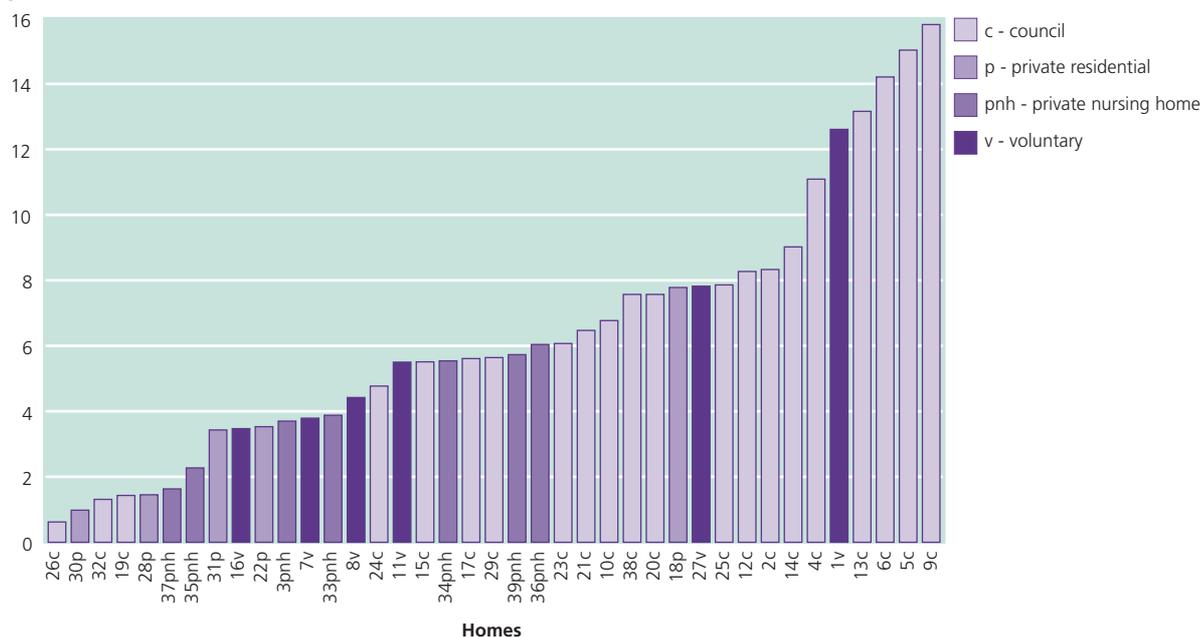
Note: Care staff includes nurses, senior care officers, care officers and care assistants.

Exhibit 10: Sickness absence among care staff between sectors

Overall, absence is highest in the council sector.

Type of home	Range %	Average within the sector %
Council residential	0.6 - 15.8	8.1
Voluntary residential	3.5 - 12.6	6.6
Private residential	0.9 - 7.8	3.4
Private nursing	1.6 - 5.4	4.4

Note: Percentages rounded to 1 decimal place

Higher than average levels of sickness for the service as a whole may reflect the physical and sometimes stressful nature of the work. There could also be an argument that in order to protect frailer residents, staff should not come into work if there is a risk of passing on an illness. Nevertheless, the exhibits demonstrate that managing sickness should be a priority for some homes. There are clear differences between sectors that may be explained, in part, by the terms and conditions of staff. However, there are homes in every sector which have very low levels of sickness absence, and we found examples of good practice, such as return-to-work interviews and active use of occupational health staff in cases of long term sickness.

Homes should set themselves realistic targets for sickness absence and, in line with the principle of continuous improvement, revise these targets downwards as they are achieved[12].

Turnover of care staff

Staff turnover is a useful measure of continuity of care, and thus one aspect of quality. Turnover is a complex issue, reflecting factors such as staff terms and conditions, job flexibility and satisfaction, and the local labour market. Clearly, employers cannot influence the local market but they need to be aware of how it affects their own services, and manage the factors within their control[13].

A certain amount of staff turnover can be advantageous, as new employees can bring in new ideas, experiences and approaches to service delivery. On the other hand, high turnover poses a number of risks:

- Continuity of care may suffer unless care planning is exceptionally good.
- Residents value the human contact and companionship provided by familiar staff. This is more difficult to achieve with a rapid turnover of staff.
- The home may lose too much experience and expertise, with negative effects on the quality of care.

Low staff turnover can, however, lead to staff becoming 'set in their ways' unless there is an active training programme.

High turnover of staff is a bigger management problem in the private residential and nursing home sectors than in the council and voluntary sectors (exhibit 11). The availability of trained nurses may be a contributory factor for the private nursing homes.

"There is a lot of new staff. It takes a while to get accustomed to it."
Resident

With two exceptions turnover is highest in the private residential care and nursing homes.

Percentage of staff leaving

Legend:
- c - council
- p - private residential
- pnh - private nursing home
- v - voluntary
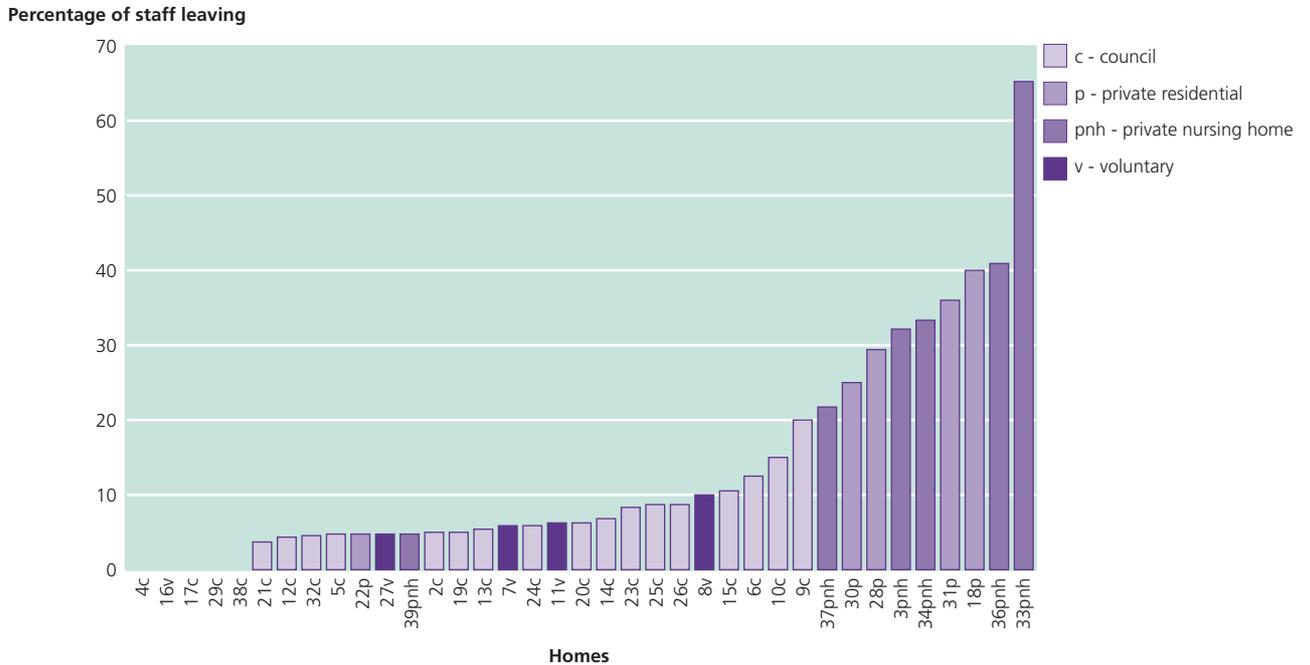
Homes

Note: Because of the importance that residents attach to the familiarity of staff, percentages are calculated using actual numbers of staff rather than WTE. Data not available from all homes.

Managers should monitor trends in turnover over time and take appropriate action if it affects the quality of care.

Qualifications and training[14]

So far, we have focused mainly on the number of care staff available in residential and nursing homes. However, the quality of staff is also important. There are strong arguments for investing in training and qualifications for care staff to enable them to practice and manage effectively[15]. Some homes and councils are investing heavily in both formal qualifications and in-house training; others are doing much less. There will be resource implications for those homes that have not yet developed a training programme for staff; these may include financial and managerial support for staff, or the provision of study time during working hours.

Managers' qualifications

For registration purposes, the home manager or 'person in charge' is required to have a relevant qualification. In the nursing homes, managers are required to have a nursing qualification. The range of qualifications held by managers of the residential care homes is more varied, reflecting the more flexible registration requirements for these homes where either a nursing or social care qualification is considered relevant (exhibit 12). Some residential care managers who have nursing qualifications are also studying for, or have achieved, social care qualifications. Most senior staff below the level of residential care home manager have nursing or social work qualifications, although a small number have no relevant qualifications.

"Some people think that common sense and experience of caring for one's family are the only qualities residential care staff need. This view is wrong and outdated. People who need residential care today usually have a variety of complex and acute problems. The people who work with them need… to develop the competences necessary to meet residents' needs."
Residential Forum: Training for social care

One third of the qualifications held by residential managers are in nursing; two thirds are in social care. Nursing home managers are all qualified nurses.

Number of qualifications

Legend:
- Other
- Workplace assessor for SVQ
- Studying for HNC
- HNC in social care
- CQSW
- CSS
- Cert in Res SW
- Studying for Dip SW
- Diploma in SW
- Nursing
- Studying for SVQ3
- SVQ3
- SVQ2
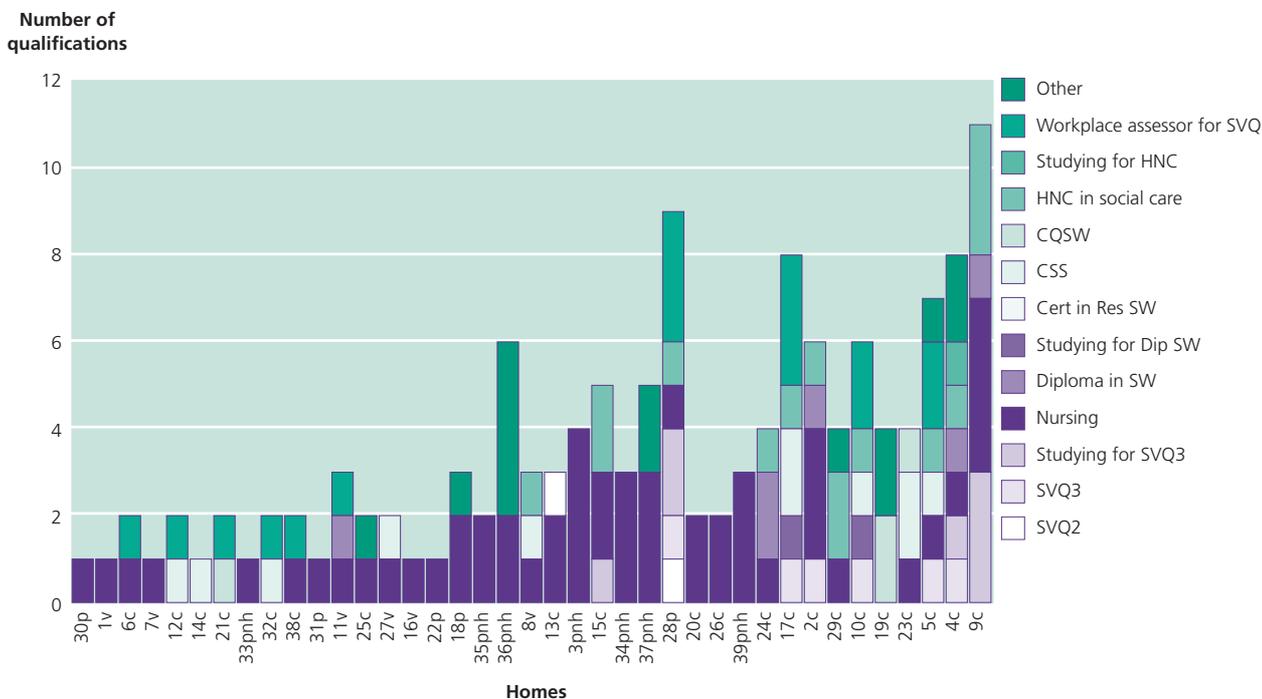
Homes

Note: Homes are ordered in ascending order of WTE number of managers, deputy and assistant managers. The picture is affected by the management structure within the home.

Some homes are investing heavily in their managers. For example:

- Home 4c has an average of 2 qualifications per manager, and is aiming for a broad range of qualifications in recognition of the varied skills needed to manage a home effectively. This home is one of the few reporting a manager studying for a management qualification.
- Home 9c has a relatively high number of nursing qualifications that it is now supplementing with qualifications in social care.

Both these homes are run by the same council, which has a policy of management development.

### Care and nursing staff qualifications

Around 60% of care staff do not have, and are not studying for, any formal qualification. In recognition of the lack of a national qualification for care staff, Scottish Vocational Qualifications (SVQs) have been introduced as the industry standard for the social care sector. SVQ levels 2 and 3 have been specifically designed for the care worker role. These are practical qualifications based on a combination of written work and observation and assessment of skills by workplace assessors. One third of the homes have in-house workplace assessors. The other homes have to buy in this service, or are unable to support staff in training for SVQs.

In residential care homes, just over one in six care staff (17%) are studying for a qualification, primarily SVQs. This contrasts with the nursing homes, where 1 in 12 care staff (8%) are studying. This includes nurses doing EN conversion courses. These compare with figures for Great Britain as a whole, which are 15.6% for staff in residential homes, and 12.4% in nursing homes[16].

There is wide variation between homes in the qualifications held or studied for by care staff (exhibit 13). Some councils and independent sector providers are developing strong training programmes. A few homes, however, have very few, or no, care staff with qualifications.

Exhibit 13: Qualifications held by care and nursing staff by home

There is no direct association between the number of staff and the number of qualifications held.

Number of qualifications
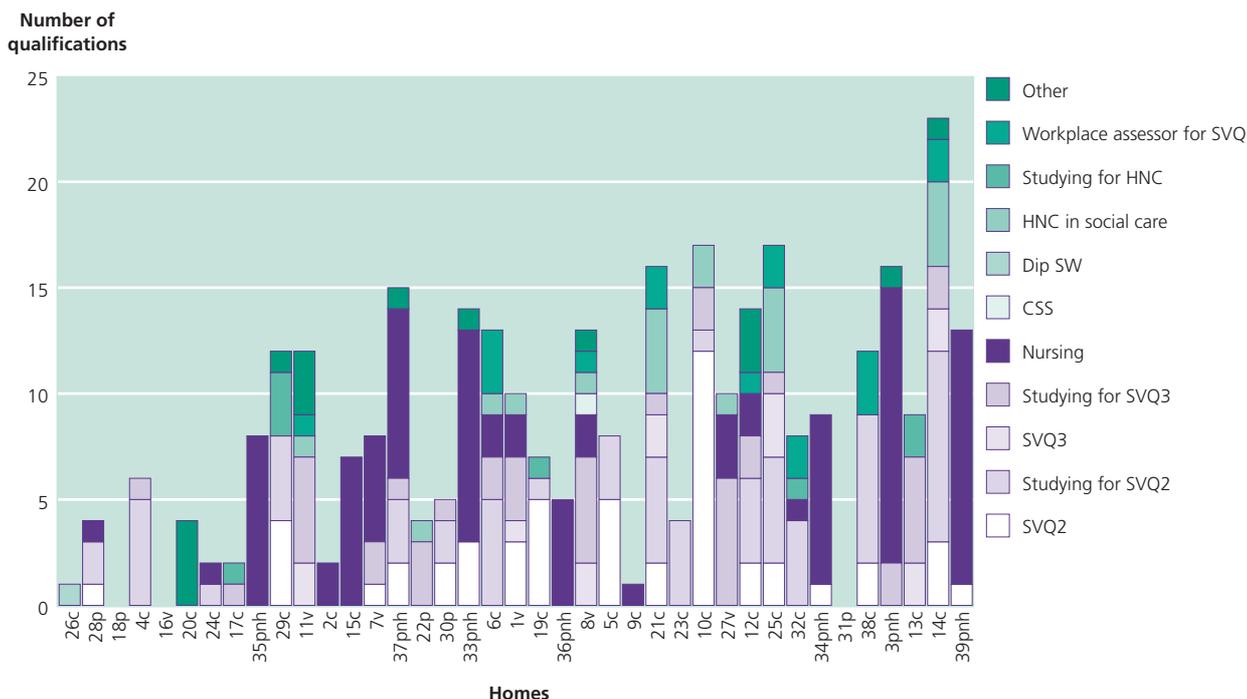
Note: Homes are in ascending order of WTE number of care and nursing staff. Care staff includes senior care officers, care officers and care assistants. Pre-SVQ courses are excluded.

Registration requirements specify the number of qualified nursing staff required in nursing homes. Most nurses have the higher ('first level') registered qualification - RGN or RMN. Few hold any additional social care qualifications.

Training courses

Formal qualifications, in themselves, are not enough. Residents' needs change constantly and staff should receive continuing development and training to meet these needs. To be effective training should:

- involve residents in identifying skill gaps
- be relevant to the training needs of individual staff members
- have clear goals linked to the home's objectives and philosophy of care
- be subject to evaluation so that benefits can be demonstrated
- be shared with colleagues where appropriate.

All the homes have training programmes for new staff, which range from one to six weeks. These programmes vary significantly: some are little more than shadowing an experienced member of staff for a week; others demonstrate a more systematic approach.

"There was a high correlation between understanding, commitment and job satisfaction. If people are clear about what they can and should be doing, and know how their job contributes to the larger picture, they tend to be more committed: the result is higher productivity and better quality services."
Audit Commission: The melody lingers on

> **Training for new staff**
>
> New members of staff need:
> - a clear understanding of the home's values and objectives
> - sensitivity to the unique needs of each resident
> - written information on policies and procedures
> - tasks which enable the manager to assess understanding and implementation of the policies and procedures
> - feedback on progress
> - support to learn new skills
> - time to form relationships with residents and other staff.

On-going training and development is equally important. Overall, care staff and nurses in the homes attended over 450 types of training courses during 1997/98 (excluding those related to professional qualifications). The picture is very uneven, however; about one quarter of these courses were attended by staff from the homes of one council (6c, 12c, 14c, 21c, and 25c).

> **Training and qualifications**
>
> Homes 6c, 12c, 14c, 21c and 25c are in the same council area and have an active approach to training. Training needs are identified through induction, observation, supervision, assessment of current residents' needs, and staff feedback. Each home has protected time on the rota for care staff studying for SVQs, and all the homes have more than one workplace assessor. In addition, in home 21c the manager sets all staff case studies of different situations that can arise in residential care. Staff as a group then discuss these, so that views and approaches can be shared.

The types of training are wide ranging, illustrating the complexity of residential care. The most commonly attended courses include:

- philosophy of residential care
- moving and handling
- food hygiene for all staff
- first aid
- dementia awareness.

"Staff need to be trained more for dementia."
Relative

Training for nurses in nursing homes focuses more on updating nursing skills across a range of clinical areas. This is to be expected given the nursing profession's emphasis on the maintenance and development of skills. Some of the most common areas for training are:

- wound care
- care of urinary catheters
- management of continence/incontinence
- care of the dying
- nursing people with Parkinson's disease.

However, nursing homes should ensure that staff also receive training in social care.

Costs of training

It was impossible to identify robust costs associated with training in most homes. In councils, training costs are allocated to a range of cost centres and not necessarily charged to the budgets of individual homes. This means that it is impossible to assess the cost effectiveness of training. In order to help assess the extent and effectiveness of training we recommend that all homes should:

- have a staff development plan linked to the home's objectives
- develop individual staff plans which directly reflect the home's objectives and are informed by supervision sessions and appraisals.

We found some very good examples of training plans in a few homes.

What do residents think about the staff in their homes?

Residents and relatives were asked a number of questions about the staff in their homes. These were designed to assess:

- how responsive staff are to the preferences of individual residents
- how residents and their families rate staff
- how satisfied residents and their families are with the time that staff spend with them.

It is important to note that surveys of older people receiving care services do not generally elicit high levels of dissatisfaction. Any dissatisfaction that is expressed, therefore, should be taken seriously.

The most basic, but important, quality indicator used was whether residents were always called by their preferred names. This was achieved in over half the homes (exhibit 14). However, some residents in a significant minority of homes are not always called by their preferred name. This finding was not associated with other factors that might be expected to influence it; for example, the levels of staff turnover or sickness absence, or the proportion of part time staff. It is likely, therefore, that the prevailing culture of the home is the most important factor, reflecting the ability of the manager to ensure that all staff respect residents' right to be called by the name of their choice.

"Staff are first class. They can fairly handle old people"
Resident

## Exhibit 14: Are residents always called by their preferred names?

Most people are always called by their preferred names.

Percentage

Never
Sometimes
Always

Homes
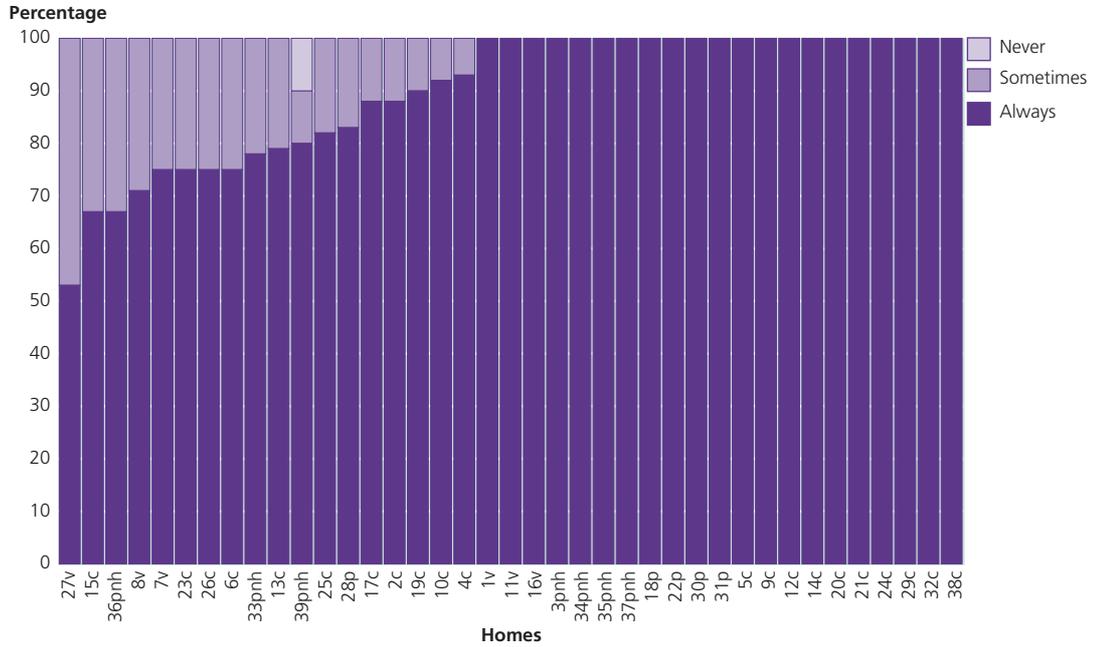
Residents and relatives were also asked which word they would use to describe staff: excellent, good, adequate or poor (exhibit 15). Most residents and families describe staff as excellent or good. However, a few people describe staff as merely adequate, or as poor. Providers should examine the underlying causes of these ratings to identify areas for improvement.

Exhibit 15: Word used to describe staff by residents and families

Most residents and families are very positive about staff, describing them as excellent or good.

Percentage

Poor
Adequate
Good
Excellent

Homes
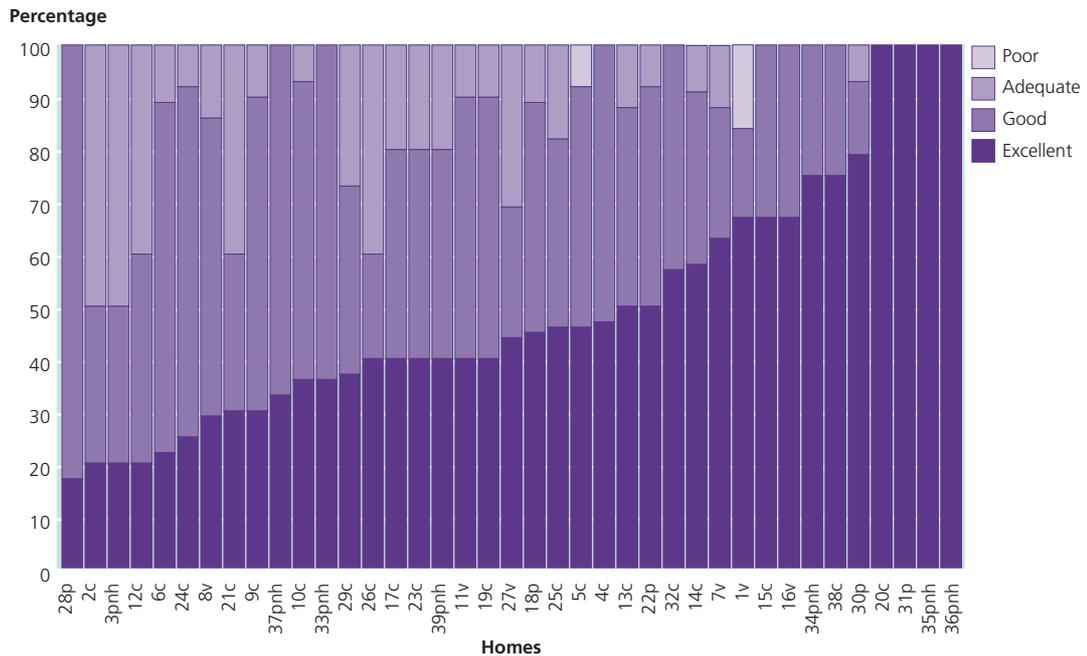
There is no correlation between residents' and families' views on staff and staffing levels, turnover or the percentage of part time staff.

Finally, residents and families were asked whether they were satisfied with the amount of time that staff spend with them or their relatives. A significant majority of them (82%) reported being very or quite satisfied. Relatives were more likely to express dissatisfaction. However, residents and relatives may have different perceptions and therefore any differences should be treated with some caution. In addition, a smaller number of relatives were interviewed in comparison to residents.

There are wide variations in reported levels of satisfaction between homes (exhibit 16).

**Exhibit 16: Satisfaction with the time staff spend with residents**

The percentage of residents highly satisfied with the time staff time spend with them ranges from 0% to 100%.

There is no statistical correlation between staffing levels and satisfaction, although we have already indicated that some staffing levels may not be good enough to provide more than the physical care required (see exhibit 5). Physical care is obviously crucial, with many residents needing help in moving from one place to another (exhibit 17). However, residents also want social interaction and company from staff. Failure to provide this influences the poorer ratings in exhibit 16.

"Staff are very busy, but I'm not the only pearl on the beach."
Resident

Exhibit 17: Percentage of residents who need assistance in moving location

Percentage of residents

% needs supervision /
assistance - 2 people

% needs supervision /
assistance - 1 person

% copes
independently

Homes
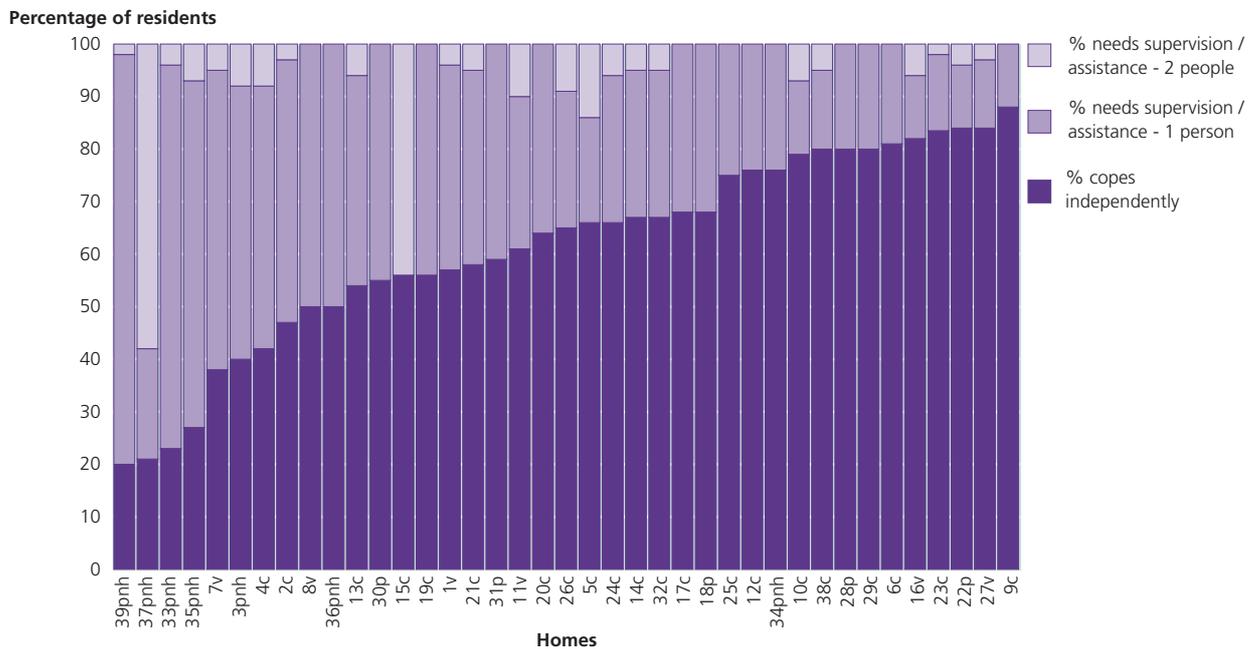
Recent research carried out by the Office of Fair Trading had similar results: three quarters of respondents were very satisfied with the home they lived in, although 41% said that staff were too busy to sit down and talk[17].

"This home is second to none - the staff are a marvellous group of people."
Resident

Residents and their families value staff and rate most of them highly. Nevertheless, in the spirit of continuous improvement, homes should be striving to improve the way in which staff interact with residents. Requirements will change with different groups of residents and individuals; that is one of the key challenges for care home managers. The three questions we asked residents provide a basis upon which to develop more detailed resident feedback, and so identify areas for action.

Summary

Staff are a home's most valuable resource. The quality of the manager, and the effective organisation and deployment of staff can enhance residents' lives. Overall staff numbers should be sufficient to provide high quality physical and social care. But attention to the number of staff is not enough in itself. Providers should also have good management systems in place to assess and manage the impact of the use of part time staff, sickness absence, and turnover. It is in the interests of residents and staff to work towards a properly trained workforce. Training programmes for staff should be clearly linked to the home's overall objectives and to residents' preferences and needs. Effective recruitment and training procedures can greatly enhance the quality of care without the need for significant additional funding.

Service quality

This chapter looks at different aspects of life in the home. It starts with a discussion of the quality of information available to prospective residents and moves on to look at the importance of care planning.

It then considers the more intangible aspects of quality of life such as:

- privacy
- independence and choice
- satisfaction with arrangements for visitors, food, activities and outings
- maintaining links with the local community.

The next chapter *'Quality of the environment'* picks up the themes of independence, choice and privacy and looks at them in the context of the physical environment of the home.

Informing choice

Moving into a care home is a major life event.   It is important that prospective residents have access to sound information on which to base their choice of where to live.

Information about homes comes from a range of sources including:

- care managers
- 'word of mouth'
- visits to the home
- leaflets, brochures and contracts
- registration and inspection reports.

In this section we consider written information sources, such as brochures, contracts and inspection reports.

Brochures and contracts

Residents and potential residents have a right to the fullest information about their home[18]. Brochures should provide clear and comprehensive information, and should be sufficiently detailed to assist people in making informed choices.

Most homes have a brochure or leaflet describing the home and the type of care provided. The private and voluntary sectors have had to be better at 'marketing' their services than councils, so it is not surprising that independent sector brochures tend to be more attractive than those of most council homes. Councils are beginning to recognise the need to adopt some of the independent sector's best practice in this area, but a few leaflets date from before local government reorganisation and could confuse rather than inform. These should be updated.

Councils have a better record when it comes to producing general information on financial assessment and paying for residential and nursing home care. This information serves an important purpose in helping people to work out their eligibility for financial assistance when moving into a care home.

> **Informative booklets**
>
> The best brochures and information booklets provide the maximum of information in the simplest, user-friendly way.
>
> Home 11v has a detailed booklet covering all the issues in the framework contract below, plus a number of other practical questions such as smoking policies and involvement of volunteers. It includes a 'charter of rights' and is presented in a question and answer format with a detailed index. There are spaces in the booklet for individual details such as the name of the key worker and the designated member of domestic staff. The manager believes that since the booklet has been used there has been a marked reduction in depression on admission.
>
> In addition to brochures and leaflets, home 33pnh provides a useful checklist for prospective residents to go through with the matron of the home on the initial visit. This covers all facilities and routines, financial matters and links with other services.

Once the choice of home has been determined, each resident should sign a contract with the home, specifying the terms and conditions of their stay. Residents should receive a signed copy of their contract. The contract serves to protect residents' rights and makes clear their responsibilities to the home. The Office of Fair Trading (OFT) has found that fewer than one in five residents was aware of being a signatory to a contract, and only one in four residents and relatives had ever had a copy of their contract. In addition, the level of awareness of the contents of the contract was very limited[19]. This suggests that considerable work is needed to develop contracts and raise residents' awareness of their rights and responsibilities when moving into a home.

To assist in the development of care home contracts, the OFT has produced draft guidance on potentially unfair contract terms[20]. This guidance, in conjunction with the framework contract given below, provides useful suggestions for developing good practice contracts between homes and residents. The second part of this study will examine the way in which councils contract with homes on behalf of residents, and the extent to which this information is shared with residents.

> **Framework contract for agreeing terms and conditions of care**
> The contract should include:
>
> - assessment and care planning
> - regular reviews
> - what is included in fees (and what would incur extra costs)
> - facilities
> - arrangements for visiting
> - medical arrangements
> - staffing
> - insurance
> - privacy and confidentiality
> - personal money
> - complaints procedure
> - temporary absence
> - procedure for ending the agreement
> - arrangements for a trial period
>
> Framework contract between residential care provider and resident reproduced with permission from Continuing Care Conference (CCC). Copies of the framework are available from the CCC, 12 Little College Street, London SW1P 3SH.

Both brochures and contracts should be written in plain English and laid out clearly, preferably in large print for people with poor eyesight. Depending on the needs of residents, some homes should also consider producing material in Braille, other languages or on audiotapes.

> **Residents know best**
>
> The manager of home 17c wanted to improve the quality and range of information available to residents once they had moved into the home. She worked with residents to identify:
>
> - what information would have been helpful but was not available when they moved in
> - the best format for this information
> - where it should be kept.
>
> Following this consultation she produced a booklet, a copy of which is kept in every resident's bedroom.

Inspection reports

The registration and inspection units of local authorities currently inspect all residential care homes; health boards inspect nursing homes. Since 1996[21] reports on residential care homes have been open to the public, and most local authorities place copies of reports in public libraries. These can provide valuable information to prospective residents as they highlight areas of good practice and areas for improvement. However, they cannot be used to make direct comparisons between homes because coverage varies between individual reports.

Nursing home inspection reports have not been routinely published. Some health boards, although not all, make these reports available to the social work authorities in their area. Lanarkshire health board also has an agreement with local nursing homes that their inspection reports can be given to a member of the public on request. There is nothing to prevent other health boards doing the same and, in the interests of public accountability, we recommend that this practice be adopted across Scotland.

Well-managed homes have nothing to fear from making their inspection reports available. We found a number of homes that placed copies of their latest report on a noticeboard in the home, or discussed them at residents' meetings.

Care plans and key workers

The philosophy of providing all residents with an individual care plan and identified key worker is widely accepted as good practice. At best it facilitates a more individualised approach to care, and gives the resident someone with whom they can develop a close relationship[22]. Care planning is a difficult and time-consuming task, and it is high on many managers' lists of priorities for development. Most of the homes visited are actively trying to develop and improve their care plans, albeit with varying degrees of success.

All the homes have arrangements for individual care planning, and all have a system of key workers (and named nurses in the nursing homes). In all but one home the designated key worker or named nurse writes care plans. In the other home, the manager writes all the care plans. To ensure that residents remember their key workers, some homes have pinned photographs on residents' doors; others have the names of key workers and named nurses displayed inside residents' rooms alongside other useful information.

In order to examine care planning in more depth we:

- asked residents and relatives about their knowledge of their care plans and key workers
- examined a sample of care plans in the residential care homes against a checklist of good practice.

For care plans and key workers to be fully effective it is essential that, wherever possible, residents and relatives should be fully involved in the care planning process, and should know their individual key workers. However, when we asked residents and relatives if the home gave each resident a specially designated care worker, 43% answered 'no' or that they did not know. Awareness of care planning was even more limited; just over a third of people interviewed (37%) thought that the home reviewed each resident's care needs. In a few cases this may have been due to a policy by homes to treat care planning in an informal way.

'Without a clear managerial vision of service users' rights to make their own decisions… care will be done to people.'
Mallinson

Residents or their families had signed the majority of care plans we reviewed, or clear reasons were given where this had not happened. The key worker was recorded on almost all the care plans examined. This contradicts the findings of our survey of residents and families, and suggests that residents may not always realise the significance or purpose of care planning meetings, or do not feel part of the process of assessing their care needs and determining how they are met. This is an area that managers and care staff need to address to ensure true participation in the process.

Elements of a good care plan
- resident and family involvement (with the right of the resident to refuse elements of the plan)
- the identification of key workers or named nurses
- regular reviews
- good record keeping and dating of all entries
- non-judgemental
- identification of physical, social and emotional care needs, with corresponding actions to meet these needs
- attention to mental health needs
- the inclusion of an assessment of risk
- setting of clear goals (vague well-meaning statements do not make good care plans)
- monitoring that identified needs are being addressed
- unique care plans for each individual.

Care plans should be living documents that change with residents' needs. They should be reviewed regularly and updated as necessary. To provide good management information all entries should be dated, and there should be an efficient system for highlighting when formal reviews are required. Against these criteria the picture was mixed.

All homes were good at identifying and planning for residents' physical care needs, and these were easy for managers to monitor. In most plans there was clear evidence that daily activities related to an individual's unique personal care needs. In a small minority of homes, however, bath rotas are still used. These emphasise the convenience of the staff and home over the individual, and do not easily fit with the concept of individual care planning.

Not surprisingly, planning for social and emotional needs was less well developed. This picture supports our other findings on satisfaction levels among residents with activities and trips discussed in more detail later in this chapter. In general, those homes with higher levels of resident satisfaction with activities and trips appear to have given most thought to these areas in their residents' care plans.

For example, home 6c keeps a detailed record of each resident's involvement in, and enjoyment of, activities and trips. This record is linked to the care plan, and key workers can ensure that individual residents are offered activities that they like. This home is in a council area which has established standards for care planning and a process for monitoring these standards.

Overall, care plans for people with dementia tended to be the better plans, with a more detailed focus on physical and social needs and closer attention to the assessment of risk. This may be because many people with dementia may not be able to articulate their own needs, although it is important that they should be involved as much as possible.

Audits of care plans

The matron in nursing home 3pnh undertakes regular audits of care plans using a structured set of questions. These questions address process issues, such as whether all entries are dated and signed and the named nurse recorded. It also reviews whether the care plan is completed and accurate in the following areas:

• personal care
• mobilisation
• eating and drinking
• communication
• social
• nursing related care (eg blood pressure, body mass index, pressure sores).

Not only is this an audit of record keeping - important as this is - it also addresses the more fundamental issue of whether the care plan is appropriate to the individual. This requires a detailed knowledge of each resident.

Monitoring falls

Managers in homes 3pnh and 5c have carried out detailed audits of the number of falls in their homes. These were carried out in response to specific concerns.

The manager in home 5c was concerned about the increase in falls for a number of residents. These did not appear to be related to an increase in frailty or changes in the environment. She suspected that there was a pattern emerging in the times when the falls occurred. She reviewed all falls for the previous six months and identified the shift when they occurred – early, late or night. By doing this she was able to identify training needs for some staff and initiate improved safety measures.

The matron in home 3pnh believed that an increase in falls might be related to the level of sedatives being prescribed for some residents. In liaison with the GP, sedation was decreased or discontinued for those residents who had had a lot of falls. Early evidence indicates a small improvement in the number of falls overall, and a reduction in the number of people having multiple accidents from the highest recorded figure of eight a month to none. This audit is ongoing.

Quality of life

Generally speaking a good quality of life largely depends upon having a range of opportunities and the ability to exercise choice. Achieving this is more difficult in care homes than in many other settings, since the needs of the individual have to be balanced with those of the group. Success in meeting the needs of residents should be kept under constant review to ensure that:

• individuality, dignity and privacy are respected
• independence and choice are maintained and encouraged
• links with the local community are sustained and developed.

Once again, these issues depend to a great extent on the abilities of the manager in charge, the culture of the home and the quality of care planning. It is not sufficient to have good policies; staff must be willing and able to apply these principles at all times in planning and delivering care to residents.

In measuring these intangible aspects of quality, we used a standard measure[23], which takes account of a range of factors, including privacy, self determination and community links.

We also asked residents to rate their satisfaction with these elements and with other aspects of life in their home.

Privacy

Respect for privacy is essential in a shared living environment. It is an important indicator of the culture of the home and the attitudes of staff. We measured privacy by examining whether residents:

- had their own room
- could receive visitors in private
- had somewhere to lock away small items
- could lock their bedroom doors if they wished.

"My previous sharer was aggressive."
Resident

Not all homes meet all of these criteria and practice did not always follow policies on privacy. Most of the residents (86%) in the homes we visited have their own room (see exhibit 21). However, this still leaves one in seven having to share a bedroom, often with a stranger. This situation does not provide an acceptable level of privacy for these residents.

All homes have somewhere for residents to meet visitors in private. Many residents choose to use their own rooms for this, although where the bedroom is shared this is not ideal. Of those dissatisfied with arrangements for visitors, two fifths highlighted a lack of privacy for guests.

In most homes lockable drawers were provided and some or all residents had keys for their bedroom doors. In a few homes the locking of bedroom doors was restricted as staff felt that residents with dementia made locked doors impractical or dangerous. During a few home visits, we were shown into bedrooms without the permission of the resident showing a disregard for privacy.

> **Receiving mail**
> In home 14c each bedroom has its own letterbox for mail and newspapers. This respects residents' privacy as their mail is delivered directly to them, and it reinforces the concept that a person's room is private space.

Independence and choice

We assessed independence and choice by examining the flexibility of daily routines. For example, whether residents:

- are able to get up when they wish
- can furnish and decorate rooms
- are free to leave the home.

Three quarters of the homes scored as having 'flexible' regimes according to the measure[24] used; nursing homes were less likely to offer flexibility, with only two of the seven scoring as flexible.

"They treat you as you like to be treated."
Resident

Two thirds of residential care home residents believe that they make decisions about their daily routines, such as getting up and having a bath. Less than a third of relatives feel that the residents of nursing homes make these decisions.

The flexibility of morning routines can be measured by when breakfast is provided. In most homes, breakfast times suggest that residents can get up when they choose, but five homes limit breakfast to a period of one hour or less (although residents can ask for food at any time).

Many homes try to support flexible daily routines for their residents, but the extent of support available is variable. Most homes base their routines for getting up and going

to bed on individual care plans and residents' daily preferences. One home, however, has a set waking and bed time for residents, claiming that this was necessary due to a shortage of staff.

Arrangements for bathing are also an important indicator of flexibility. However, helping residents to bathe can take up significant staff time, and in some homes residents are only offered a bath every five to seven days. In most homes we found that residents can generally decide for themselves when to have a bath, although there may be some constraints related to the availability of the key worker.

Choice is also limited in deciding when and what to eat and drink. Almost a quarter of homes had no facilities for residents to make themselves or visitors a snack or drink. Most of these were nursing homes, where many residents may be unable to use such facilities. Those residents in residential care homes who have the opportunity to make themselves hot drinks without waiting for the tea trolley value this. If there is no such opportunity, residents will quickly come to rely on staff or go without.

In some cases, it appears that individual residents are not empowered to make choices about their basic routines. Often the preferences expressed when first moving into the home become fixed, with little opportunity for variation.

Food

Much of the daily routine of a home revolves around mealtimes. Food was rated highly by most survey respondents in both residential and nursing homes (exhibit 18). The main factor influencing satisfaction seems to be choice. All but seven homes provide a choice for the midday meal, and residents of these seven homes account for half of all the dissatisfaction with food. There is no strong association between the cost of food and residents' satisfaction with it. Clearly, the cost of ingredients is no guarantee of an appetising meal. The presentation of the food, the atmosphere of the dining room, and the people with whom residents eat affect satisfaction ratings.

Exhibit 18: Satisfaction with food by home

Most people are very or quite satisfied with food.
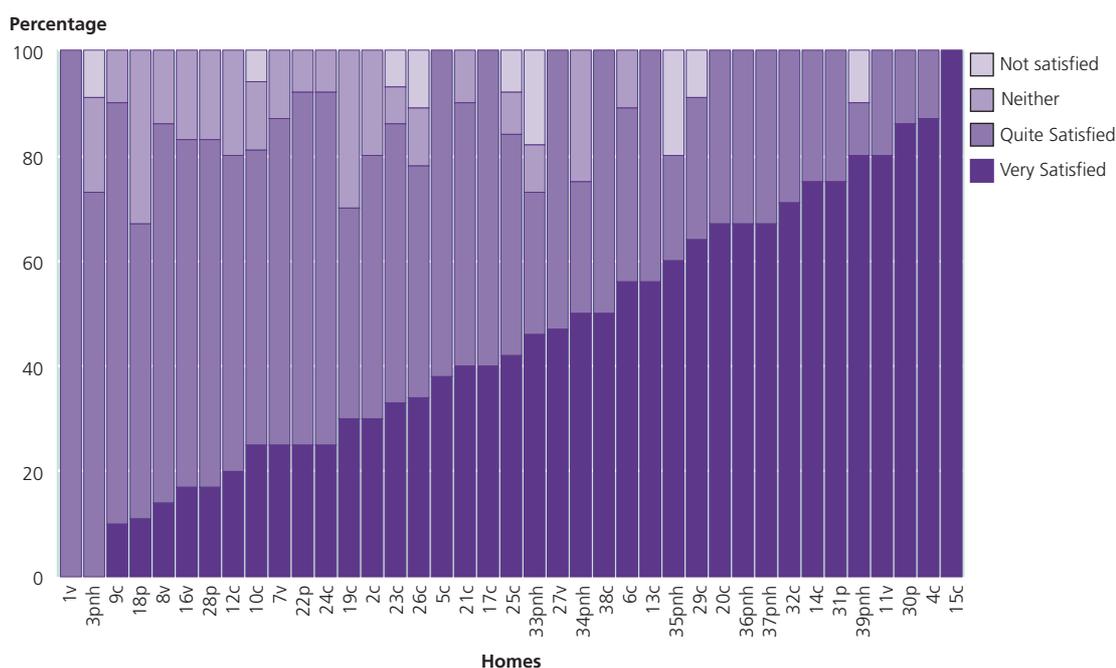
Where residents were not satisfied, the main reasons fell into three groups:

- individual tastes not catered for (for example, food too salty, not enough fresh fruit)
- food too plain
- the timing and serving of meals.

> **Empowering residents to help themselves**
> In home 13c a group of residents expressed a desire to shop and cook for themselves, away from the large kitchen and dining areas. Staff supported this, handing over part of the food budget for shopping and assisting with preparation when needed. The participating residents enjoyed the experience; they reported feeling useful (passing on tips to young staff members) and occupied.

Organised activities

"Staff should organise more activities and think about them more."
Resident

Residents think organised activities are important but few are 'very satisfied' with them (exhibit 19). Organised activities can be both group activities and individual ones. It is interesting to note that where residents are 'very satisfied' with this aspect of their home, they are more likely to be 'very satisfied' with the home overall.

Exhibit 19: Satisfaction with activities

Satisfaction levels vary widely between homes.

"There's loads to do. I think it's wonderful what they can do for us."
Resident
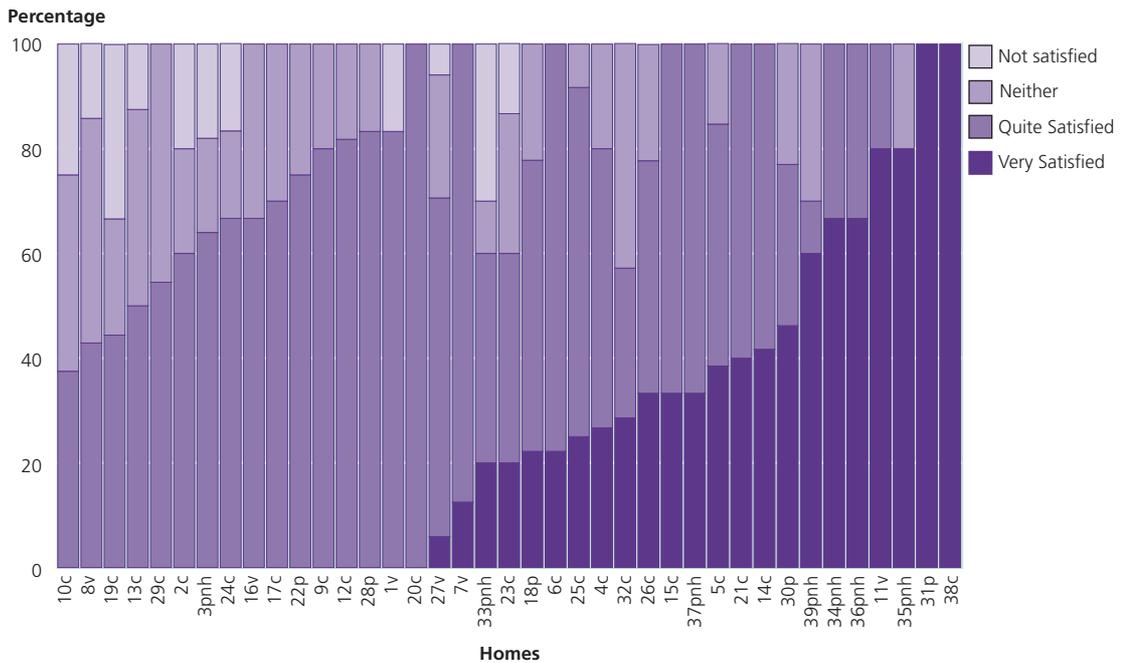
Residents expressed different opinions on organised activities, ranging from there being 'plenty of activities' through to there being a need for more activities. Some residents preferred not to take part in any of the activities on offer.

Bingo, quizzes and reading aloud from the newspaper to generate discussion were most likely to be happening on any given day. A small number of homes have staff trained in basic aromatherapy, hand massage and manicure skills. The most popular activities, however, involved music and singing.

There is some debate about how the need for organised activities should be addressed. Most of the nursing homes, and a few of the residential care homes, have dedicated part time activities co-ordinators. The majority of the residential care homes, however, see this role as an integral part of care staff duties.

The two approaches to providing activities need not be mutually exclusive. Activities co-ordinators are most successful when they:

- are integrated members of the staff group
- contribute to care planning, so that activities are appropriately tailored
- support other staff in working with residents.

They work least effectively when the organisation of activities is seen as their sole preserve, and is not linked with individual care plans.

Our survey of residents does not give conclusive evidence of the respective value of either approach. However, there is some evidence to show that where there are vacant activities co-ordinator posts (homes 10c and 19c) care staff have not filled the gap. This may be explained, in part, by relatively poor resident to care staff ratios in these homes (see exhibit 5) or by staff not seeing the organisation of activities as their role.

Visitors
Visits from family and friends are important to residents of residential care homes, but only a small proportion of residents were very satisfied with the arrangements for receiving visitors. Satisfaction levels were significantly higher for the relatives of those in nursing homes. For those residents who receive visitors, the major reason for dissatisfaction with arrangements was a lack of privacy. As already discussed, some homes do not have facilities available for residents to make tea or coffee for themselves or visitors. It is important that all homes ensure that there are suitable facilities for residents to entertain visitors.

Homes can encourage visits from volunteers and local community organisations for residents who do not have many visitors.

Community links
We examined the way in which homes interact with the community by considering the extent to which links had been developed or sustained. We also considered residents' access to the wider community through holidays and excursions.

Using our standard measure only one home was found to have 'open' links with the community. The measure examines the extent to which residents:

- spend weekends or holidays away from the home
- attend social activities or clubs outwith the home.

It is probably more difficult to satisfy the first of these criteria, since many people move into residential or nursing homes because they do not have a support network of family or friends. Evidence from the homes we visited confirms this. In such circumstances, managers need to be creative in finding alternative solutions. Seven residential homes (four of them in the voluntary sector) organise resident holidays.

Attendance at local clubs or societies helps to maintain community links. In practice, however, we found little evidence of this. In only seven residential care homes did more than half the residents regularly attend local clubs or societies. Three of these homes were run by the same local authority, which has a strong commitment to developing and sustaining community links.

Opportunities for socialising may be limited by the location of the home and the facilities available locally. However, other factors are within the control of the home, such as the availability of transport and staff and a commitment on behalf of management.

"I can't get into town. They refuse to organise it."
Resident

Transport is a major factor affecting the availability and frequency of trips out of the home. In some homes staff cars or cars belonging to the homes were used. Twelve homes had a minibus of their own, while five more could use a day centre's bus. Homes 16v and 27v are the only homes with neither a minibus or staff trained and insured to use private cars for residents; satisfaction with trips is low in these two homes.

Most homes organise 'day trips' at least monthly and often more frequently than this. Some homes limit these to every two or three months and a few provide no excursions at all. This means that some residents rarely or never leave their home. Excursions are important for the majority of residents, but were found to be the least satisfactory aspect of home life (exhibit 20). Only a small proportion of residents who consider excursions to be important are very satisfied. The main reason for dissatisfaction was that outings were too infrequent.

Exhibit 20: Satisfaction with outings

Satisfaction with trips is lower than many other aspects of home life.
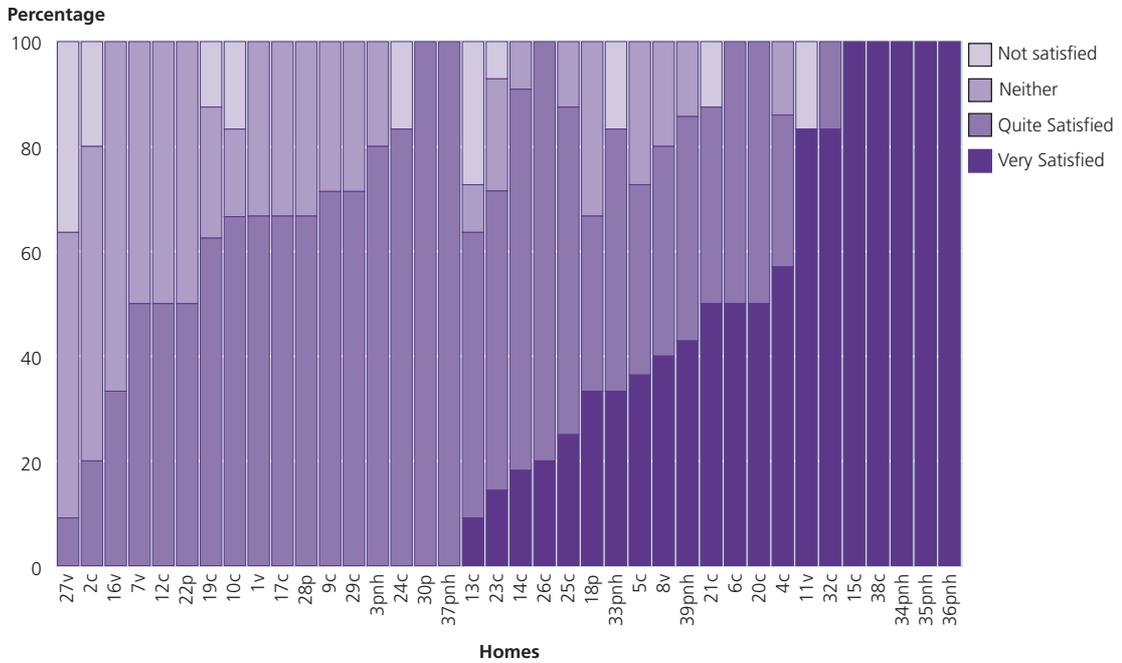
Note: Residents who think outings are unimportant are excluded from this exhibit.

Our evidence suggests that only small numbers of residents are able to go out unaided. In nearly half of the homes, none of the residents go outside of the grounds unaccompanied. It is important, therefore, that managers find ways to facilitate short journeys for residents.

Maximising transport opportunities

In home 21c any member of staff, including the handyman, going out in the minibus offers lifts to residents. This is highly valued.

Many churches will provide volunteer transport if residents wish to continue attending their own church, rather than rely on church services held within the home. A resident in home 10c wanted to exercise this choice. The home contacted the resident's church, which provided a volunteer car service.

Home 24c has a pool of volunteer drivers who take residents on local excursions and shopping trips. These volunteers also raise funds for residents' excursions.

Quality of the environment

Earlier sections of this report have focused on two key areas: the staff who provide care and support, and the experience of everyday life in the home. The physical environment of the home, the building and grounds, also plays an important role in determining the quality of residents' lives. The main factors we examined were:

- the size of the home
- personal and shared space (bedrooms, bathrooms, sitting and dining areas)
- access to gardens and grounds
- the extent of residents' participation in the running of the home.

Size of home

Our findings indicate that there is no direct link between the size of a home and residents' satisfaction; nor is satisfaction influenced by whether the building is converted or purpose built, new or old.

"It is my home now. It's very good, though I would prefer to be at home."
Resident

There are 22 purpose built homes in our study, nine of which have self-contained wings for residents which can facilitate 'small group living'. A few of the other homes have also adopted this approach although their buildings have some physical limitations. Small group living arrangements can offer particular advantages in larger homes or where residents have a wide range of care needs. It is common for homes with small group living arrangements to have regular staff teams working in each wing, which residents value. However, managing rotas can be more complex, particularly providing absence cover, and this can add to costs. More importantly, small group living should not be used to impose limits on residents' choices about where, and with whom, they spend their time.

Accommodating different needs

Home 11v has a number of residents with severe dementia. This was causing some friction in the shared dining area and lounge. Despite being constrained by the layout of the building, which is a converted older property, staff have developed a social area for residents with dementia where they eat and mainly choose to sit. A small kitchen has been up-graded so that staff can work directly with these residents to maintain basic independent living skills. This has been achieved without developing a completely separate unit in the home.

This approach is being evaluated through monitoring individuals' care plans and quarterly review meetings with relatives.

Personal space

Within a home, the only personal space for a resident is his or her bedroom. Nationally, there has been a steady move towards providing residents with single rooms. Some councils pay a premium of about £10 a week to the independent sector for single en suite rooms. In the 39 homes most residents have single rooms (exhibit 21)[25].

The majority of residents have single rooms but some homes still have a high proportion of double rooms.
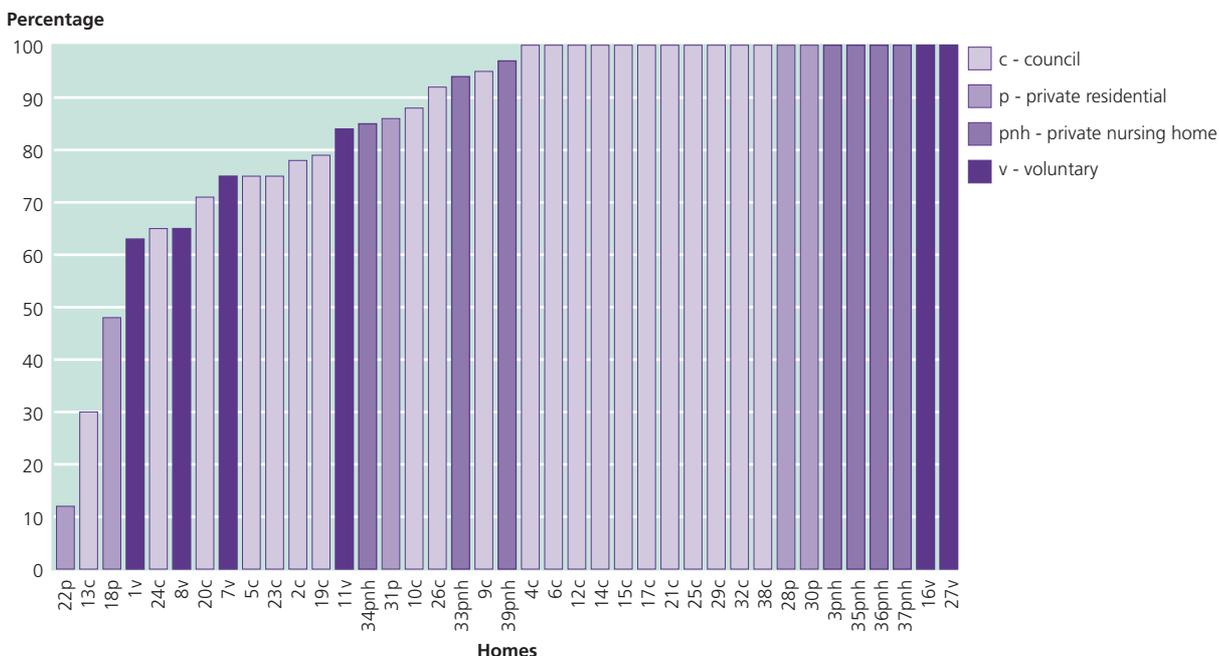
Residents are more satisfied with their bedroom than with any other aspect of the home (exhibit 22).

Exhibit 22: **Satisfaction with bedroom by home**

Satisfaction with personal space is high.
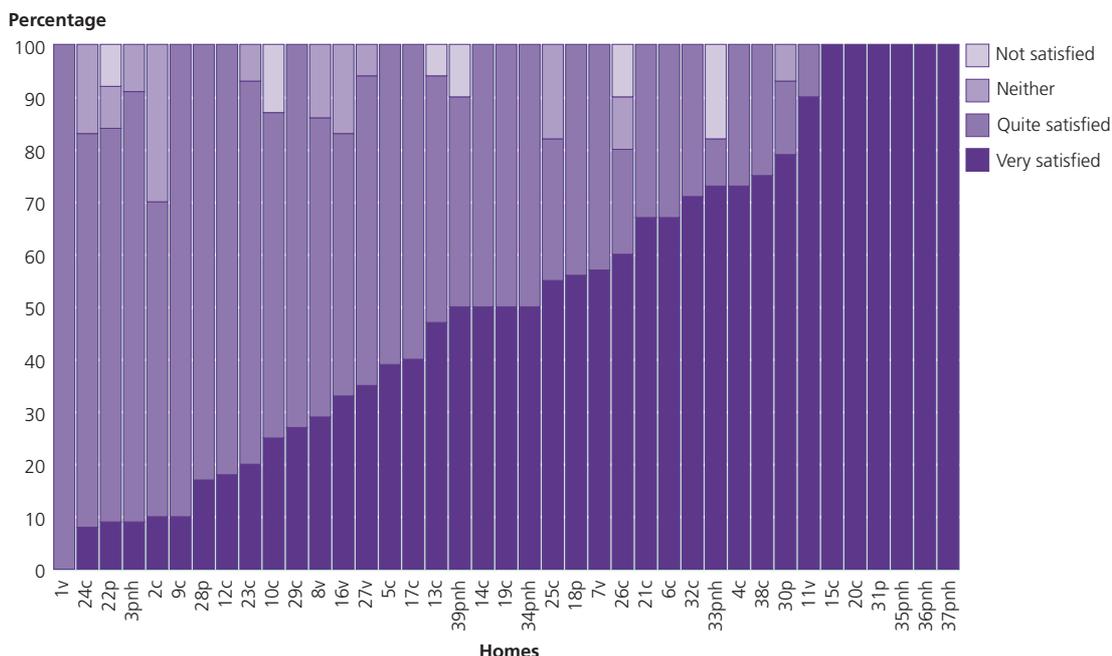
Satisfaction is significantly higher among people who do not have to share. Thirteen per cent of the residents we surveyed share a room and, of those, less than 20% of them were very satisfied. In contrast, almost 50% of those with single rooms were very satisfied. Sharing also has some effect on overall satisfaction with the home.

Three other factors were important in explaining satisfaction with bedrooms; the size of the room, being able to have personal belongings, and having en suite facilities. Only home 2c has rooms that cannot accommodate even small pieces of personal furniture, such as a favourite chair; this home has high levels of dissatisfaction. Two-fifths of residents have en suite rooms (exhibit 23).

Exhibit 23: Percentage of residents with en suite facilities

En suite rooms are most common in nursing homes.
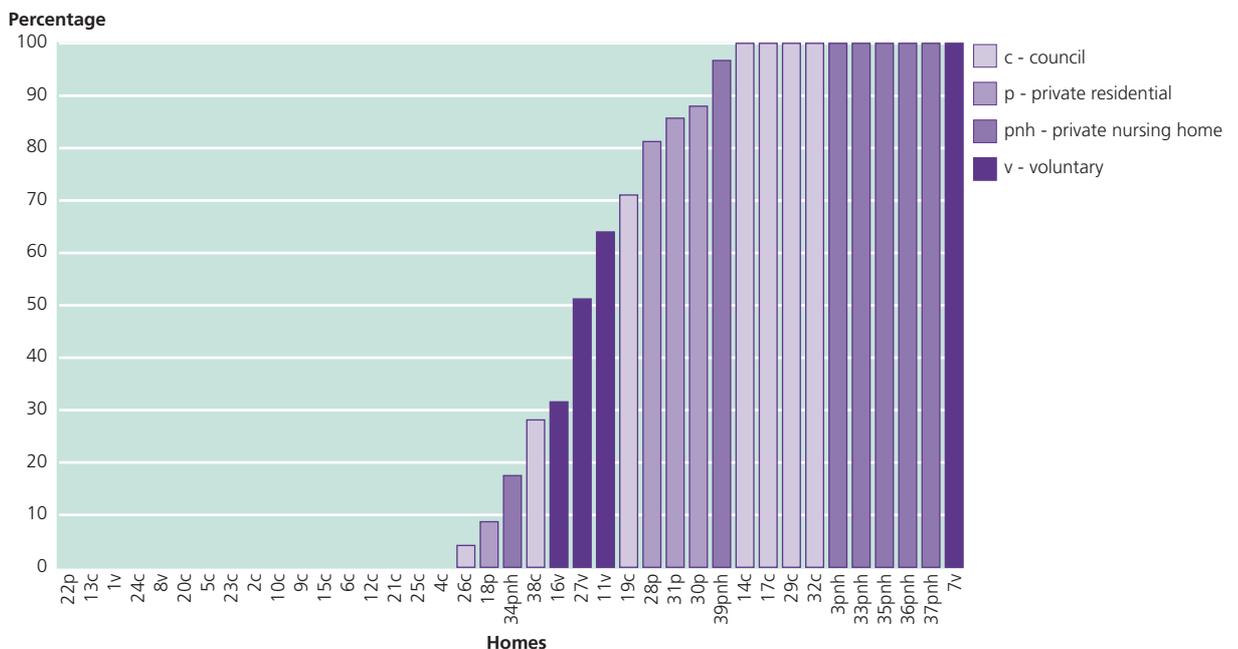
Note: en suite is defined as a room with a toilet and wash hand basin as a minimum.

As would be expected, residents prefer spacious, single, en suite rooms, which can accommodate their own furniture. Allowing people control over decoration and privacy in this personal space increases satisfaction.

Communal areas

Although most people who live in care homes have their own room, other areas of the home are shared. These include sitting rooms, dining areas and, for many residents, bathrooms and toilets. Satisfaction with these areas is relatively low (exhibit 24).

Exhibit 24: Satisfaction with communal areas by home

Satisfaction with communal areas varies between homes.
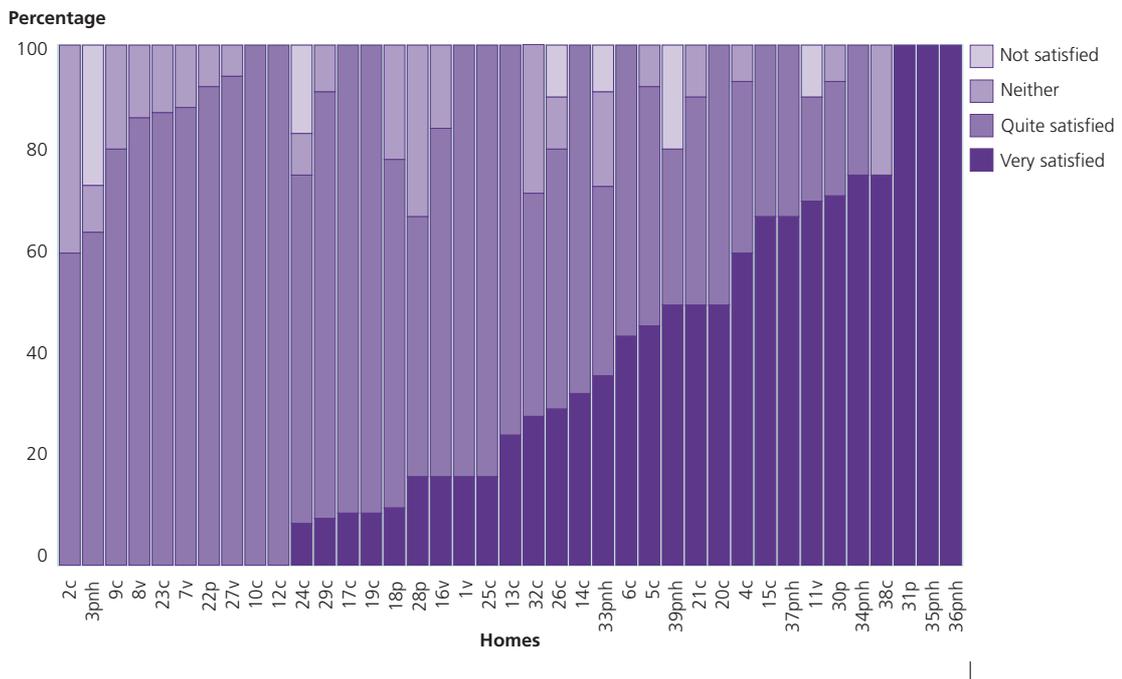
A small number of residents said that they preferred not to use the communal lounges, often because of difficulties with hearing in large groups. The stresses of communal living and the often conflicting needs of residents also affect levels of satisfaction. Home 2c illustrates the problem well. It is home to people with a broad range of care needs, and also has a high percentage of residents with difficult behaviour (exhibit 25). Residents do not live in small groups within the home, and there is a relatively poor resident to staff ratio. This combination of factors is reflected in the high level of dissatisfaction expressed by residents. No one was very satisfied, and just over a quarter of residents were not satisfied at all.

Exhibit 25: Percentage of residents whose behaviour requires intervention

Percentage

Legend:
- More than once a day
- Once a day (on average)
- More than weekly, but not daily
- Less than once a week
- No need for immediate intervention

Homes: 21c, 3pnh, 2c, 27v, 15c, 22p, 11v, 37pnh, 4c, 17c, 8v, 24c, 9c, 13c, 1v, 31p, 35pnh, 29c, 14c, 5c, 26c, 38c, 7v, 20c, 32c, 19c, 10c, 36pnh, 28p, 23c, 25c, 39pnh, 6c, 12c, 16v, 18p, 30p, 33pnh, 34pnh

Source: Scottish Care Resource Utilisation Groups, ISD, 1998.
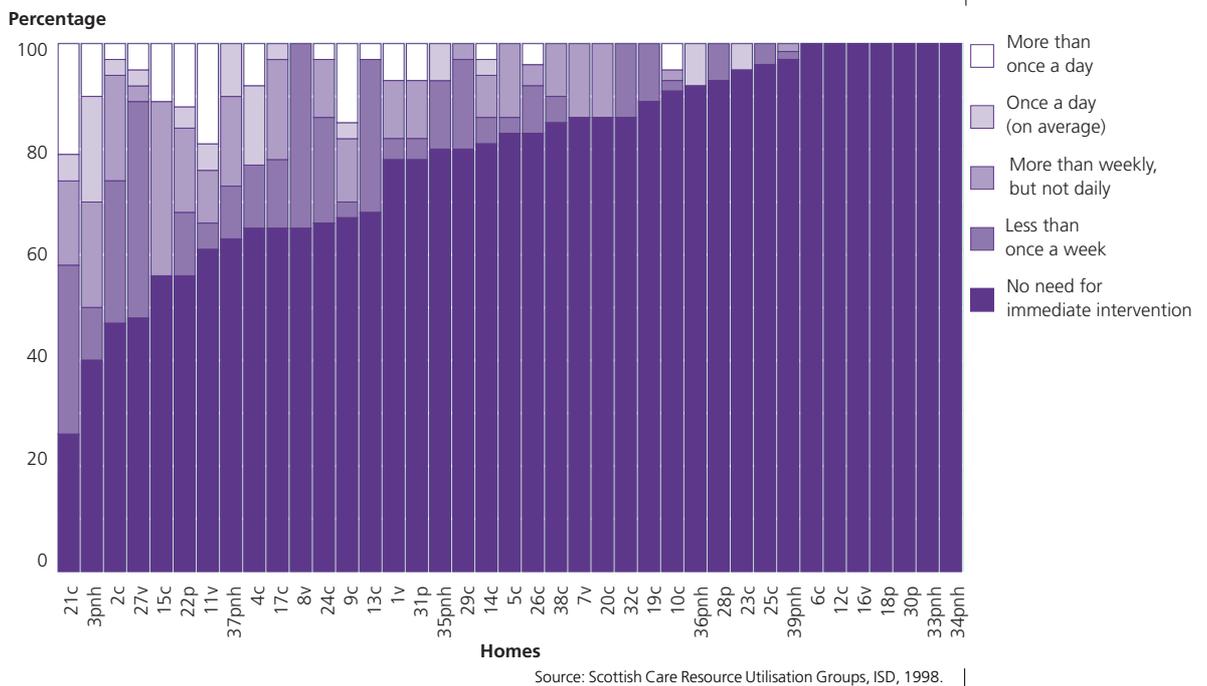
Although residents mentioned dining rooms less often than sitting areas, there is some evidence that communal eating is also a source of dissatisfaction in homes. In one large nursing home (home 39pnh) a number of relatives commented that, as mealtimes are not staggered, it takes staff a long time to get everybody seated, resulting in long waits for many residents. This is reflected in the high level of dissatisfaction with the communal areas in this home.

Those homes where residents have widely different needs tend to have higher levels of resident dissatisfaction with mealtime arrangements. A number of homes with a broad mix of dependency levels amongst residents have found that different dining areas, or mealtimes, have enabled them to better meet the needs of their residents. Others, such as home 21c, have found that staff eating with residents helps to promote mealtimes as an enjoyable social activity.

Managing communal areas well

Home 21c actively manages its communal areas. It has a number of residents with high physical care needs, and the highest proportion of residents whose behaviour requires immediate intervention by staff. However, satisfaction with communal areas is relatively high. This is one of only two homes where staff eat their midday meal with residents. Tea or coffee are also served at the table after the meal, prolonging the opportunity for social interaction.

The challenge for managers is to accommodate the variety of individual needs and preferences within the home.

Most residents have to use communal bathrooms and toilets. Of the 39 homes, 22 have some bedrooms with en suite toilets, but in only 10 homes do all residents have their own toilet. Bathrooms and toilets are in the main functional and practical, and are the most 'institutional' aspect of all the communal areas.

Personalising bathrooms

Specialist baths and equipment can make bathrooms feel institutional. Some homes, however, have worked very hard at making the communal bathrooms feel homely. Home 14c has achieved the standard of a good hotel with the minimum of expense. The home has used matching towels, stencilling and borders, and a few ornaments to create comfortable and pleasant bathrooms. A creative member of staff did the stencilling.

Access to gardens and grounds

Since many residents rarely leave the home, the gardens or grounds are particularly important. To assess the impact of gardens on quality of life, residents and relatives were asked about the way in which they can use the grounds.

A significant minority of residents said that they did not use the garden out of choice or because of their limited mobility and the need for staff assistance. Access to the garden affected satisfaction. Of the residents who do use the garden, nearly half found it physically difficult getting in and out of the home to the garden. Only a quarter of residents were very satisfied with the use they can make of the grounds. This issue is closely related to the availability of staff to support residents. In the majority of homes, at least a third of residents need the help of one person to assist them in moving about. In some homes, this proportion is much higher with two thirds of residents needing help (see exhibit 17).

Control of the environment

A positive commitment by staff is required to enable residents to participate in decisions about how the home is run. This increases residents' control over their lives. We looked at three specific ways of ensuring this:

• resident involvement in determining how the home is run
• resident meetings
• use of welfare or comfort funds.

Resident participation in running the home

In most homes, residents can take part in determining how their home is run through menu planning, assisting with domestic chores, or attending resident meetings. Seventeen homes regularly consult residents about menus; in thirteen homes staff plan the menus and then try to accommodate any special requests made by residents; while in the remaining nine homes there is no resident involvement. Given the importance of food and meal times to residents, and the ease with which their preferences can be accommodated, we would have expected a higher level of resident participation.

Taking part in domestic chores is a way for some residents to participate in normal home life and retain their independence. The homes in which most residents do some domestic chores tend to have more able residents. Of the seven homes which reported that most residents undertake domestic tasks, three belong to the same council. This council has a programme for assessing the life skills of residents, and the results of this assessment are used in care planning.

We have already seen that residents think that organised activities are important. Other studies have also shown that involvement in planning and organising activities are important to the majority of residents, including people with dementia.

Resident meetings

One of the main ways in which residents can influence the running of their home is through resident meetings, but merely holding meetings is not enough to ensure active participation. Many managers commented that traditional resident meetings were of limited use, either to keep residents informed or to get feedback, due to:

- levels of dementia among residents
- deafness among residents
- peer pressure.

We found examples of good practice in a small number of homes, which had tried to overcome these problems. Some had set up small group discussions in each wing of the home. Another home continues with large resident meetings, but key workers follow up issues with individual residents to ensure understanding and to gather their views.

The topics discussed at these meetings depend on local circumstances, but minutes suggest that food and fund raising are the most common areas of discussion.

Welfare/comfort funds

All but one of the homes has money from donations and the proceeds of fund raising. These funds range from £150 to £9000; around half the homes have more than £1000. Money is raised through coffee mornings, craft sales and other activities to purchase or subsidise things such as trips, entertainment, presents for residents and 'luxuries' for the home. These luxuries are usually small items such as fish tanks, water coolers, lamps or tablecloths. Two homes use the fund to cover pet expenses. In some councils, the fund is used for larger items such as a minibus or minor alterations to the home, such as patio doors.

Opinions are divided on whether these funds should be used to fund or subsidise excursions or other entertainment; in most homes funds are used for trips and entertainment although in some homes residents are required to pay for these. It is important that information given to residents, prior to moving into the home, is explicit about what services they will need to fund themselves (*see also 'Service quality'*).

From the examples given above it is clear that funds are used for a range of items. The main issue is that providers should be aware that the money is held in trust for residents and, therefore, residents should determine how the money is spent. Most homes try to involve residents in these decisions where possible, primarily in residents' meetings. As already discussed, these may not be the best mechanism for getting the views of all residents.

Overall satisfaction

*"Staff are caring and take the time to listen."*
Resident

In addition to asking residents about their satisfaction with different aspects of life in their home, we also asked them about their overall level of satisfaction. Half of them were very satisfied with their home. It is worth restating here that relatives were interviewed in nursing homes. Their higher level of overall satisfaction (62%) may relate to the relatively small sample and their different perspectives (exhibit 26).

Exhibit 26: Overall satisfaction

Most people are very or quite satisfied with their home but some have reservations.
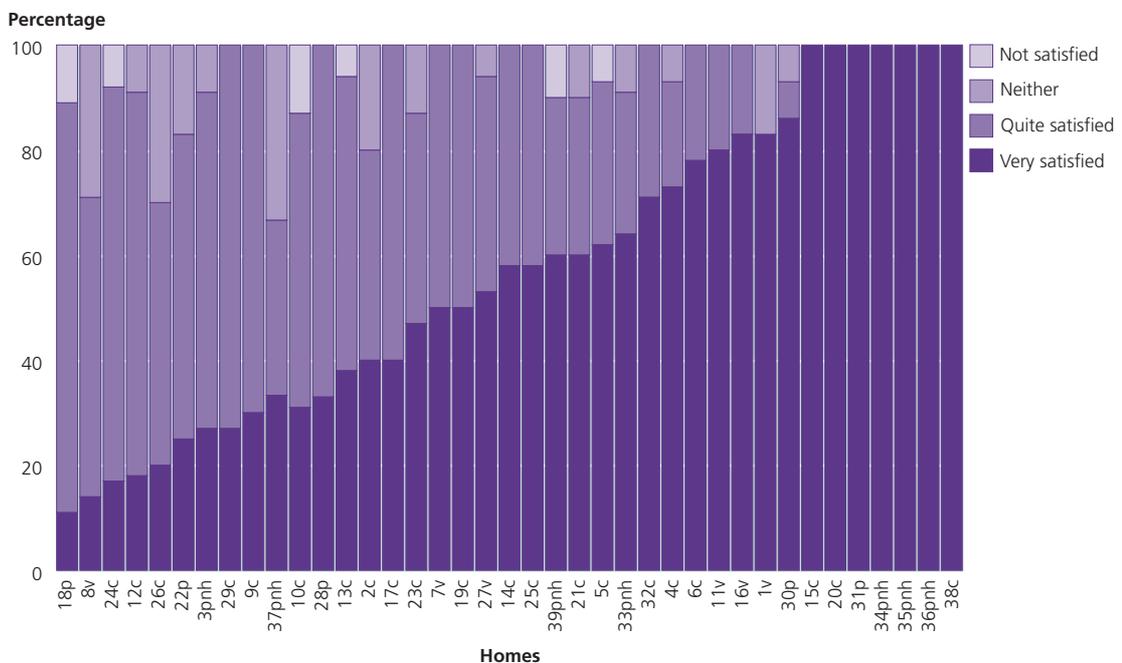
As previously discussed, overall satisfaction is influenced by whether residents have a single room. However, there are many other factors that can increase satisfaction. All aspects of communal living need to be carefully managed to meet the preferences of individual residents, including mealtime arrangements, who they spend time with, the activities available, and how often they can leave the home.

"Staff should take more interest in dressing clients in outfits which match up."
Relative

The three things which residents most liked about their homes were the staff, meals, and company. Despite being rated relatively highly, staff also topped the list of things which residents would most like to change. This highlights the importance of staff on the quality of life. The other things that residents would most like to change were other residents and the extent to which they can control their own environment. This demonstrates the complexity involved in meeting the needs of individuals within a group setting.

Summary

Inevitably, residents of care homes will not be wholly independent and will require support in many areas of life. Some may also have limited expectations of what life can be like in a home. Therefore, homes need to promote individuals' independence and choice, and guard against over-cautious approaches to risk assessment, poor staffing levels or poor practice.

The routines of many homes can quickly undermine independence and freedom, particularly for less mobile residents. Having a cup of tea, visiting the garden, going to the toilet or even returning to your room can depend on help from a member of staff. If no-one is available, then the resident cannot exercise choice. These practical problems are exacerbated if staff are not fully committed to a culture of independence and dignity. Staff, therefore, can help a person to retain their independence once they have moved into a residential or nursing home by taking a range of positive actions. Care plans should focus equally on maintaining skills, independence and dignity and on areas where support is needed.

As community care develops and people remain in their own homes for longer, they will be frailer and less able to care for themselves when they are admitted to a care home. This will only serve to increase the demands made on already busy care staff and managers. Councils should pay close attention to staffing levels and the quality of care planning in the homes from which they purchase care, since these factors have such a critical impact on the quality of life for residents.

Broadening resident consultation

A council commissioned research into the views of current and potential users of residential and nursing home care. This was part of a joint council and health services review of services for older people. Findings were similar to those highlighted in this study. Potential residential care users stated that they would want to live in a home which:

- had trained staff
- was close to family and friends
- gave them their own bedroom with a lockable door.

Potential users of nursing homes also wanted homes that had trained staff and were close to family and friends. In addition, they said they would want these homes to be regularly monitored for quality.

Over half the respondents expressed no preference about which sector should provide the care, as long as quality was the same.

Expectations of services are rising. It is useful, therefore, to widen consultation to the wider public.

Service costs

Councils need information about the cost of residential and nursing homes for both strategic and operational purposes. Strategic decisions about the appropriate mix of internal and external provision require full costs, including relevant capital and overhead costs, to be taken into account[26].

For operational decisions about how their own homes should function on a day to day basis councils should focus on running costs. The method of accounting for capital and overheads differs between sectors and the inclusion of these costs would have made inter-sector comparisons difficult. For this reason *our data excludes capital and overhead costs.*

The information in this report is intended to assist councils in undertaking reviews at an individual home level. Details of our methodology are outlined in appendix 3 and given in more detail in the data collection handbook accompanying this report. Our intention is that it will be taken forward and developed by councils.

Good quality financial information is essential for the management of any service. Councils are continuing to experience problems with information systems inherited from their predecessors following local government reorganisation. Many of these systems are unsuited to providing the type of information necessary for demonstrating best value. The quality of financial information available for our review reflects the quality of the underlying financial information systems, which varies between providers and across sectors.

There were sound reasons for the former regional and district councils to refrain from implementing new financial systems during reorganisation, not least the increased risk attached to anything which might weaken financial controls. In addition, the outgoing councils were not in a position to predict the financial information needs of new councils working in a more flexible environment of decentralisation and joint arrangements for service delivery. However, councils need to introduce appropriate systems as a matter of urgency. There is evidence from the audit process that new and more appropriate financial information systems are now being implemented by councils.

Our costing data is for the year to 31 March 1998, the second year of the new councils. None of the councils in the study had a fully integrated financial information system, perhaps due to the complex and diverse nature of the services which councils deliver. However, the number of information sources which were needed to provide information was surprising. In practice, service accountants had to contact several people and use information from a number of different systems to compile costs for individual homes. Often special requests were required to obtain basic information; in most cases councils expressed some reservations about the quality of information available, and its usefulness as a tool for service management is clearly limited.

In general, private sector homes found it easier to produce detailed financial information, particularly in relation to employee costs. The reasons include:

- the smaller scale of their businesses; many owners operate only one or two homes
- the concentration on a single function
- the recognition of the value of good financial information
- the direct relationship between cost and profit (which creates a focus on cost control)
- the need to provide detailed information to support requests for finance.

Timely and user friendly financial information

The best financial information came from a private sector provider which currently runs six nursing homes. They were able to produce cost details and analyses on request. The information was in a form easily understood by users, requiring no specialist knowledge of the system or complicated coding structures.

The information produced for home 3pnh included:

- a profit and loss account with well specified expenditure classifications, identifying the main expenditure categories without unnecessary detail
- a report analysing wages costs by category of staff
- a detailed report showing activity for the year for each expenditure category
- a full asset register showing historic cost, depreciation and net book value.

No manual intervention or additional explanations were required to enable the information to be understood by an external user.

The key areas of difficulty in determining the full cost of community care services such as residential care have been identified[27] as:

- the allocation of costs between different services provided within the home
- the identification and allocation of relevant overheads
- the identification and allocation of appropriate capital costs.

There was limited evidence of progress in these areas. In order to support local best value reviews, we have concentrated on direct running costs, which include staff costs, premises costs, supplies and services. A discussion of the issues surrounding councils' central overhead costs and capital costs, and our reasons for excluding them from our definition of running costs, is included in the data collection handbook which accompanies this report.

Weekly running costs

In general, the council sector has higher running costs, the private sector is at the lower end of the scale, and the voluntary sector falls between the two (exhibit 27). This finding is consistent with other studies in this area[28]. Staff account for most of the difference in cost.

Exhibit 27: Weekly running cost per resident

Weekly running costs range from £148 to £673, with council homes at the higher end of the range.
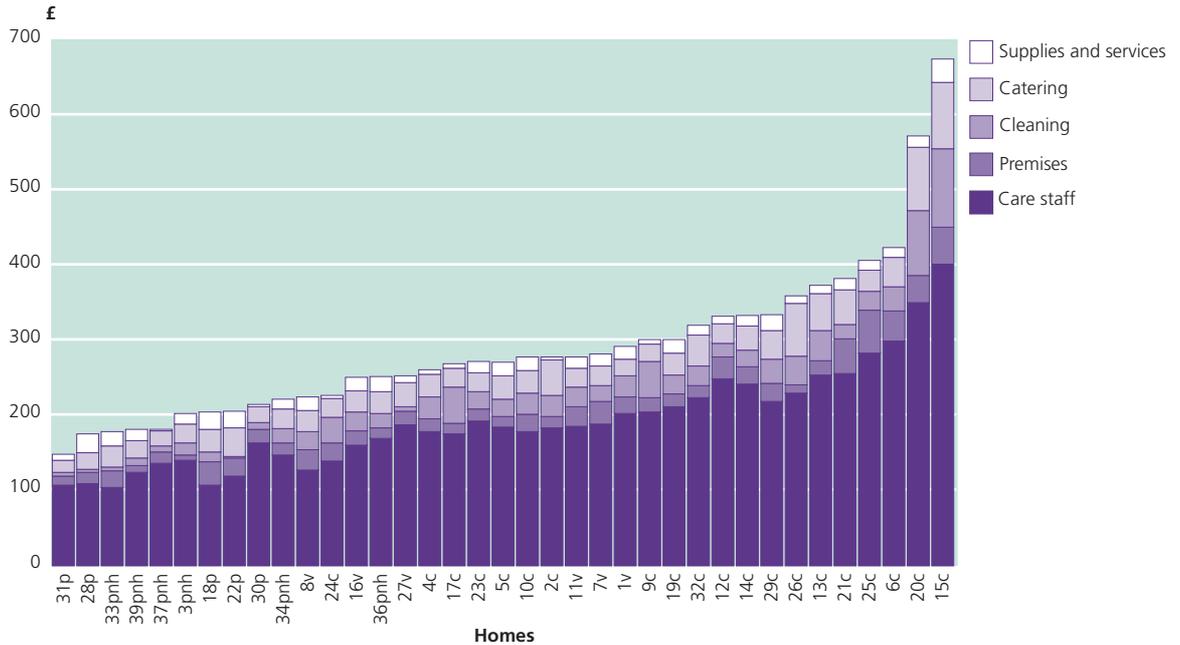
Note: Two homes have been excluded from the cost graphs because of difficulties with the underlying costs data. Home 20c provides an unusually complex mix of services which disproportionately inflates its costs.

The key cost drivers we identified were:

- staff terms and conditions
- staffing levels
- the method of providing catering and cleaning services
- the age and nature of the building.

Care staff costs

Care staff costs represent the highest proportion of costs, reflecting the importance of this category of expenditure. We have used an annual measure for this indicator to enable easy comparisons with annual salary rates (exhibit 28). As we have shown, the quality of the manager and other care staff, and good resident to staff ratios are key factors in determining the quality of care provided.

Exhibit 28: Annual care staff costs per resident

Annual care staff costs per resident range from £4,494 to £20,774.

£
(000s)

Legend:
- NI and pension
- Relief staff
- Other care staff
- Manager

Homes (x-axis): 30p, 33pnh, 31p, 18p, 28p, 22p, 39pnh, 8v, 37pnh, 24c, 3pnh, 34pnh, 16v, 36pnh, 17c, 4c, 10c, 2c, 5c, 11v, 27v, 7v, 23c, 1v, 9c, 19c, 29c, 32c, 26c, 14c, 12c, 13c, 21c, 25c, 6c, 20c, 15c
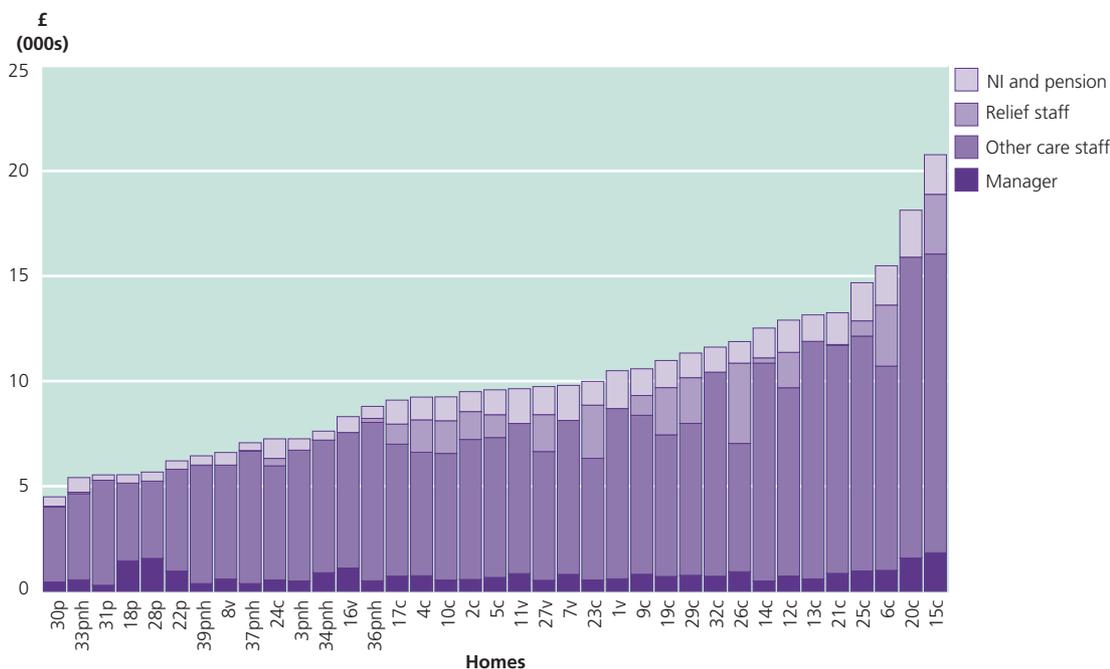
Good staff ratios will increase costs. In the council sector wage rates are agreed nationally and are generally higher than those paid in the private and voluntary sectors. Councils must ensure, therefore, that this higher cost is reflected in the quality of the staff they retain. Good training opportunities and the creation of a culture which recognises the value of staff improves staff morale and has a direct effect on the quality of care. The council homes with the lowest salary costs had low staffing ratios, showing staffing levels as an important indicator of quality and cost.

In addition to higher wage rates, councils also contribute to a pension scheme on behalf of those employees who opt to join. Earlier work by the Accounts Commission[29] identified that this costs councils an average of 7% of the total payroll for employees within the pension scheme. Four of the voluntary sector homes also make contributions to a pension scheme for their employees, and these are the more expensive voluntary sector homes. None of the private sector providers has an employee pension scheme.

For private homes run by single owners or partnerships, where the owners play an active role in the business, we allocated a notional salary of £25,000 under the catagory manager. However, owners often play a wider role than managers do in other homes, undertaking catering, domestic or general caretaking duties, and they may work long hours.

The use of part-time staff also tends to drive down costs, since the level of employers' National Insurance contributions is lower.

Residential and nursing homes are exempt from the majority of the provisions of the European Community Working Time Directive[30]. As a result, the Directive is likely to have minimal impact on staffing levels and costs, although it may involve the re-organisation of staff rotas. The financial impact of the minimum wage is more difficult to assess. Draft regulations specify wage levels of £3.60 an hour for employees over the age of 22, and £3.00 an hour for employees between the ages of 18 and 22.

Employees under 18 are exempt from the provisions of the Act[31]. These wage levels will not affect councils, which currently have a minimum pay rate of £4.12 per hour. Laing and Buisson have estimated that the minimum wage will not have a significant impact on the independent sector either, as it will increase costs by only 2%[32].

Catering costs

There was a wide variation in catering costs between homes (exhibit 29). Councils which use direct service organisations (DSOs) run the five homes with the highest catering costs. Councils need to consider whether there are sound economic or operational reasons for using DSOs to provide catering in residential homes; the relevant councils in our study are examining this issue.

Exhibit 29: Catering costs per resident per week

Catering costs range from £16 to £88 per week. The homes with the highest costs are those which use DSOs.
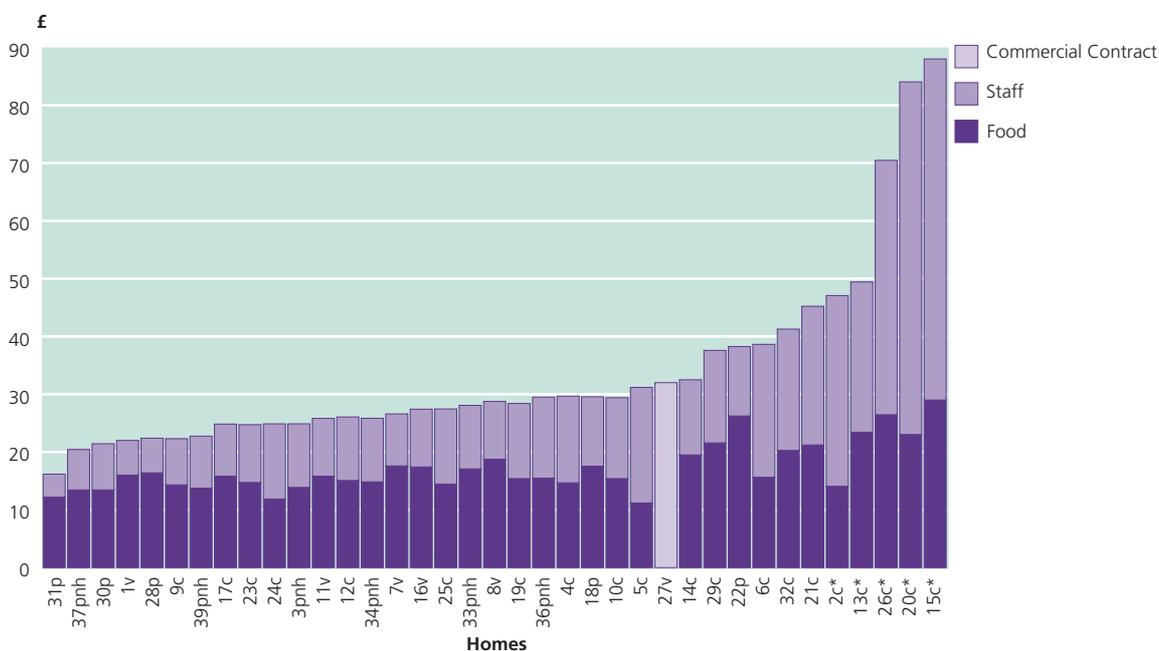
Note: * denotes homes where DSOs provide the catering.

Food costs ranged from £11 to £29 per resident week, with some evidence that larger homes tend to have lower costs. It is difficult to specify an acceptable level of expenditure on food. However, a small private sector home (28p) with food costs of £18 per resident week has won a healthy eating award, usually given to hotels and restaurants. A council, with some of the larger homes, has identified a sum of £15 per resident week as sufficient to provide nutritionally balanced meals. This slightly cheaper figure probably relates to the economies of scale possible in larger homes.

Cleaning costs

Once more, council homes with amongst the highest cleaning costs use DSOs to provide cleaning services (exhibit 30). Some other council homes with higher cleaning costs are those with poorer ratios of residents to care staff. This suggests that these homes may be using domestic staff for some duties carried out by care staff in other homes. The lowest costs are found in the private sector, and are explained by a combination of lower wages and more flexible working practices. It is also likely that some domestic duties are undertaken by owners and care staff in the private sector. There is a stronger demarcation of duties in the council sector.

Exhibit 30: Cleaning costs per resident per week

Cleaning costs range from £2 to £104 per resident per week, with the lowest costs in the private sector.

£
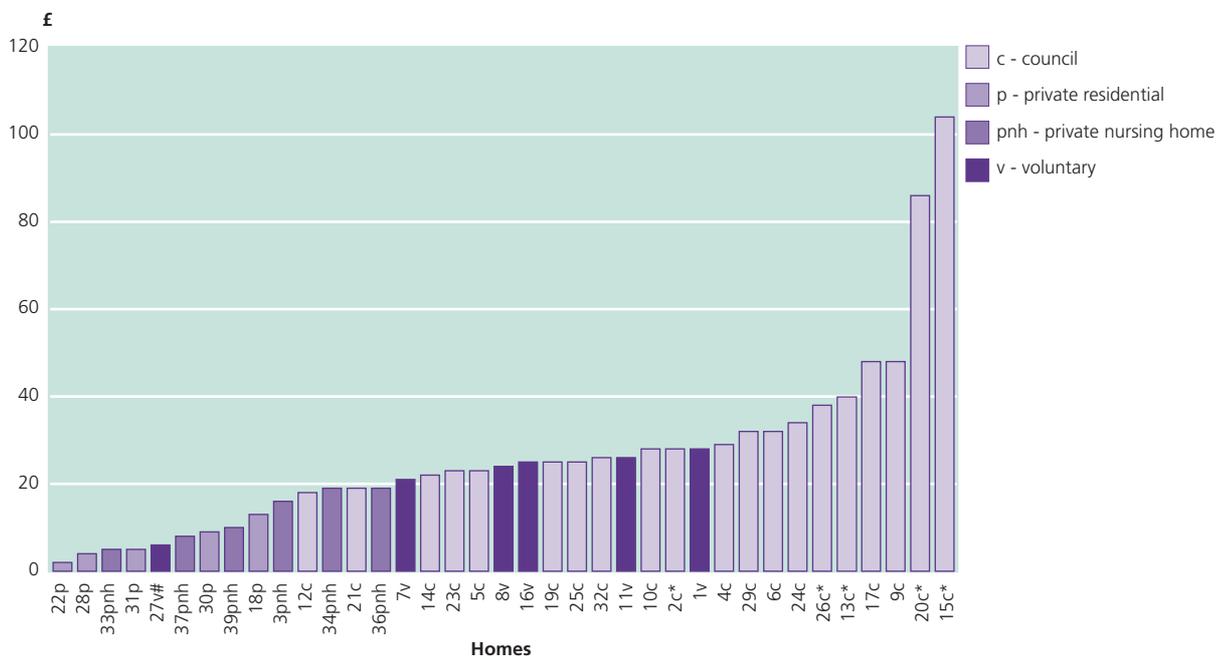
Note: * denotes homes where DSOs do the cleaning. # denotes commercial contract.

Premises costs

In addition to cleaning, the main elements of premises costs are energy (exhibit 31) and repairs and maintenance. There is clear evidence that recent, purpose built buildings have lower energy costs, reflecting the increasing emphasis on energy efficiency in building design and materials in recent years. It is difficult to reduce energy costs in older buildings without significant capital investment, which may take years to recoup in the form of reduced heating bills.

Exhibit 31: Energy costs per resident per week

Energy costs range from £5 to £30 per resident per week.
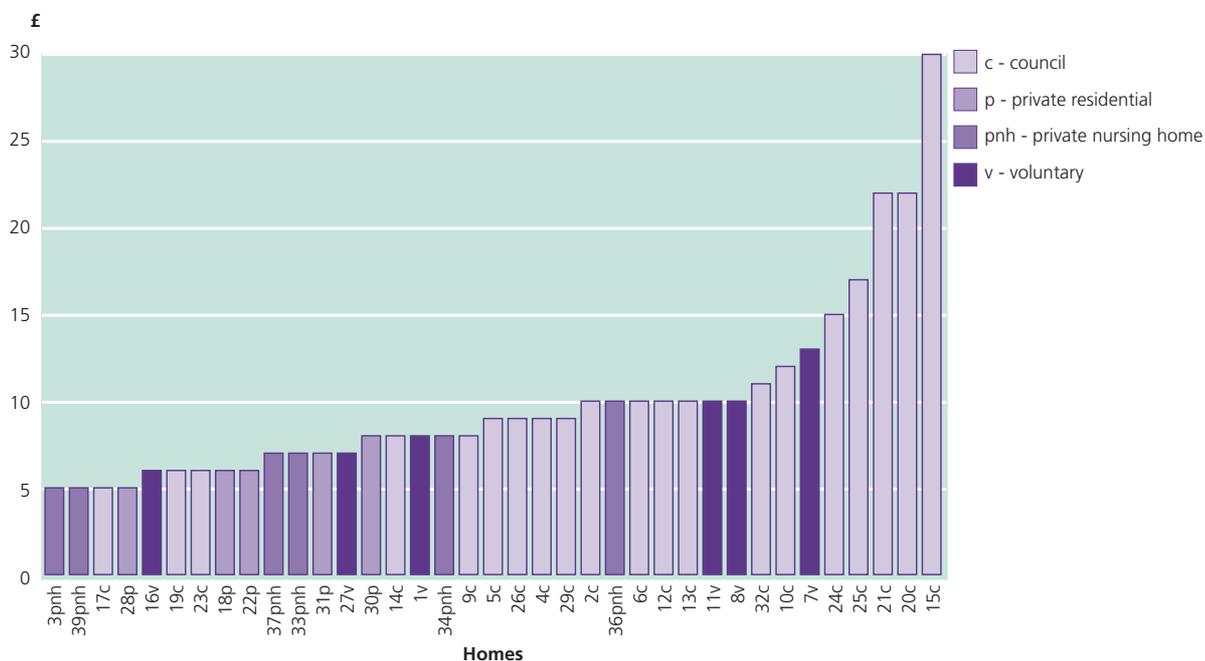
There were difficulties identifying relevant repairs and maintenance costs due to the different treatment of these in the three sectors. Due to limitations in the data available it is not possible to draw meaningful conclusions from the repairs and maintenance costs gathered. This is an important area which would benefit from more detailed examination by councils[33].

Reviewing the cost effectiveness of upgrading homes

One local authority has approached its review of in-house residential provision for older people by working through a series of steps which will form the basis of their best value study. These include:

- An audit of buildings measured against current registration standards and the projected desirable standard of single en suite rooms.
- A cost analysis comparing in-house establishments with each other and with external providers.
- An analysis of current and projected trends of usage of residential care, by need and locality.
- A market analysis, identifying independent sector developments - including known plans for upgrade to single en suite standard - in relevant services, and by locality.

On the basis of the above a number of options will be formulated, with appropriate financial modelling, to determine the future role of the local authority as a provider in this service area.

Costs and standard charges

Councils are required to calculate a standard charge for their own homes, which is the amount paid by residents who meet their own fees. COSLA has issued guidance on calculating the standard charge, which is required by law to recover the full costs of care[34].

Detailed examination of the composition of councils' standard charges and the basis of the fees they pay to external providers was outside the scope of this phase of the study. These issues and other strategic concerns will be looked at in the course of our follow-up study on commissioning care services for older people.

We include, for information, a graph showing the standard charges applied at our study sites against weekly cost information (exhibit 32). Councils are permitted to base their standard charge on the average cost for all their homes. We would, however, have expected the standard charges to be higher, given the statutory requirement to recover costs in full and the exclusion of overhead and capital charges from our costs.

Exhibit 32: Comparison of weekly costs and standard charge

The standard charge does not always recover the weekly costs of care in council homes.
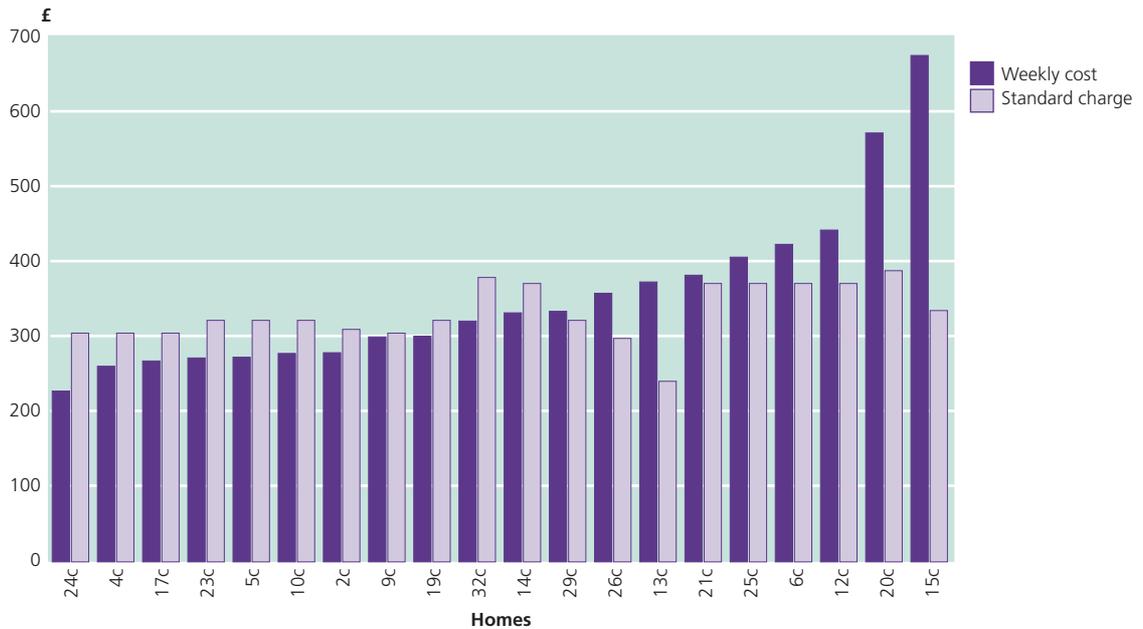
Summary

- Staff, including ancillary workers, account for some 80% of direct running costs. Wage rates are higher in the council sector.

- There is clear evidence that the method of delivering catering and cleaning services can have a large influence on overall costs. This is an area which would merit further consideration by councils, particularly where DSOs are employed.

- We have identified general problems with the quality of the information produced by councils, although there is some evidence that this is being addressed.

- Councils need to review their standard charges to ensure that they comply with the statutory requirements. In the data collection handbook we have included a discussion of the issues which councils need to consider in relation to overheads and capital costs. These must be included in the calculation of standard charges.

Best value is designed to ensure than an appropriate balance is achieved between cost and quality. We have shown that higher costs may be justified in terms of added value where appropriate performance indicators demonstrate that a higher quality service is being delivered. Even where this is the case, however, attention must still be paid to controlling costs. Where excessive costs can be reduced with little or no impact on the quality of service this must be addressed as a matter of some urgency.

Conclusion

Councils need suitable financial and other information systems in place to underpin their best value initiatives. In setting up these systems, they must identify the information needs appropriate to their local circumstances and supportive of the policy decisions taken by elected members. It is hoped that the findings presented here and the methodology we have developed will act as a foundation for more detailed work in relation to the provision of residential care for older people.

Councils cannot satisfy the requirements of best value by basing current levels of expenditure on what was spent in previous years, plus an increase for inflation, as has often been the case in the past. Containing costs within outdated budgets adjusted for inflation is not a substitute for determining the appropriate expenditure required to meet current needs and controlling that expenditure in line with service levels.

Evidence from the councils involved in our study suggests they recognise the need for the wide ranging reviews of services entailed in demonstrating best value. The results of these reviews need to be used to inform commissioning decisions.

Achieving best value

Councils have many competing demands for limited resources, and achieving best value in residential and nursing home care is a major challenge. The projected growth in the elderly population, and the Government's emphasis on maintaining people in their own homes for as long as possible, mean that future residents are likely to be frailer and have more complex needs than may have been the case in the past. In addition, people are increasingly seeing themselves as 'consumers' of services and have rising expectations of acceptable standards of service. Determining the appropriate balance between cost and quality becomes ever more crucial: councils need to examine closely the relationship between the two, and ensure that services are delivered in the most economic, efficient and effective way possible. Methods of service delivery must be evaluated for their cost effectiveness against specific quality indicators.

In this report we have shown that high costs do not necessarily mean high quality. For example, both top heavy management structures and the use of DSOs for catering and cleaning can increase costs without demonstrable advantages. We have also shown that quality could be improved in some homes without increasing costs significantly. For example:

- good care planning, linked to activities, trips and managing the home environment, helps ensure that residents' individual requirements are met
- tailoring activities in the home to meet individual residents' needs increases satisfaction levels
- in-house training and mentoring increases the understanding and commitment of staff to the philosophy of care within the home. This is particularly important in relation to fostering independence, respecting privacy and offering choice
- integrated team working (care staff with domestic and other staff) provides residents with a smaller and familiar staff group with whom to relate
- residents' enjoyment of communal areas increases where staff actively seek to respond to individual needs and preferences
- developing better links with local communities enriches residents' lives.

Undeniably, however, some improvements in quality will have cost implications. These include:

- upgrading some properties to provide all residents with the option of single en suite bedrooms
- training and supporting staff to study for formal qualifications
- improving staffing levels, although some councils have demonstrated ways of achieving this within current spending limits
- providing transport for residents to go on trips

Councils must make judgements about what constitutes best value in service delivery. The mix of internal and external provision will depend on the local market and on the ability of councils to deliver their own service standards at an acceptable cost. Councils should take due account of the views of residents, their families and the wider public in setting local policies.

Performance measurement is a prerequisite for accountability, value for money and best value. Councils need access to full and accurate information to support and justify decisions about service delivery. Providing performance information on staffing and costs and an approach to reviewing quality, this report should assist councils in their best value reviews of residential and nursing home care.

Recommendations for achieving best value

Continuous improvement in service delivery is at the heart of best value: increasing effectiveness and customer satisfaction, improving efficiency, and managing and reducing costs where possible. All well-managed organisations will be interested in achieving continuous improvement.

Most of the recommendations from this report are aimed at all providers. Specific recommendations aimed at councils only are given separately under each heading.

Increasing effectiveness and residents' satisfaction

Councils and other providers should:
- Ensure that residents are fully involved in:
    - assessing and planning for their own care needs
    - planning and evaluating all aspects of life in the home.

- Ensure that care plans are based on individual needs and preferences.

- Undertake regular audits of care planning.

- Ensure that all residents understand the role and identity of their key worker.

- Work towards providing all residents with single en suite rooms.

- Maximise the arrangements for privacy, providing all residents with:
    - keys to their doors if they want them
    - a personal lockable drawer for valuables
    - an alternative place to meet with visitors for residents who share rooms.

- Provide facilities for residents or their visitors to make tea or coffee.

- Develop and sustain links with the local community for the benefit of residents.

- Review the effectiveness of residents' meetings.

- More closely match staffing levels to the care needs of residents.

- Ensure that the home's policy on the use of part time, relief and bank staff does not affect the quality of care. Residents should be regularly consulted on the impact of the policy on them.

- Ensure that staff have adequate channels of communication to raise concerns about care practice in the home.

- Involve residents in identifying gaps in staff skills.

- Have an overall staff development plan linked to the home's objectives.

- Develop individual staff development plans which directly reflect the home's objectives and link to regular staff supervision and appraisal sessions.

- Provide comprehensive induction training for new staff.

- Provide domestic and other non-care staff with training in:
  - the values of the service
  - promoting the maintenance of residents' skills and independence.

Improving efficiency

Councils and other providers should:
- Develop sound financial and other information systems which provide reliable information for management and comparative purposes.

- Compare performance on selected indicators with other providers to target areas for improvement.

- Benchmark with other providers to identify areas of better practice which can be adapted into their own service delivery.

- Ensure that home managers have clear job descriptions which recognise the importance of:
  - inducting and developing staff
  - sustaining links with the local community
  - monitoring the effectiveness of care planning
  - promoting and monitoring the involvement of residents in all aspects of life in the home.

- Ensure that adequate administrative and information technology support is available.

- Monitor sickness absence; compare performance with other providers; set targets to reduce these if they go above an acceptable level.

- Monitor staff turnover; compare performance with other providers; develop an action plan to improve performance if necessary.

- Assess the benefits of managing care and non-care staff in the same teams.

'What often stops people improving is not lack of ability but simply lack of knowledge: not knowing how others do things and how much better they could be.'
District Audit

Managing or reducing costs

Councils and other providers should:
- Consider consortium arrangements to share the cost of SVQ training and workplace assessment.

Councils should:
- Review the delivery of catering and cleaning services to their residential care homes, particularly where DSOs are involved. This should focus on both cost and quality, and the opportunity costs associated with having different management structures for care, kitchen and domestic staff working in the same home.

- Review the management structure within the home to maximise the number of front line care staff; ensure that adequate management controls remain in place.

- Share with other councils different approaches to service delivery which improve staffing levels within current resources, or achieve cost savings.

- Compare costs with other providers as a way of identifying areas to target for cost savings.

Being accountable

Councils and other providers should:
- Provide clear comprehensive information for prospective residents on the home and care provided.

- Make copies of inspection reports available to residents, families, and prospective residents.

- Provide each resident with a contract which clearly outline the resident's rights and responsibilities.

Councils should:
- Base their decisions on the local provision of residential and nursing home care on sound information on the quality and cost of providers. These decisions should be open to public scrutiny.

Health boards should:
- Provide councils with copies of all nursing home inspection reports.

- Make copies of nursing home inspection reports available to the public.

Appendix 1

Profile of the homes

We have collected comparative information from 39 residential care and nursing homes across Scotland (exhibit 1).

Exhibit 1: Homes by sector

Type of home	Number of homes
Private nursing homes	7
Private residential care homes	5
Voluntary sector residential care homes	6
Council sector residential care homes	21

These homes represent a broad range of residential and nursing home facilities. They vary in size from a 12-place council sector residential care home for people with dementia through to a 61-place nursing home (exhibit 2). A few are dedicated homes for people with dementia or have small self-contained dementia units within the home. Some are converted from large private dwellings; others are purpose built residential and nursing homes from the 1960s through to the present day.

Exhibit 2: Size and type of homes
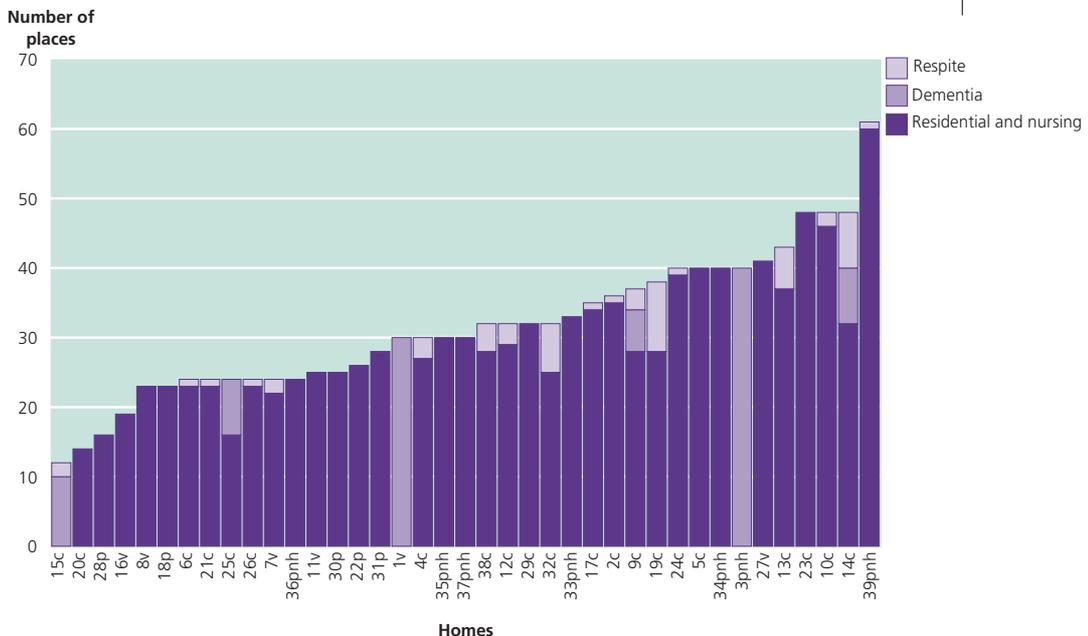
Most of the council homes and some of the voluntary and private sector homes run a range of services from the home including respite, day care, meals on wheels and other community support services. Issues relating to the cost of these additional services is discussed in more detail in the data collection handbook.

Appendix 2

Profile of residents

At the time of our visits 79% of the residents in the homes were women. Fifty one percent were over 85 years of age.

Exhibit 3: Age of residents

	(n)	Percentage
Under 65	19	2
66 to 75	87	8
76 to 85	425	39
86 to 95	494	45
96 and over	62	6

There are many approaches to measuring dependency. All have some limitations but the most important point to make is that whatever dependency scale is used, it should be consistently and regularly used. We have used Scottish Care Resource Utilisation Groups (SCRUGs) as developed by the Information and Statistics Division of the NHS in Scotland. This measure has eight levels of dependency ranging from 'A', representing the least dependent through to 'H', which represents the most dependent. Using this measure shows that whilst nursing homes tend to have the largest proportion of highly dependent people, some residential care homes also have large proportions of people with complex care needs.

Exhibit 4: Dependency levels of residents
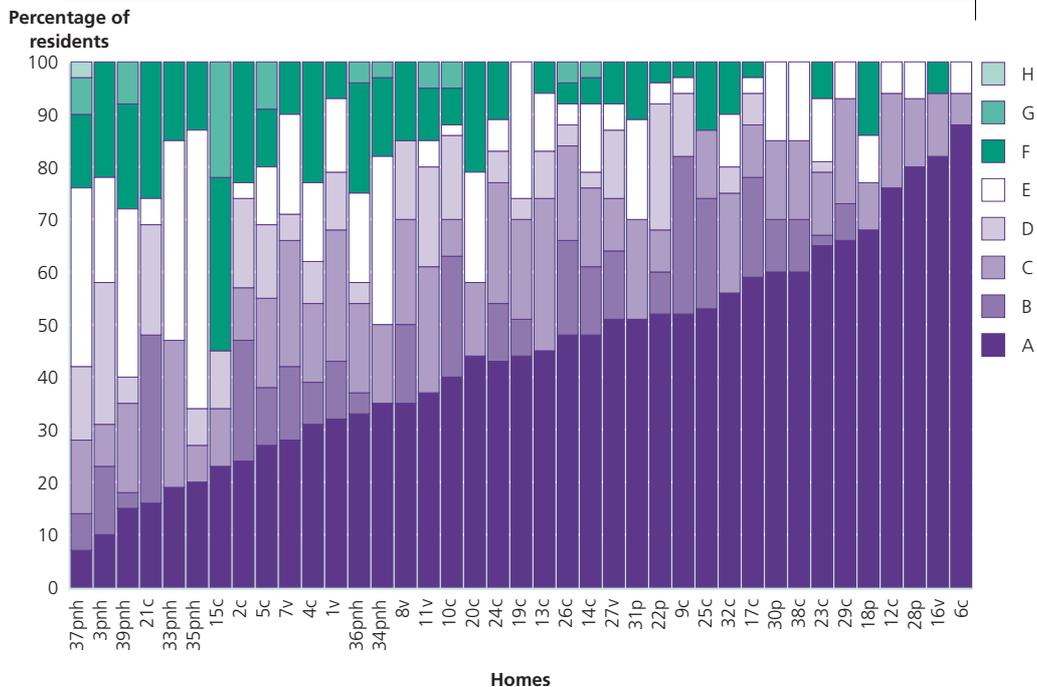
Source: Scottish Care Resource Utilisation Groups, ISD, 1998.

We have used two underlying variables from SCRUGs in this report:

- the proportion of residents who need assistance moving location
- the proportion of residents whose behaviour may need intervention from a member of staff.

Appendix 3

Study methodology

From each of the homes we requested quantitative and contextual information in advance of a visit from members of the project team. This included information on:

- type and size of home, including the range of other services provided from the home
- age and gender profile of residents
- staffing
- inspection reports
- cost of the service.

Costing information is as supplied by homes in the study. Although efforts were made to ensure the amounts were reasonable, the figures given are unaudited.

This was followed by home visits, which involved:

- a tour of the home and observation of routines
- structured interviews with residents (in the residential care homes) and relatives (in the nursing homes)
- a semi-structured interview with the home manager
- a questionnaire designed to review management and care practices[35]
- a review of the staffing rota
- an examination of care planning
- a survey of the dependency of current residents.

Approximately a third of residents (318) were interviewed in the residential care homes, with a smaller proportion of relatives (47) interviewed in the nursing homes. We interviewed both residents and relatives to test that our survey methodology worked for both sets of respondents. The survey did not weight for residents' expectations. It was designed to provide practical information about the things which would improve residents' quality of life.

Appendix 4

Table of performance indicators

The best measure of service quality is users' perceptions. The quantitative staffing indicators are proxy measures for quality only. Some of the quality indicators may have cost implications but are not cost indicators in themselves; for example, the provision of single, en suite rooms.

Performance indicators	Type of indicator
Staffing	
Ratio of WTE care staff to residents (staff establishment; at 8.30 am, 4.30 pm, 1am)	quality
Percentage of staff working less than 20 hours per week	quality
Percentage sickness absence - managers	quality
Percentage sickness absence - care staff	quality
Percentage of staff turnover	quality
Number of staff studying for, or with, relevant qualifications	quality
Percentage of residents always called by their preferred name	quality
Percentage of residents who describe staff as 'excellent' or 'good'	quality
Percentage of residents who are very satisfied with the time staff spend with them	quality
Service quality	
Comprehensive and user friendly brochures and contracts available to all clients	quality
Each resident has a *known* key worker	quality
Care plans include all elements of good practice	quality
Care plans actively reviewed and up-dated	quality
Residents exercise choice in: • daily routines • the furnishing of their own rooms • use of grounds	quality
Residents' privacy respected in practice	quality

Percentage residents who attend local clubs, societies or attend the church of their choice	quality
Percentage residents satisfied with trips or excursions	quality
Availability of tea/coffee making facilities for residents and visitors	quality
Percentage residents satisfied with meals	quality
Percentage residents satisfied with activities	quality
Quality of environment	
Percentage residents with single rooms	quality
Percentage residents satisfied with their room	quality
Percentage residents with en suite facilities	quality
Percentage residents satisfied with communal areas	quality
Percentage residents satisfied with access to garden and grounds	quality
Percentage residents satisfaction with home overall	quality
Service costs	
Weekly running cost per resident	cost
Annual care staff costs per resident	cost
Weekly catering costs per resident	cost
Weekly cleaning costs per resident	cost
Weekly energy costs per resident	cost

Appendix 5

Members of the advisory group

Ian Baillie	Director of Social Work, Church of Scotland Board of Social Responsibility
Rosemary Bland	Social Work Services Inspectorate, The Scottish Office
Douglas Boynton	Head of Social Work (Central), Aberdeenshire Council
David Bruce	Social Work Services Group, The Scottish Office
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Colin Cowie	Chairman, Scottish Council for Independent Care
Sandra Greer	Head of Community Care, Argyll and Bute Council
George Hunter	Head of Community Care, East Renfrewshire Council
Alexis Jay	Head of Social Work Services, North Lanarkshire Council
Bill King	Social Work Area Manager, City of Edinburgh Council
Robert Peat	Director of Strategic Planning, Commissioning and Criminal Justice, Angus Council
Andrew Reid	Chair, Community Care Standing Committee, Association of Directors of Social Work (ADSW)
Vivien Reynolds	Director, Abbeyfield Edinburgh Society Ltd.
Robert Samuel	Nursing Officer, Department of Health, The Scottish Office
Dorothy Sutherland	Board Member, Age Concern

Members of a finance sub-group also provided help and advice. These were:

Monica Boyle	Convener, Finance Officers' Task Group, ADSW
Paul Douglas	Support Services Manager, Aberdeenshire Social Work
Les Hutchinson	Head of Finance, IT and Human Resources, Angus Council
Robert Nelson	Management Accountant, Church of Scotland Board of Social Responsibility

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[1] CiPFA, Statistical Information Service: *Personal social services statistics,* 1996-97 actuals.

[2] General Register Office for Scotland, 1996 based projections, quoted in Scottish Office: *Community care, Scotland, 1997.*

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[6] The Scottish Office: *Community care, Scotland, 1997*

[7] Laing and Buisson are specialist consultants in the care homes market.

[8] CPA: *Home Life,* 1984. Burton: *Managing residential care,* 1998. Residential Forum: *Managing a home from home,* 1997.

[9] The Scottish Office: *Modernising community care: an action plan,* 1998.

[10] Office of National Statistics: *Labour market trends,* November 1998.

[11] ibid.

[12] Accounts Commission's handbook *Managing people* provides practical guidance on managing absenteeism.

[13] Audit Commission's bulletin on turnover in the NHS - *Finders, keepers: the management of staff turnover in NHS trusts* - may be of particular interest to the nursing home sector. Further detailed guidance on monitoring staff turnover can be found in the Accounts Commission's handbook *Managing people*

[14] The Accounts Commission collects performance indicators on qualifications for residential care. The qualifications have been agreed as appropriate by the Association of Directors of Social Work and the Central Council for Education and Training in Social Work.

[15] Residential Forum: *Training for social care,* 1998.

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[17] OFT: *Older people as consumers in care homes,* 1998.

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[23] Booth: *Home truths,* 1995.

[24] ibid

[25] This is in line with the Accounts Commission's performance indicators for Social Work published February 1999.

[26] These issues are examined in more depth in the data collection handbook.

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