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A consultation on the accreditation of residential care homes, nursing homes and mental nursing homes

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King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment and direct grants.

A CONSULTATION ON THE

ACCREDITATION OF RESIDENTIAL CARE HOMES, NURSING HOMES AND MENTAL NURSING HOMES

A report of, and commentary upon, a conference held at the King's Fund College on 25 January 1985

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FOREWORD

It is recorded of Abraham that, receiving a call, 'he went forth knowing not whither he went' (Hebrews 11 verse 8). So with those of us in the Fund who suddenly found ourselves launched on an exploration that led to the Consultation from which this Project Paper derives.

It will be clear enough that no more than Abraham have we reached any Promised Land. Indeed one of the most challenging features of this Paper is its agenda for future action, and that not just for the Fund but for everyone else with similar concerns.

That we got as far as we did is cause for congratulation and gratitude to those friends of the Fund we were fortunate enough to enlist as fellow travellers on this occasion. Their expertise and abilities are obvious enough in what follows. They were brought to bear so effectively only because, from lives that don't have enough of it, time was so generously made available.

Even so, without Dr Higgins' skills as rapporteur and analyst, we might well have thought ourselves some way from the landmarks she has here described. It is not just that the content and flavour of the occasion have been so accurately recalled. As well, and more importantly, the salient points of a long day's discussion have been identified and then collected into a coherence largely unrecognised at the time by the participants. Whatever guiding light the Consultation offers through a tangled field derives from the focus she has given it.

The field is one in which the particularly vulnerable members of society may be at risk, in which their anxieties and bewilderment as well as their material welfare need enlightened attention. It will be in keeping with the spirit of the Consultation if those who read this Project Paper will, by comment and suggestion, help the Fund to see where next it might most helpfully move.

William Spray
Grants Secretary

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1 INTRODUCTION

The one-day conference on accreditation of residential care homes, nursing homes and mental nursing homes held on 25 January 1985 took place within the context of three related developments.

First, there was the wide-ranging debate about standard-setting and the measurement of quality in public services. Second, there were the more specific concerns about standards of care in residential accommodation for the elderly and, third, there was the passage of the Registered Homes Act 1984 which came into force on 1 January 1985.

The first debate, about quality, has a long history. It is concerned with a whole range of issues from the protection of the consumers of health and social services to a utilitarian interest in 'value for money'. The concern to secure all that is best in public services for vulnerable people combines with a growing conviction that such services must demonstrate their cost-effectiveness. The actual measurement of quality has been the subject of considerable debate and, although a number of initiatives have been taken in this area, no easy solution to the problem of finding appropriate measures has emerged. As Klein and Hall observed in 1975:

> It is difficult enough to establish criteria of performance even in those public sectors (e.g. the state-owned industries) where it is possible to use seemingly precise yardsticks like return on capital invested. The difficulty is compounded in sectors such as the health and personal social services where it is impossible to encapsulate the objectives in simple concepts like the supply of utility or the maximisation of profit. The promotion of health or welfare is much too vague to be useful as a touchstone for actual administration. (p11)[1]

Nevertheless other countries, notably America, have sought, and – to a degree – found, measures of quality which have been made operational. The Joint Commission on the Accreditation of Hospitals (JCAH), for example, has devised a manual for hospitals which sets out many thousands of criteria for judging not just the quantity but also the quality of services provided. The current manual, which runs to 226 pages, lays down carefully defined guidelines for good practice but it expects hospitals to devise their own ways of reaching desired ends. In recent years the JCAH model has moved from a concentration upon process to looking at outcomes and allows individual hospitals a good deal of room for flexibility and innovation.[2]

An experiment in Britain, testing out the JCAH model in two health districts

(Basingstoke and Havering), demonstrated that valuable lessons in quality measurement and control could be learned from the American experience.[3] The study showed that there was considerable interest, within the health service, in defining and seeking quality. Many staff were eager to know how well they were doing relative to others and in relation to objective criteria. There were great variations in quality of care (with standards sometimes falling below those regarded as a minimum level in the United States) and also great variations in existing quality measurement systems. While many staff could say what criteria they would use to judge other departments they were unable to analyse quality conceptually. The researchers recommended that any accreditation system in Britain should have a number of features:

1 it should be voluntary but could be run on a self-funding basis by charging the participating hospitals for inspections;

2 surveys should be comprehensive and should look at the overall impact of services in a district;

3 survey teams should be multidisciplinary and their activities should be based on the principle of peer review;

4 survey methods, approaches and standards should be stated openly for public scrutiny and challenge.

Despite the undeniable problems involved in identifying and applying measures of quality, some progress has been made in recent years (particularly within certain professional groups in the public services) and a more fruitful debate is evolving.

The second aspect of the discussion centres upon the growing concern for the protection of elderly people living in residential homes. It is part of an increasing awareness of the vulnerability and possible abuse and exploitation of dependent people in institutional settings.[4] The current debate has been fuelled by specific incidents involving cruelty or neglect, which have attracted public attention, and by the rapid increase in the number of private rest homes (and, to a lesser degree, private nursing homes) since the late 1970s.

In 1984 the working party which had been set up by the DHSS to establish guidelines for good practice in residential care published its report, *Home Life: a code of practice for residential care*.[5] Apart from offering detailed guidance to proprietors, registration staff and others on such things as record-keeping, staffing, catering and physical surroundings, the report also emphasises the need to preserve the basic rights of all residents. As the chairman notes in her introduction:

> Concepts such as privacy, autonomy, individuality, esteem, choice and responsible risk-taking provide the foundations and reference points for good practice, and observance of these concepts in all possible circumstances is, in itself, good practice. (p10)

Although the report relates to very different types of homes, including homes for the mentally ill and mentally handicapped, children's homes, homes for the elderly and for those receiving treatment for alcohol and drug abuse, the working party is emphatic that these basic rights should be 'accorded to all who find themselves in the care of others' (p15). Throughout the report the emphasis is upon optimum levels of care rather than upon establishing minimum acceptable levels. *Home Life* combines a concern with abstract, qualitative concepts such as 'dignity' and 'fulfilment' with clear guidance (and a checklist) on the measures which must be taken in any home to ensure that those goals are realised.

The analogous document on the registration and inspection of nursing homes, produced by the National Association of Health Authorities early in 1985, contained a good deal more detail about physical standards, staffing ratios, fire precautions and so on.[6] However, as a number of conference participants commented, it had relatively little to say about issues of quality. It does note that:

> Patients should live in comfortable, clean and safe surroundings and be treated with respect and sensitivity to their individual needs and abilities. (p48)

and also that:

> . . .patients in nursing homes should be treated well; should live in decent conditions; should be encouraged to be as independent as possible and should have their self-respect preserved. (p49)

Despite their inevitable shortcomings, these two documents have gone further than before in identifying those areas of life which, in residential settings, are most at risk and in establishing guidelines for good practice, measures of quality and objective criteria against which performance and outcome can be assessed.

The third important development was the passage of the Registered Homes Act 1984. It consolidated (or repealed) earlier legislation relating to rest homes and nursing homes and contained a number of new provisions which are likely to have a significant impact upon health authorities and local authorities who are currently responsible for the registration and inspection of such homes.

One of the main changes in the legislation has been the provision for 'dual registration' of institutions as both residential care homes and nursing homes.

This change is intended to allow a wide range of care to be offered in a single establishment and to ensure that a resident whose condition improves (or deteriorates) will not need to move from one home to another. Although it reflects a recognition that residents of both types of home share many characteristics and may not be appropriately placed, it is likely to give rise to considerable problems of implementation, especially in the distinction which is to be drawn between 'personal care' and 'nursing care'.[7]

A second change in the law exhorts registration authorities to take a much more vigorous approach than previously to rooting out unregistered homes. Health authorities are instructed to institute special programmes of inspection for premises suspected of operating as nursing homes and are required to maintain a 'continuing search' in their district for unregistered homes. A national list of people whose registration has been cancelled is to be established and it is hoped that this will go some way towards preventing unsuitable proprietors from opening new homes in different areas.

Finally, registered homes tribunals have been established under the 1984 Act to hear appeals against cancellation of registration. Cases were previously heard in Magistrates' Courts.

The new legislation is an important attempt to improve registration and inspection procedures in residential care and to eliminate anomalies in the rest home and nursing home sectors. It is designed to eradicate unsatisfactory practices and to identify unsuitable proprietors. As the Minister of Health, Kenneth Clarke, commented recently:

> There is no room for cowboys in the field of health and nursing care.[8]

Nevertheless, it leaves many problems (especially problems of definition and implementation) unresolved and the King's Fund seminar on accreditation, discussed in this paper, was a timely initiative.

The origins of the seminar lay in discussions between William Spray (Grants Secretary, King's Fund), Dr Donald Dick (Consultant Psychiatrist, formerly Director of the Health Advisory Service) and Professor Malcolm Johnson. Donald Dick prepared a paper (Appendix A, page 51) on the accreditation of nursing homes and residential homes for the elderly in which he outlined four tasks which would precede the establishment of a national accreditation system:

1 It would be necessary to write the criteria for provision and make them public so that any home applying for accreditation would be aware of the requirements which were to be met.

2 General principles for judging the quality of life in homes (using concepts such as dignity, privacy and self-determination) would need to be set out.

3 It was necessary to test some of these ideas about accreditation in a pilot project.

4 If these early stages proved fruitful, the possibility of developing a national organisation should be explored.

The consultation on accrediation, then, was a response to some of these ideas and a first attempt to bring together a group of people whose experience and expertise could be valuable in evaluating proposals for an accreditation system.

In a paper circulated prior to the meeting, William Spray (the Chairman) set out the terms of reference of the group and some of the issues which required consideration.

As well as looking at private and voluntary residential care homes, nursing homes and mental nursing homes, other areas of provision – sheltered housing, statutory services and alternatives to residential care – would need to be examined.

Two crucial requirements would have to be met for any effective monitoring of quality of care: the establishment of standards which would be accepted as nationally valid and information to consumers about how particular homes rated against the standards.

A number of models for accreditation seemed to be available. One was the Automobile Association or Egon Ronay approach where stars could be awarded to a home for its level of physical provision, and rosettes for the quality of life it offered. Second, there was Donald Dick's idea of a national system of inspection with assessment made by an independent inspectorate. Third, there was the possibility of a system which would be run by local agencies and, fourth, informed consumers might judge for themselves the quality of services offered in any particular home. Consumers would need guidance on the kind of criteria they might use and a manual which gave advice on selecting homes in different areas, finding the right type of home and a checklist of points to look for during an exploratory visit. Registration authorities might provide factual information about the homes in their area and CHCs might be encouraged to seek out consumer reports and more subjective assessments of the facilities available.

2 CONFERENCE PROCEEDINGS

William Spray (Chairman) began by outlining the aims of the seminar. These were to assess the need for an agreed strategy on accreditation, to consider the form it should take, to define its first moves, to determine whether there was a role for the Fund in this process and, if so, what it was. He emphasised that it was to be essentially a 'brain-storming' session with no formal papers.

Session 1 Is there a problem?

Rudolf Klein opened the proceedings by suggesting that we ask not 'What are the problems?' but 'Are there any problems?'. He was not convinced that they were self-evident and such information as we had about private sector homes seemed to indicate reasonable standards of care. The research conducted by the Personal Social Services Research Unit (University of Kent) and by the University of Bath had reached similar conclusions – that there was a small number of excellent homes (around 10 per cent) which were better than anything provided in the public sector, that there were many homes (as many as 70-80 per cent of the total) which had quite acceptable standards and only relatively few (around 10 per cent where there were serious problems. A disproportionate number of these were in the voluntary sector where management skills and capital for improvement of facilities seemed to be lacking. There was little evidence that the problems resulted from 'cowboy profiteering'. He added, however, that the research had been completed some years previously and that recent developments may have changed the picture. The numbers of residential care homes and nursing homes had increased at different rates. There had been a rise of 10 per cent in the past two years in the latter case and it appeared that these changes were containable within the existing machinery of inspection. However, the introduction of dual legislation was likely to create growing pressures upon inspection staff, and health authorities would need to consider investing more resources in their inspectorates. It may be that the key issue is not the question of standards overall but of how to ensure high standards amongst new entrants to the private sector.

As far as health authorities themselves were concerned, the Bath research seemed to suggest that although many of those interviewed felt that the income from registration fees was derisory they, nevertheless, had an interest in making the system work because of the savings realised from relief of pressure on the public sector.

In looking at accreditation a number of questions seemed to present themselves:

1 Are we concerned about the general level of *standards* or about local variations in the national pattern? Are we really saying that documents, such as the NAHA guidelines or *Home Life*, are not sufficient in terms of defining national standards, or are we really concerned about the *implementation* of regulations and whether local authorities and health authorities are equal to the task? We also need to be clear whether we are talking about accreditation of registration authorities or accreditation of homes themselves.

2 Is accreditation primarily about *information to consumers ?* If so, who are the consumers and are they the kind of people who could make use of an Egon Ronay type of guide? We need to consider whether we are in a market situation where consumers need detailed information if the market is to work properly or whether we are talking about a situation in which market principles cannot apply because consumers are in no position to make use of information about competing suppliers, even if it is made available to them.

It had become clear from the research undertaken at Bath, that registration authorities did not see their role as providing information to consumers. Some were able to produce lists of names and addresses but few could quote weekly fees. In that sense, the existing registration system had its weaknesses.

An added dimension to the problem involved looking at 'value for money' issues. In the market model we might argue that consumers themselves should be allowed to make their own trade-offs between quality of care and charges. Some might be happy to settle for rather spartan conditions if weekly rates were low. On the other hand we might argue that this is an area of provision where consumers (because of their vulnerability and the nature of the product they are purchasing) require special protection. There may be standards we regard as unacceptably low however modest the charges.

3 Is the primary purpose of accreditation the *protection of the public purse ?* The recent flow of social security payments into the private sector had brought this question to the fore and, although limits had now been set to the level of payments permitted, an issue of principle still remained. Did the Treasury know that it was getting value for money and could it ensure that it did? Was it a function of an accreditation system to fulfill that role in any sense?

As far as the protection of the public purse was concerned it was necessary to ensure both that the charges were reasonable in terms of what was provided and that the appropriate people were receiving support.

A number of other questions remained. First, we need to consider whether any

system of accreditation would be confined to the private sector alone or whether we might envisage a mechanism which looked at both public and private homes. The fact that there may be as many problems in the former as in the latter indicated that there could be some logic in this suggestion. It would also make sense to have a single agency, possibly the DHSS, responsible for all accreditation. The task, however, would be enormous, with as many as 4,000 private homes at the present time, and with a possible annual growth rate of 5-10 per cent. Whether one went for a national or a local pattern the problems of scale would be considerable. The danger would be that an all-inclusive and unselective approach would lead to mechanistic and crude measures. As an analogy, the Automobile Association Guide might tell you whether your room will have a television but not whether there is dust on the floor. Square footage of space and the number of TV sets are easy to measure but qualitative issues, such as whether the cooking is any good, are much more difficult.

American experience tends to suggest that accreditation only works there because the size of institutions is larger – often very much larger – than our own. The system of accreditation, in its widese sense, in America may indeed have produced a movement towards larger institutions.

Second, it is important to consider the possible effects of accreditation. Will the outcome necessarily be higher standards? Would accreditation lead to an emphasis upon inputs and upon measuring standards in terms of those inputs? It is much easier for large institutions and organisations to meet these requirements and easier still for Trust House Forte type organisations (that is, 'chains') to produce the kind of standardisation which may be implicit in setting standards in this way. The measures used may, effectively, alter the system radically. That may not be undesirable.

Finally, it is necessary to look at the economics of the present system. The Bath research concluded that the economics of nursing homes depend precisely upon the smallness of the scale and the involvement of owner/proprietors. This is a classic instance not of exploitation of the customer but of the 'self-exploitation' of the owners – not because they are saintly people but because the autonomy offered by working on one's own is particularly attractive. They are prepared to put in longer hours and so on than managers would be.

In looking at accreditation, **Klein** concluded, these were the points which should be taken into account.

Discussion

A discussion followed which ranged widely across the issues **Rudolf Klein** had raised.

Dianne Willcocks began by defining the nature of the problem of private homes as she saw it. Her recently completed study in Norfolk suggested that there were perhaps three dimensions to the problem. First, it appeared that the notion of greater *consumer choice* in the private sector was not borne out, and potential residents were not shopping around a great deal before selecting a home. Only 28 per cent of her sample had actually visited their home before becoming a resident there and 25 per cent of the sample had a choice between only two homes. The situation in the private sector appeared to be similar to that in the public sector and there did not seem to be a significant opening up of choice.

Second, there was evidence of considerable *exploitation of staff* in the private sector. Nine out of ten homes did not offer contracts of employment, people were often on call for very long periods and the system of payment for staff on call was unclear. People were called in from around the corner with no advance warning and often worked long hours for low rates of pay. Similarly, systems of remuneration for overtime were unsatisfactory and staff who actually lived on the premises sometimes got no more than 'pocket money'.

Third, the *level of physical provision* in the homes was a critical factor. Stair lifts were not liked by staff and residents and did not seem to be adequate for the more frail people. Ten per cent of the residents in the sample were marooned on an upper floor and could not get downstairs.

Another problem was the fact that it was the number of bedrooms provided in a home which brought in the income. In many homes, in consequence, there was very little public space – in dining rooms, lounges, and so on. Some of the more progressive proprietors had begun to extend the public space because they recognised that it lifted the whole tone of a home. In general, however, the private sector compared unfavourably with the public sector in this respect.

A number of participants were interested in the notion of an *independent and local inspectorate.*

Sheila Millington commented that the DHSS had already considered this question and found that some groups, notably Age Concern, favoured an independent inspectorate. Most, however, opposed the proposal because they were concerned about who would pay for it and also because they believed that local authorities already had sufficient expertise to inspect the private sector.

Colin Godber, while agreeing that local knowledge was valuable, also saw the need for a central validating inspectorate. There were many problems in a local body vetting standards for the private sector, especially where the authority involved might have to house residents of private homes which were closed down.

In any future scheme it would be important to look at standards in the public sector (which were often low) as well as those in the private sector and to consider the establishment of an independent group to look at methods of inspection around the country.

Other speakers emphasised that the collection of detailed information on homes and regular and effective visits of inspection could only be done at the local level. A local inspectorate could respond more quickly and flexibly to changing conditions. The volume of information required about homes and the fact that it could change from year to year meant that only a local inspectorate could expect to maintain accurate records.

Joan Higgins felt it was important to recognise that whether or not an inspectorate was *independent* of health authorities and local authorities and whether or not it was a *local* inspectorate were two different issues. There were certain conflicts of interest in having existing local agencies acting as inspectors, especially in the private acute sector of health care, where health authorities lost significant incomes with the development of competing private facilities. There appeared to be a case for an inspectorate which had a local (or, preferably, regional) base but which was independent of existing district health authorities and local authorities.

Peter Millard pointed out that groups in the private sector were also concerned about standards of care and that some of the most important constraints were self-imposed. The Registered Rest Homes Association and the Registered Nursing Home Association were involved in *self-policing* and in monitoring the care offered by their members.

Robert Bessell suggested that a *registration fee* of £12 per place per year be set. This sum, he said, would be a reasonable figure which would not bankrupt any private residential organisation and would allow the operation to be self-financing. The fee suggested by the DHSS of £10 per home was far too low. However, his main interest was in looking at *reasons for the growth of the private sector.* Although present Government policy had accelerated this development it was not its primary cause. The key factor, he claimed, had been changes in the economic circumstances of elderly people. These had been in two main areas – in the growth of their capital assets and in the increasing availability of second pensions. The capital assets of the elderly are now 'phenomenal', he argued. Owner-occupancy unencumbered by mortgage is now well over 50 per cent and growing fast. The large amount of capital in the hands of elderly people (often representing the major capital asset of the family as a whole) was the principal engine of

change. Families were often eager to retain these assets and might be inclined to steer their elderly relations towards hospital care because it was free rather than towards the private sector because it was expensive.

Peter Millard touched upon a number of matters of concern. His department, he explained, had been inspected by John Cornelius-Reid of the Registered Nursing Home Association and it had been clear that the standards being set in the private sector were considerably higher than those currently being set for the public sector.

The real question, however, was *whether public money was being spent in the right way.* Was the cheap option of warehousing people in old institutions an appropriate one? Was it right to use public money to subsidise the private sector through social security payments when there was no effective rationing procedure and when there was no way of measuring or ensuring good standards of care? Accreditation would not necessarily solve these problems and 'if it was a stone thrown upon the ground it would miss'! Rather than focus upon accreditation, he concluded, we should consider the alternative of employing people, making them responsible and training them. Higher standards were more likely to be achieved through *training staff* than through a system of accreditation and inspection.

Colin Godber agreed that we must look at the use of public money and we should be thinking about what are the *'best buys'* in terms of residential care and extra care in homes for people of different levels of disability. It was crucial to invest resources in assessing the needs of people before they went into residential care. At the present time, insufficient attention was being given to planning for different sorts of requirements. Options other than residential care should also be considered. The current system of Government subsidies was anomalous because it would support low-income individuals in institutions but would not contribute to their support if they stayed at home and received full-time assistance.

Within the residential care sector there were homes providing very different standards of care which were all subsidised at the same rate. Some catered for very demented people and gave good value for money while others had a very low threshhold of tolerance and either pushed people out or refused to accept residents with any degree of disability.

He felt strongly that there should be both *better assessment of need* at the outset and better information about the range of care available. Homes should indicate not just the number of rooms and choice of menu available but also what kind of disability and impairment they were prepared to tolerate.

William Spray reinforced these points, commenting that Professor Elaine Murphy had recently claimed that millions of pounds were being wasted by

sending people into residential homes without assessing them properly.

Richard Clough raised the question of whether we were concerned with the accreditation of *people or buildings*? The present requirements, in terms of the qualifications of nursing home staff and residential care staff, were quite different and the first priority should be the accreditation of people. Although a national accreditation system, employing broader criteria, was desirable it would involve many practical difficulties and was unlikely to be workable in the immediate future.

Linda Challis made two observations which were central to the discussion. First, that we needed to be clear about the *distinction between registration and inspection and accreditation* and, second, that the debate hinged upon the kind of *information to be made available to consumers.*

In her view accreditation would be unnecessary if the codes of practice were part of the system of registration and inspection and if they were put into practice effectively.

Donald Dick took up the point about the distinction to be made between these activities and suggested that, while registration and inspection were necessary and mandatory, accreditation was voluntary in nature and would be sought by private homes wishing to demonstrate their excellence. It was important that accreditation be seen as a voluntary activity because of the effect on standards of care. Where standards were imposed from without there was a tendency for institutions to aim for minimum levels; but where the urge for quality came from within there was a movement towards optimum levels (especially where homes were paying for formal recognition). Accreditation was not just a means of attracting custom but reflected a concern for quality and a pride in meeting high standards.

The discussion moved on to the second question, concerning the kinds of information which should be given to consumers. **Linda Challis** made three observations:

1 Information was a very important part of the equation. Good information was a way of squeezing out poor performers and poor providers. Information of a general kind, which would look at the problems involved in giving up one's home and moving into care, was necessary. **Dianne Willcocks** commented that the College of Health had recently published such a guide and she, herself, was writing one entitled *Living in Homes*, which was to be published by the British Association of Service to the Elderly. It looked at questions such as 'Will I have a choice?', 'Can I view several homes?', 'If I do not settle down can I leave?', 'What can I take with me?', and 'What kind of room will I have?'. It was

increasingly important that consumers should have access to information of this kind.

2 There was also a need for information of a specific kind relating to individual homes. The University of Bath was helping to devise a set of guidelines which could be used by homes in their brochures. A standardised format would be helpful to enable consumers to make comparisons between different institutions.

3 Information was important if consumers were to judge whether they were getting value for money. They needed to have some idea of what to expect from a home, and any promotional material ought to include a statement about the objectives of the establishment.

Colin Godber commented that, in his experience as a psychogeriatrician, it was very rare that his particular clients were in a position to make any decision about what sort of home they required. The kind of person who could cope with brochures and guides did not really need to be in a home!

Robert Maxwell, summarising the debate, suggested that *five problems or needs* had been identified:

1 The first arose when people were contemplating going into a home. There was the question of *choice.* Did they have a choice? Should they be helped to make the right choice? At this stage the relatives may be very involved and their motives may not always be entirely unselfish. As Malcolm Johnson had once commented 'Where there's a will there are relatives' !

2 The second was the prevention of *exploitation and abuse* of residents in both private and public sector homes and hospitals. This may involve only a small number of residents in a small number of homes but we would be deluding ourselves if we thought there would be none. There would be some cases about which we would be grossly disturbed.

3 Third (and a related point), we should pay particular attention to the *protection* of the very sick, the very frail, the very demented and the very handicapped. It was appalling that so many homes would not provide for them and a matter of great concern that they might seek to move on the very dependent as their condition deteriorated.

4 The fourth was the encouragement of *aspiration and self-learning.* It was important to prevent the isolation of staff in public and private sector homes and to help them question existing assumptions about standards of care.

5 Finally, the public sector needed to have *information about 'best buys'.* Prices in the private sector varied fantastically but this was more often related to

the way the homes were run and when they were acquired than to the type of care offered to residents.

Commenting on these five points **Peter Millard** argued that choice did not really exist unless residents were prepared to wait.

The prevention of exploitation and abuse within the hospital service and the private sector was the greatest worry. In the previous two months he had sent three patients to the coroner and patients were coming back to hospital from private homes in a very poor condition. Patients were being rejected by homes when they could no longer cope with them. The standard of medical supervision was frequently inadequate. The general practitioner often had neither the education nor the knowledge to cope with the intricate problems of chronic disabilities of patients in homes.

There was a problem in dealing with poor homes. Organisations concerned with monitoring standards did exist. GRACE (Mrs Gould's Residential Advisory Centre for the Elderly) gave advice on private homes in the south of England and provided information on costs and value for money. Those homes which did not meet the standards were blacklisted. Nevertheless, people still moved into them and they remained open. Health and local authorities were reluctant to close them down because they would be responsible for rehousing the residents. At the end of the day, however, only the health service (and the state system generally) could really protect the severely disabled, the very frail and isolated and demented people without families.

Rudolf Klein concluded the first session by summarising some of the points which had been raised.

He doubted whether a voluntary system of accreditation would really deal with the problem of standards – if, indeed, it was a problem. Would it not have the effect of widening the gulf between the best (who would seek accreditation) and the worst (who would do their best to avoid it)? There was no guarantee that it would do anything to resolve the problems of individuals.

Whether or not accreditation was a successful device might be determined by the social and economic context within which it was operating. It could work best in a truly competitive market where the unsuccessful homes went bankrupt.

One factor stressed by a number of speakers had been that it was no one's job to ensure value for money, either on behalf of individual consumers or on behalf of the Treasury. It was important to ask whether accreditation was a suitable means of tackling the value for money issue.

The question of scale must be borne in mind. With around 1,000 nursing homes and 3,000 residential care homes, it was necessary to look at practical

issues such as the frequency of visits an inspectorate could reasonably make. The Bath research suggested that the present localised system worked extremely well, when it did work, because it was relatively flexible and when a problem home was encountered it was possible to make repeated visits. This was valuable in dealing with the question of isolation which was discussed earlier. It would be helpful to know how the Health Advisory Service had dealt with problems of scale and how effectively its work had been integrated into that of the existing institutional structures of the health service. The final question was how any system of accreditation would link in to current registration and inspection procedures. Would accreditation be mere top-dressing or would it be part of an integrated whole?

Session 2 Methods of accreditation

Donald Dick: 'A national approach'

The need for an accreditation system, set within a national context, arises from a concern for the protection of vulnerable people. The last few years of life are clearly of immense importance to individuals and their families and we need to look at the situation of the frail and elderly and their period of dying. For many of those involved, including workers in the health and social services, it means a juggling act between the range of resources available in the community. The real question is: which parts of the system do we feel safe about?

Hospitals tend to exclude people who do not need what they are providing while homes tend to exclude people whose needs they cannot meet. The distinction is between the hospital which says 'This person does not need to be here, therefore he/she must go', and the home which says 'We cannot meet this person's needs and therefore he/she must go'.

Many professionals are involved in discussions with other colleagues and with relatives about the correct balance of care in individual cases and about the appropriateness of one home as against another. They face the anxiety of sending people off to unknown places and worrying about the correctness of their decision. There is a great reliance upon local knowledge but more detailed information about homes outside the statutory system is clearly needed.

The introductory paper (Appendix A, page 51) was really concerned with this anxiety and how one might approach it. Should we have a very expensive accreditation system which meets the needs of 1,000 nursing homes and 3,000 residential homes? The Health Advisory Service, which is one model, has a seven-year cycle for visiting 1,400 hospitals, each with around 20 wards – amounting to a total of 28,000 different units. This involves a large number of visits in a

seven-year cycle and the cycle is probably far too long. HAS, however, has never had the resources to do anything more.

We need to ask what kind of national system might be reasonable. Self-rating is one option and one which is used in America by the Joint Commission on the Accreditation of Hospitals. This is a voluntary system and hospitals are expected, first of all, to rate themselves and then to offer themselves for external checking. The next step is to have some form of quality rating and published criteria against which institutions can be measured. Herein lies the distinction between registration and accreditation: registration deals with basic minimum standards which are measurable, such as the number of toilets and the amount of space available. It is concerned with inputs to the system. Accreditation, on the other hand, is essentially about quality and, as the Health Advisory Service found, there are considerable problems of measurement. Quality involves abstract concepts such as dignity and also involves questions of personal space and personal possessions. One asks whether all 36 patients in a ward share the same shaving brush and not whether the shaving brush is of a good quality.

If a method existed which would allow not only a check on resources for registration purposes but also some measure of their quality, many professionals would feel much happier about devising programmes for the vulnerable and those at risk.

The existing literature on quality control indulges in endless conceptualisation, but instead of theorising about quality one should go out and do it. The accreditation system in the United States, for example, began in 1918 when it became apparent that people in some hospitals did not know that it was necessary to wash their hands before entering an operating theatre. The result was that one of the first standards in 1918 was that every hospital, to be accredited, had to demonstrate that all staff washed their hands before they went into an operating theatre. In 1985, the ninth edition of the accreditation manual sets out very many more standards. It reflects the slow accumulation of what are, essentially, a whole set of practical measures. It seems preferable to aim for a voluntary system of accreditation where standards are gradually established over a period of time (and which are not expected to produce ideal outcomes immediately) than to engage in abstract theorising about the meaning of quality, its measurement and its outcome. The experience of other countries suggests that, in such accreditation systems, standards begin to rise because it becomes important to the hospital and nursing home to display their certificates of quality in the front hall.

The resolution of problems, however, must take place at the local level. Even where central or national standards exist it is not for external bodies to impose solutions.

Malcolm Johnson: 'A local approach'

At the present time, accreditation seems to be the cream on the cake and we probably need to be less ambitious. First, we must ensure that our existing registration and inspection procedures are adequate and that the standards of people who are registered are acceptable. There is a danger that accreditation would be like being a member of a club: once you are in you are all right and the opportunities to remove people from membership do not come along very often.

A number of issues seem to be relevant to the discussion:

1 One important question is whether regulatory agencies will be *tough or timid.* The tools they have can be used as blunt tools which they do not bring out very often or tools which are sharp because of frequent use.

Should inspection and regulation be a single agency matter or a multidisciplinary – or, rather, multi-agency – matter? There would be some virtue, both at local and regional level, in *bringing together* health authorities, social services departments, fire authorities and planning authorities, to undertake joint assessment. They could be paid through a joint funding mechanism but would remain accountable to their existing employers. It no longer seems appropriate for different agencies to engage separately in inspection, because the private sector is now spreading across a whole range of services. If we create an interim mechanism to deal with the problems as they were three or four years ago we shall have missed the boat.

It is very important to learn the lessons of *other countries,* such as America and Australia, where procedures were only tightened up when crises had occurred. Britain now has the opportunity to establish a workable system and must take note of problems elsewhere.

It is also necessary to consider whether inspectorates should be advisory or whether they should employ carrots and sticks. There is a choice between tough regulations firmly enforced, which may be problematic, and the encouragement of high standards within a nurturing relationship.

These points all relate to the public regulation of the private sector but we should not forget the voluntary sector where standards are not always as high as they should be.

2 The task facing public regulators has a number of dimensions.

a. First of all, it involves *clarification of the legislative package.* We now have (in addition to the Act) new regulations, a new code of practice and a new tribunal. What these will add up to is not at all clear. We could have a package of rules and approaches that will allow regulation of the private sector in a very effective way but it will require resources, skill and political commitment

as well as good management. Whether the public services could deliver that right across the country is a matter for discussion. Some authorities are making valiant attempts to do just that while others, before moving in, are sitting back to see what those on the firing line suffer.

b. Second, the question of registration staff arises. If the task is to be done well then *registration staff* have to be of a high quality. They must have experience of the kind of world in which they are operating because the private sector will not tolerate people who do not know anything about their business. They must be people with professional expertise who can command respect from those who are trying hard to provide good care – even if they do not always succeed. They should have seniority and recognition within their own organisation and should not simply be people who are out there doing the dirty work for the rest of us. They must be properly remunerated, not least because the private sector may wish to offer them inducements to behave improperly and unprofessionally. The prospect of corruption should not be ignored – we need only look at North America to see that it can and does exist.

Capital and revenue involvement in the private sector is vast. It runs into hundreds of millions of pounds. Registration staff will need training in business and law. Private care in Britain may be a cottage industry but we already see strong evidence of corporate bodies moving in with their own lawyers and advisers. Some of these people can run rings round local authorities and we must face that issue. Those local authorities who employ registration officers with workloads of more than 100 homes (as well as their other responsibilities) are clearly not taking the matter seriously.

c. An important aspect of the new package is the notion of the *'fit person'*. There are two kinds of 'fit person' under the legislation – a 'fit person' to own a home and a 'fit person' to be in charge of a home. The former presents few problems but we need to give a lot of thought to the suitability of persons running homes and having executive authority. Running a private home requires not only skill in social and nursing care but also skill in management and business. Such a package of skills is not asked of people in the public sector because the tasks are shared. Persons running a home in the private sector, therefore, require more skills and a wider range of aptitudes than those in the public sector. They are at the interface between social care and business.

d. Fourth, it will be necessary to examine the hostility to the private sector which is evident in the public sector. Some occupational groups have taken the view that they wish to have nothing to do with developments in private care but this attitude might be short-sighted and unwise. It is up to the leadership,

within nursing and other groups, to confront the issue and to encourage more constructive attitudes.

e. The question of training for private sector staff has already been discussed. It is clear that standards of care in some private sector homes can be extremely bad and if training is not given we can expect to see standards decline even further as the number of homes increases and conditions of employment deteriorate.

3 Another important question concerns the responsibility of the public sector for long-term care. Is the public sector willing and able to take on the private sector in the consumer market? Although consumers have a very limited choice of homes, this choice is increasing now because of the growth of private provision. Can local authorities and health authorities take on this challenge and offer consumers something which is as good as, or better than, that offered elsewhere? It remains to be seen whether the Government, which is putting money into both public and private care, is prepared to see fair competition or whether the scales will be tipped in favour of commercially provided care.

4 A fourth issue concerns the mechanism for public accountability. Being a consumer in this particular market is very difficult. There is a shortage of information and choices are not easy to make. The Oxfordshire Community Health Council produced a very useful guide to homes in their area and it may be that CHCs are the right mechanism for ensuring accountability. We need to ask whether they should be allowed to go into nursing homes and residential homes. There was some question about the role of local authorities in all this. Many of them maintained that they did not need the equivalent of CHCs because they were doing the job of consumer protection themselves. It may be necessary, however, to set up some other accreditation agency which could identify what is good and bad in each locality.

It is important to consider which professionals should intervene between the potential resident and his/her place of residence. There must be some concern about whether GPs, geriatricians, psychogeriatricians, social workers and others would actually carry out a proper diagnosis of the needs of people going into residential care or whether they would simply recommend homes which they happened to know of, and which might be all right. All our talk about quality and matching needs would be irrelevant if the professionals involved in placing people in homes were uncooperative and acted in a paternalistic manner.

Any move to tighten up registration and accreditation procedures may have the effect of increasing the number of unregistered premises. The DHSS has recently ruled that registration authorities should seek out unregistered homes

but that will require extra resources. Such homes will find all sorts of ways of evading inspection, and one of the undesirable consequences of the new system may be that more homes will try to avoid inspection and registration.

The growth of multi-service centres, which include residential homes, sheltered housing and shops on the same site, is important. There are places where health provision is being established in campus settings where people can get anything from long-term care to hairdressing.

It is essential to look at the management of public money. Around 40 per cent of people in residential homes now receive supplementary benefit. It may be that the best way of dealing with the current situation would be to give extra money to local authorities (perhaps through the Rate Support Grant) to provide care rather than putting money into the hands of individuals (through supplementary benefit) and thereby boosting the private sector. There is some doubt, however, whether local authorities could respond to such a change, and that is a real worry.

5 Finally, there is the role of the King's Fund in all this.

We need more information about the industry, its composition, its capital structure and its personnel. There is also a dearth of knowledge about the quality of care and about lengths of stay, transfer to other homes and so on, but the list goes on. . .

At this point the group broke for lunch. A number of participants had expressed interest in particular issues which were to be discussed over lunch:

Linda Challis (dual registration)

Robert Bessell (the accreditation of private sheltered housing)

Colin Godber (the assessment of need for Part III and long-stay hospital care)

Joan Higgins (the regulation of private acute health care)

Peter Millard (staff training in homes for the elderly)

Session 3 Some Answers

The aim of the third session was to identify some of the best answers to the problems that need tackling and to consider whether we were concerned with trying to affect what was happening as well as trying to assess it.

Ralph Chapman: 'The East Sussex experience'

In East Sussex the private sector and the voluntary sector outnumber the public sector by a factor of more than four to one. There are about 8,000 people in about 120 establishments and most of these establishments are small. A typical home would have 13 to 15 beds. In some senses the situation is unique and the problem is how to apply uniform criteria and standards to unique situations.

As a nation we do not have the skill and resources to deal with the demographic explosion which has occurred. Whatever we conclude about accreditation that fact will remain. There are not enough skilled personnel and there are not enough people skilled in management techniques. Training and development, in both the public and private sectors, are much more important than the accreditation of specific homes.

There is the question of whether the body which enforces standards should be the same body which raises and encourages high standards. It relates to the issue touched on earlier of whether regulatory bodies should take a facilitative line or a coercive line. Robert Baldwin, in *Public Money*, March 1984, argues that two types of regulatory agency have grown up since the nineteenth century: those sponsored by Government and the courts, and those of a different kind, such as the Milk Marketing Board. In each case there has been a tension between the facilitating/developmental and coercive approaches and this would be no less true for a voluntary accreditation process than it is for local authorities with more specific responsibilities.

Another concern is that much of our attention seems to have been focused upon the residential sector of private and voluntary care. This has distracted us from the policy decisions which need to be made in building up other services for dependent people. In particular we need to look at the development of community services and should not preclude the growth of imaginative community services in the private sector.

Consumer education has already been discussed. Experience suggests that the level of consumer appreciation is very low and efforts should be made to increase consumer awareness. It is not a free market situation. Although some organisations do provide information, this needs to be done more systematically and professionally.

Sheltered housing presents particular difficulties. It does not appear to fall within current legislation but controls need to be devised – and quickly. There is a rapid growth of private facilities for the elderly, many of which call themselves 'sheltered'. In some cases they are sheltered in name only and would be likely to fall foul of the Trades Description Act, though it does not seem to apply. It is important to ensure that sheltered housing does not simply delay the build up of enormous problems for health and local authorities.

As far as models of accreditation are concerned, the analogies with the Automobile Association and Egon Ronay do not seem appropriate. The people who are using private homes in East Sussex are not like the traveller looking for accommodation to suit his purse, who has the opportunity to stay a night and move on the next. If he does not like hotel A he can move on to hotel B, but it is not like that with nursing homes. It is not that sort of market. Similarly, the Egon Ronay model is too simplistic. We must ask who, apart from the proprietor, suffers if the stars are withdrawn on the next visit. People will simply take their trade elsewhere? It is clearly a different situation with residential homes and, in any case, such homes are not the purveyors of that kind of service. They are communities and should really be judged on their ability to change rather than on their ability to turn out a service regularly which is just the same. The ability to move forward and to respond to individual needs and new needs is what we should be looking for. It is difficult to envisage an accreditation system which would not be part of the on-going inspection and regulation procedures required by legislation.

Discussion

Anthony Golding The first aim of any system must obviously be to improve standards. Some speakers have said that in any group of homes 10 per cent are excellent, 80 per cent are more or less average and 10 per cent are bad. The experience of looking at abortion homes suggests that it is relatively easy to identify those which must be closed down and those which, with a little encouragement and understanding, could improve their service and could do so fairly rapidly. An inspectorate must have a stick but it should aim not to use it. Even if the body as a whole has sanctions it is still possible for teams working for it to take a supportive approach. Teamwork within institutions also helps to push up standards, and pressure for improvements from within may be more effective than those which come from outside.

It is clear, from the discussion, that there is also a fundamental need for *'brokers'* to help elderly people make their choices about homes. One cannot expect the elderly person or their relatives to have sufficient knowledge of the system. In this context it will probably be the GP, geriatrician or social services department which steers people to appropriate facilities.

Finally, there is a need to relate cash to the facilities available. If, for example, a home were prepared to deal with more disabled people, social security support should be increased accordingly.

Stuart Etherington Although the discussion, so far, has concentrated upon the problems of the elderly we must also look at *provision for the chronic mentally*

ill. Many of them are living in boarding houses which are not governed by the legislation or in unregistered homes. When they are discharged from hospital, especially in urban areas, they do not move into well-regulated care and they miss out on the higher care sector entirely. It is one thing to add accreditation to the superstructure of regulations which already exist but we must also look at those areas which regulations do not even touch. Many of the residential facilities for the chronic mentally ill fall into this category and may only be covered by environmental health legislation.

John Randle The spectrum of provision in the private sector ranges from residential homes to acute hospitals with greatly varying lengths of stay. The need for accreditation diminishes as one moves up the ladder to acute care. The controls exercised by consultants and nurses probably work quite effectively at this level. If that is so, the requirements of accreditation are very different in residential care homes, nursing homes and hospitals.

If we are talking about 1,400 or 1,500 nursing homes throughout the country and around 200 health authorities that is only seven homes per authority. It does, of course, vary dramatically but it can mean that the inspectorate in any authority may have very little experience. The Association of Independent Hospitals has found that the *quality of inspection*, especially in hospitals, leaves something to be desired. The inspection team may well consist of a community physician who has not worked in a hospital environment for 15 years and a nurse who may be 20 years out of date. That does not give a hospital a great deal of confidence. There seems to be a case for establishing inspectorates, especially where nursing homes are concerned, at a regional level. In a larger unit, where the numbers of homes averaged 100, the inspection team could build up a wider expertise. At the same time it would relieve DHAs of a responsibility which may involve conflicts of interests, where they are in a competitive situation with the private sector. This does not appear to be a problem at the moment but it is a potential source of difficulty which should be eliminated.

As far as the quantitative elements of registration and inspection are concerned, the NAHA guidelines are really quite good. There is something to be said for keeping the qualitative accreditation process separate from registration and inspection procedures.

Finally, dual registration and dual inspection are going to bring new problems. Apart from the practical difficulties involved there is a danger that different levels of standards will prevail. If the qualitative issues can be kept apart from simple mechanical quantitative standards, however, this may help to overcome the problem.

William Spray expressed some disappointment with the NAHA handbook and felt

that it had said little about quality of care and those issues which *Home Life* had emphasised, such as the importance of dignity.

John Cornelius-Reid The view of the private sector is that it should regulate and monitor itself. The Registered Nursing Homes Association has, in membership, 600 homes from a total of 1,374 nursing homes. The Executive Council determined some time ago that it would only allow membership to those homes meeting certain standards. Everyone who applies for membership will receive a visit (not an inspection) from a member of the Council – usually the Chairman of the Council – who will look round the home. If the home is acceptable it will be granted full membership and will be given an operations manual containing practical advice on subjects ranging from contracts of employment to reporting deaths. The manual is one way in which the Association seeks to improve quality.

A report on each home is filed and the home will be visited every three years. If there is any reason to think that there are problems with the home it will receive more frequent visits. If the Council has doubts about a home it will make an inspection and follow that up with a letter listing the problems. The letter will suggest a return visit in six months when the home has had the opportunity to rectify the situation. If the Association receives an uncooperative response it is recommended that the home withdraw from membership. In this way it tries to regulate homes which are slipping below the acceptable standard. The homes of Council members themselves are also inspected.

The residential care sector does not seem to be as well organised and although there is a central inspectorate of sorts it does not appear to be very effective.

If the private sector itself can establish a continuing programme and set standards for nursing homes, the number of outside visits and inspections required should be limited. Guidelines are, of course, valuable and are not new. Each health authority had its own set of guidelines which it issued to individual nursing homes. What NAHA has done has been to bring them all together into a comprehensive manual. The guidelines are very precise but should be interpreted flexibly. It would not be helpful to have authorities descending upon nursing homes and turning them upside down.

Inspection is a taxing and time-consuming task for a voluntary association. With 600 homes (and a three-year turnover) so many have to be inspected every year. It will be necessary to reinforce the inspectorate but that is not an easy task. Inspectors must be informed but sympathetic at the same time, and should recognise that all homes have a part to play with the vastly increased numbers of elderly. A recent survey conducted by the Association showed that the average age in nursing homes is rising. They are already dealing with the 85-90 year age group and it is likely to go beyond that. The private sector can ill afford to

dispense with homes offering a reasonable service, especially when the public sector is threatened with closures and amalgamations which are reducing their capacity.

Given time, the inspectorate in the nursing home sector will produce realistic and reasonable standards. Homes are nurse oriented and it is nursing discipline which should prevail. The Association has produced a manual for auxiliaries which gives them advice on techniques and basic instructions on how they should conduct themselves within a home. This should help to improve standards and may help to counter the criticism that the private sector is trained from public funds and gives nothing back.

Thirty-six DHAs have no private nursing homes at all, some have only one and several have only three or six. A few have more than 50 and East Dorset has the highest total with 63. The expertise of authorities who have a great deal of experience should be pooled for the benefit of those who have very little.

When the Association talked to the Minister, John Patten, about the possibility of an independent inspectorate, his view was that it would be too costly and that there was no need for such a body because health authorities were already undertaking the task. He felt that DHAs were closer to the nursing homes involved and it was better to have them responsible than an outside body, like a school inspectorate, who would only be in the area from time to time. His main objection, however, was on grounds of cost. The Association envisaged that this would be in the region of £10 per bed per home plus an initial 'going-in' charge. However, even East Dorset with its 63 homes, expected to net only £10,000 per year and this would not fund one extra person. This issue clearly needed detailed thought and it might be necessary to increase the rate per bed.

Richard Clough Registration by local authorities and health authorities is here to stay and we need either to build within it or outside it. At the moment we need a test case, involving cancellation of registration, to see the strength of the code of practice set out in *Home Life.*

It is possible that a system of accreditation, outside existing registration and inspection procedures, would be advantageous. It seems reasonable, as Donald Dick said, that people wishing to pursue high standards should be encouraged to do so and should gain recognition for their efforts. In the 80 per cent of homes doing an average job there is a large number of people wanting to do a better job but the facilities for doing it are extremely limited. The main priority is to find a means of encouraging the development of skills and a procedure for recognising the care and skills which exist in homes. The important thing, however, is to start with what we've got and to live and operate within it.

Deirdre Wynne-Harley returned to the question of *self-policing* and was concerned that it sometimes led to the reinforcement of bad practice.

As far as models of accreditation were concerned, she mentioned the advocacy project which the Centre for Policy on Ageing was running (which related to standards and information for consumers) and suggested that it might throw up some useful lessons.

Joan Higgins cautioned against using American practices as a model. Some of the lessons learned from the American experience were negative lessons. If accreditation were to become a higher level of activity it would be important to ensure that the sub-structure of registration and inspection did not crumble beneath it. In some cases (especially in America) accreditation had become a *substitute for registration and inspection* rather than a complementary process.

The American case also illustrates the dangers of bureaucracy. Accreditation there is very expensive and time-consuming and there is a tendency for the *paperwork to become an end in itself.* It is very easy for that to happen.

The fact that the accreditation system is voluntary also means that those institutions most in need of inspection and monitoring are those least likely to apply for accreditation. Whatever system is devised it is important to regulate and inspect those institutions.

Finally, the success of any accreditation system depends upon the *credibility of the inspectorate.* Some of those working in the American system have a poor reputation and are allegedly out of touch with professional developments. The endless round of visits, with up to 11 months on the road, does not make for an effective system. In the end, however, the credibility of the inspectorate is crucial in making accreditation work.

Stuart Etherington returned to the distinction between the 'hard' and 'soft' functions of an inspectorate and wondered about the compatability between the two roles.

Robert Bessell found himself moving further and further away from the group. While most people had been talking about gradual changes in procedures he felt strongly that *cataclysmic changes* were taking place. Apart from changes in the economic circumstances of elderly people, it seemed that the Victorian practice of putting people into institutions was rapidly coming into question. There was a good deal of evidence to show that many people in old people's homes – perhaps even one-third – were there unnecessarily. At the same time many local authorities could see enormous gaps in their provisions for the elderly – and this at a period when their numbers were increasing so dramatically.

Other developments, in the housing field, revealed a significantly changing picture. Research conducted by the University of Surrey in 1983 showed that there were 2,000 units of private sheltered accommodation in existence, 15,000 units under construction and an estimated 400,000 units to be built during the next ten years. All the signs are that this is an underestimate and these changes will radically alter the whole perspective on care of the elderly. The changes will not be evolutionary but revolutionary.

Malcolm Johnson This concern is probably overstated. Owner occupation is not new. It is just that we have paid it more attention recently and it is not increasing that quickly.

Although public policy for the last decade has emphasised community care, the *numbers of people in residential settings* has actually grown at a faster pace than the growth in the numbers of elderly in the population. The private sector has offered people something which is easy to get, which pleases relatives, which satisfies the needs of geriatricians and psychiatrists and frees beds in the public sector. Public policy has gone in one direction but the operations of the market have pushed the private sector in another. It seems likely that the number of people in residential care will actually grow.

Sheltered housing may become a real problem. About 2,500 builders are in the business of producing it but few of them have the skills required to manage the supporting mechanism. It seems clear that sheltered housing should be included in the group of social care provision requiring public regulation.

Peter Millard developed a theory which he claimed was guaranteed to confuse!

If people in local authority homes who are present should be absent, they cannot be replaced by similar sorts of people. They must either be replaced by people who should be absent or they have to be replaced with the sort of people whom the homes wish to remain absent, and then the homes are upset because the people who are present, who do not wish to be absent, are all sick.

In other words, if you have a third of the people in your residential home who are too fit to be there you cannot replace them with fit people. The people who should be present are all sick and the fit people should be elsewhere. Therefore, we would end up with people who are in rest homes because they are sick. The fact that they are there would not be related to their age but to their sickness. There should be no difference between the people in rest homes and in nursing homes because they should all be sick. They all require skilled nursing and medical services. It is not enough to say that in-house training can satisfy the training needs. Training offered by a bad proprietor will mean badly-trained staff. Training must take place elsewhere.

Colin Godber thought it might be less confusing to refer to people as 'disabled' rather than 'sick'. Some patients were, indeed, so sick that they needed to be in hospital or a nursing home, others were less sick but mentally confused and needing help. A medical assessment was needed to determine whether those who were sick could have their sickness treated. A large number who were not sick but disabled in some sense were being looked after by their families.

Donald Dick felt that there were some people who wished to live in a community but who were neither disabled nor sick. They were people who were just getting incompetent or becoming lazy, people who may no longer be able to cope with the bills and the shopping. The original purpose of local authority homes had been to meet such needs and to provide a community for people who needed some assistance later in life.

Robert Bessell claimed that his point had been that around one-third of people in homes would not have chosen to be there but they had been subject to pressure or lacked alternatives.

Colin Godber agreed that because the waiting list for rest homes was much shorter than that for good sheltered housing, many people did resort to homes for that reason. He did not think it was possible to justify subsidies to the private sector of £125 per week just to support people who felt fed up with living alone. A cheaper alternative should be sought. Current Government policy of allowing more and more subsidies to the rest home sector while freezing support for extra sheltered housing care was questionable.

Sally Greengross and **Robert Bessell** again emphasised the anomalous position of *sheltered housing.* There was no protection for the tenants of sheltered housing and current legislation did not touch on their problems. It was possible to envisage a scheme where the providers of sheltered housing could either opt for registration or not. If they were to be registered, registration would be based upon the services offered and one model would be to look for units which would provide care until people died. Another model would be a type of housing where people remained as long as they were fit but which they left when they became unfit. The latter would not, presumably, be registered. Registered sheltered housing might be a very attractive proposition and it should be relatively easy to amend the legislation to permit local authorities to register appropriate accommodation.

William Spray observed that accreditation was clearly not the only answer to the

problems which had been raised and invited **Donald Dick, Malcolm Johnson** and **Rudolf Klein** to make a few concluding remarks.

Donald Dick remained convinced that accreditation could be a useful mechanism. He saw problem-solving processes as having a series of stages:

Is there a problem?

Is there a group of people who can deal with the problem?

Training schemes evolve and institutions become approved as training schools.

Next comes the accreditation of buildings.

Staff become licensed through qualifications and registration.

Accreditation is extended to the institutions where the trained staff do their job.

Finally, comes the establishment of a comprehensive service for a given community.

In Britain we have reached the later stages of the process and are now looking at organisations in which staff are working. If the agencies concerned with this scrutiny are too small or do not have the skills, they must be enlarged to operate either at regional or national level.

Finally, we need to ask whether money would be well spent on raising standards. A better and more cost effective service might be provided if all the consultant psychiatrists, geriatricians, social workers and administrators were replaced by home helps!

Malcolm Johnson continued to believe that accreditation was not the salient issue and that the maintenance of high standards was the crucial thing. The discussion had demonstrated the importance of consulting the private sector on accreditation. If they did not wish to have such a system, as a means of demonstrating their excellence, there was little point in pursuing the idea. If they did seek accreditation this could be offered by a nationally based team, operated by the public sector on a commercial basis.

Rudolf Klein was anxious that any accreditation system should cover both the public and private sectors and should treat them impartially. He rejected the notion that the public sector should generate the standards and that it had a monopoly of good standards.

The distinction which had been made between quantity and quality was

dangerous and misleading; the two issues could not be divorced. Professionals would always want more from quantitative standards – more nurses, more social workers and so on – and there was a danger of leaping onto an escalator going ever onwards.

It is important to distinguish between ensuring adequacy and achieving some national target of excellence. *Home Life* and the NAHA guidelines have tended to confuse the two. The purpose of registration should be to ensure that no one gets a raw deal and to guarantee adequacy. The proper role for accreditation is to distinguish between the adequate, the above average and the outstanding.

Session 4 A role for the Fund?

The final session was concerned with the part the Fund might play in helping to resolve the problems raised in the discussion.

Robert Maxwell began with the observation that, despite the great increase in the numbers of the old and very old, the vast majority of the elderly were not in residential care. What they and their relatives needed was care which was flexible and which could be provided speedily.

He outlined the activities of the Fund – in its role as a grant-making foundation, as a training organisation and in the 'networks' it fostered – and asked whether it could help in developing further some of the ideas which had surfaced in the discussion. A number of possibilities seemed to have emerged:

1 There may be a need to *train and develop inspectors.* If the Fund did move into this area there would be some virtue in bringing together health authorities and social services departments to discuss their common problems and to encourage a joint approach to their resolution. It might be useful to start with authorities which already have a number of homes and quite extensive responsibilities.

2 Another idea would be to pursue the notion, raised by Malcolm Johnson, of a *consortium.* This would bring together health authorities, social services departments, planning authorities and fire authorities for the purposes of registration and inspection. It might be possible to find such a group who were willing to work together and the Fund could consider supporting the experiment.

3 One possibility, very much in the King's Fund tradition, would be to initiate a local experiment in *good practices in advocacy.* Some work had already been done in this field and it was worth considering whether anything further could be achieved.

4 It might be worthwhile looking at experiments across the *public/private divide.* Rudolf Klein's point that the 'standards' issue is a problem for both sectors was very pertinent and it is even more complex than that because it involves the public sector, the non-profit sector and the for-profit sector. Some experiments looking at good practice across these sectors might be supported by the Fund.

5 Finally, the Fund might assist with projects which brought together *nursing homes, rest homes and sheltered accommodation* and which encouraged good practice at the local level. It was important to try out such a scheme locally before making recommendations for changes nationally.

In the discussion which followed there was a great deal of support for option 1 which would provide joint *training courses* for inspectors from health and local authorities. Several speakers emphasised the considerable preparation such a course would require (including wide-ranging consultation) and the hostility it could provoke. It was suggested that the course should offer guidance about the sorts of problems inspectors might encounter and set out ways in which good practice could be encouraged, especially in rest homes.

There was also some support for the idea of training courses for proprietors, especially in management and business skills, although this would clearly be a very heavy commitment. Some local authorities were beginning to think of offering such courses.

Most speakers also supported option 4 in which any *experiment* which was mounted would look at both the public and private sectors.

Several participants went back to the need for *better information for consumers.* Many of them regarded the Oxfordshire CHC guide to homes as a useful model. **Colin Godber** suggested that the Fund might wish to consider an experiment elsewhere to produce a consumers guide. It could seek the impressions of people who had experienced care in different homes. A local inspectorate would be unlikely to have time for this but the King's Fund might consider a research project which would produce a glossary of homes and which would canvass a wide range of opinions, including those of relatives and residents in different homes.

Sally Greengross and **William Spray** both talked about experiments in progress to set up data banks containing information on places available across the country in homes, hostels, housing association accommodation, and so on. The national data bank providing information for the severely disabled was run by the voluntary sector and required participants to register their interest. The second scheme concerned provision for the mentally handicapped. There was some

suggestion that the Fund might take an interest in the establishment of a national data bank for all care groups which would include details about the quality of homes.

There appeared to be a general consensus that we were *not yet ready for accreditation* but **Donald Dick** felt that, nevertheless, there was some virtue in developing the tools to do the job. Quality assurance, he argued, was coming by stealth and it was necessary to begin to talk about means of improving quality control. We were at the stage of development rather than implementation.

A number of modest suggestions won support. **Donald Dick** liked the idea of a broker who could help in matching individuals with available resources. **Anthony Golding** said that his authority, helped by a pump-priming grant from the Fund, had just appointed a *placement officer* who would undertake this kind of task. She will provide information to consumers and advise on the quality of care available in different homes. The Fund might have a role to play in training such people.

Ralph Chapman suggested that one way of breaking down the hostility which sometimes existed between the public and private sectors would be to integrate the private sector into the planning of services. The King's Fund could help by inviting representatives of the private sector to take part in its activities (if it did not do so already).

Malcolm Johnson set out a number of possibilities which the Fund might wish to consider:

1 Joint seminars for members of health authorities and social services committees to explore matters of mutual concern.

2 Research on resource allocation and on the best use of public money, looking at the policy of subsidising people in private homes as against other alternatives.

3 Evaluation of local innovations (for example, a consortium) which might be replicated nationally.

He emphasised the need to look at training which was being developed elsewhere by, for example, Age Concern, the Centre for Policy on Ageing and the Open University, so as not to duplicate their efforts. The Fund may be well advised to lubricate existing initiatives rather than to run courses itself.

Peter Millard shared the view that the Fund might initiate a debate on current

policy and public subsidy of the private sector. It should also look at the ways in which changes in public policy might affect London which has very few private nursing homes.

Another important role for the Fund would be to look at the self-policing which already exists in the private sector and to provide information on the voluntary associations involved in inspecting the private sector.

Sally Greengross talked about the need to look at experiments in other countries, especially those which were concerned with the development of community facilities.

Stuart Etherington suggested a research project on private residential care for the mentally ill. He was also interested in pilot schemes to look at local redress systems, complaints systems and ombudsman and advocacy systems.

3 CONFERENCE THEMES

A number of themes emerged from the conference and these are discussed briefly below.

1 The distinction between registration and inspection and accreditation

It was obviously important to begin with a clear understanding of the terms being used in the debate. Linda Challis pointed out that the key distinction to be made was between registration and inspection and accreditation. A number of participants claimed that registration and inspection were the functions currently being carried out by health authorities and local authorities, under the Registered Homes Act 1984, and that accreditation was a different process which might evolve in the future. Donald Dick felt the key difference between these procedures was that while registration and inspection were mandatory, and required by law, accreditation was a voluntary option which might be sought by institutions wishing to demonstrate their excellence.

Other participants talked rather more critically of accreditation as being mere 'top-dressing' or the 'cream on the cake' and were concerned to ensure that the statutory procedures were improved upon before any priority was given to alternative (or complementary) approaches.

In the discussion which followed it became evident that most speakers had a sense that registration and inspection procedures were essentially concerned with quantitative issues while accreditation involved qualitative judgments. The Act is, of course, primarily concerned with measurable characteristics such as the numbers of residents in a home, the keeping of records, the qualifications of staff, and so on. However, Rudolf Klein warned in his conclusion to Session 3 that it was 'dangerous and misleading' to divorce questions of quality from those of quantity. This was an important point which should not be lost. Even though current registration and inspection procedures tend to deal with the factual and the measurable, judging quality becomes important when interpreting the legislation. Indeed the Registered Homes Act 1984 raises problems of implementation and interpretation which did not exist under previous legislation and allows more scope for qualitative assessment than ever before. The accompanying circulars, LAC (84) 15 and HC (84) 21 (and *Home Life* and the NAHA guidelines) reflect this fact.

LAC (84) 15, for example, notes that the objective of 'these homes' is to 'provide care broadly equivalent to what a competent and caring relative would provide' but it is not clear how 'competence' or 'caring' are to be judged. The legislation also employs the notion of 'fit persons' and allows for the cancellation of registration of homes where the manager is not considered to be 'fit' for employment in the home. Again the question of 'fitness' is a matter of interpretation and requires qualitative judgements. Perhaps the most obvious example of all, however, where the interpretation of the legislation will rest almost entirely upon subjective assessments, is in the distinction to be made between 'nursing care' and 'personal care'. This is of great practical significance because those establishments which are registered as nursing homes but which offer only 'personal care' will be held to have committed an offence under Section 24 of the Act if intent to deceive can be demonstrated. 'Personal care' is defined under Section 20 (1) of the Act as '. . . care which includes assistance with bodily functions where such assistance is required' but no definition of 'nursing care' is offered at all. Many nurses would, no doubt, consider it part of their job to offer such assistance and the distinction between the two types of care, in practice, will be very difficult to make. David Carson has argued that the problem is analagous to the difficulties involved in implementing the attendance allowance regulations where there is reference to 'attention . . . in connection with his bodily functions'.[9] In a recent case Lord Bridge ruled that the meaning of this phrase

> . . . is largely a matter of impression and does not admit of elaborate argument or analysis [but that, nevertheless, it] connotes a high degree of physical intimacy between the person giving and the person receiving the attention.[9]

Carson quotes Richard Jones' view that

> . . . the distinction should be between the kind of nursing that relatives perform for each other and that which requires a professional touch.[9]

Whatever the correct interpretation of these phrases Rudolf Klein was clearly right to emphasise that issues of quality could rarely be separated from those of quantity and that to characterise registration and inspection as being concerned almost solely with the former while accreditation would deal with the latter was both 'dangerous and misleading'. It is interesting that LAC (84) 15 regards the two sets of processes as already operating alongside each other in many cases. It notes that:

> There is often likely to be a need for two types of visit. Local authorities should carry out inspections within the statutory period to satisfy themselves

> that standards in the home are acceptable for registration purposes. If, however, the authority is to be concerned with more than just physical facilities, its staff need to be able to gauge the atmosphere of the home and the quality of life of its residents. For this purpose they might need to visit a home on other occasions when those registered could be given advice informally on various aspects of home management. Many authorities already operate in this way.[10]

This leads on to the second question concerning the type of accreditation model which might be appropriate and workable.

2 Models of accreditation

In looking at different models of accreditation, three sets of alternative approaches seemed to suggest themselves. First, the system could be locally based or centrally based; second, it could be independent of existing health and local authorities or part of them and, third, it could be either a mandatory or a voluntary procedure.

A number of participants emphasised the desirability of a local system and a local inspectorate because it could be more flexible, because it would be more aware of local needs and requirements and because it could draw upon local knowledge and informal contacts. Only a local body, it was felt, could cope with the volume of detailed information on different homes. Inspection could be carried out more effectively by a local agency, it was argued, than by a national inspectorate which would call in from time to time. Local bodies would be in a better position to respond swiftly to changes in local circumstances. Other speakers, however, favoured a more uniform approach and the establishment of national criteria and standards. Colin Godber, for example, while appreciating the value of local knowledge, saw the need for a central validating inspectorate. Some emphasised the very different experiences of registration authorities across the country where some dealt with over one hundred homes, some with just three or four and some with none at all. The authorities with very few homes could learn a good deal from those with wider experience and the pooling of expertise could prove extremely valuable.

The second set of alternatives is very closely related to the first except that, here, it is not so much the geographical basis of the inspectorate which is at issue but its independence of existing registration authorities. Conflicts of interest are clearly evident in health and local authorities in their powers of registration and inspection. There are considerable disincentives to applying existing legislation in a firm manner and this is reflected in the fact that very few registrations are ever cancelled. The closure of a home will mean both a loss of accommodation in an

area of social provision where demand is increasing rapidly and may also involve health and local authorities in rehousing the residents who are displaced. In the private acute sector of health care the pressures operate almost in reverse. Health authorities may be reluctant to allow the registration of a home, hospital or clinic where there is the likelihood that its own income from private patients may be diverted to these establishments. Important arguments can be made, then, in favour of an accreditation system which has a regional or central base and which is independent of existing registration authorities. This view is not, however, shared by Ministers who argue that existing authorities already have the expertise to do the job and any alternative would be too costly.

Thirdly, there is the question of whether accreditation would be mandatory or voluntary. Most participants favoured the latter and anticipated that accreditation would be something which homes actively sought as a way of demonstrating the high standards of service and facilities which they offered. Participation in the accreditation system operated by the Joint Commission on the Accreditation of Hospitals in the United States, which is perhaps the most familiar model, is voluntary but around 5,000 of the 7,000 or so hospitals opt for inspection. Voluntary accreditation would offer something like a 'Good Housekeeping' seal of approval, and homes would be awarded a certificate for display in their hall. Donald Dick maintained that a voluntary system would encourage optimum standards of provision. Homes which were applying for accreditation (and paying for it) would have an incentive to aim high and would be less likely to go for the barely adequate minimum levels which might result from an enforced mandatory system. Voluntary accreditation would be self-financing, and home owners and proprietors would be charged realistic fees by the inspecting agency. The disadvantage of a voluntary scheme, on the other hand, would be that homes with very poor standards would be unlikely to apply for accreditation. It would be important, therefore, that voluntary accreditation did not become a substitute for a rigorous system of monitoring and inspection which could police the ten per cent or so of homes where standards of care were unacceptably low and where exploitation and abuse of staff and residents occurred. One or two participants expressed the fear that a voluntary accreditation system for the best homes and a mandatory policing system for the worst homes would be divisive and would be unlikely to lead to a levelling up of standards.

A number of other questions emerged in the debate. Would the accreditation agency be tough or tender and could both functions be met by the same agency? There are obvious difficulties for inspectors, who are expected to enforce legislation which some proprietors may regard as punitive or threatening, to take on – at the same time – the role of professional adviser and supportive counsellor. Some commentators have argued that the two types of function should be quite

separate or that different teams within a single agency should have different roles. The correct answer to the problem is not self-evident.

A related issue, which was not discussed at the conference, is the degree to which the supportive/advisory functions of registration or accreditation agencies should be seen as subsidies to private sector homes. As LAC (84) 15 indicates, some authorities already invest considerable time and effort in advising proprietors in 'home management' and they can be quite extensively involved in staff training and development. NHS staff often feel a particular obligation to ensure good standards in homes into which they have discharged patients. Registration fees, at present, do not reflect this input from the public sector and it is, in most senses, a free good. Any future procedures, whether in the form of a statutory registration and inspection system, or a voluntary accreditation system, will need to consider proper remuneration for such a consultancy service.

Many speakers, not least those from the private sector itself, favoured a model of accreditation based on self-policing. Self-policing is already carried out, of course, by the Registered Rest Homes Association, the Registered Nursing Home Association and other smaller groups. The advocates of self-policing claim that it causes less resentment than inspection by statutory authorities and may be more successful in encouraging members to improve their standards. Self-policing tends to operate on the basis of persuasion rather than coercion. Although it is obviously in the interests of the accrediting bodies not to have in membership those establishments where standards are unacceptably low, nevertheless the tendency – as in the public sector – may be to err on the side of keeping poor homes open rather than closing them down. As John Cornelius-Reid, of the Registered Nursing Home Association, observed:

> The private sector can ill afford to dispense with homes offering a reasonable service, especially when the public sector is threatened with closures and amalgamations which are reducing its capacity.

The dangers of self-policing, as several speakers pointed out, were that once one was in 'the club', or in membership of an association, one was rather unlikely to be thrown out, even if standards slipped. At the present time, such associations operate on rather modest budgets and do not have the capacity to visit member homes as often as might be desirable. Conditions in a home may deteriorate over quite some time before they come to the attention of the associations. This is not a problem inherent in the principle of self-policing but is really one of resources and of organisation. Another limitation of self-policing is that it may reinforce bad practices. Bad proprietors may train staff badly, or not train them at all, and the lack of outside scrutiny may be disadvantageous to residents.

Self-policing obviously has its virtues. It may, indeed, engender more co-

operation from proprietors than procedures which are regarded as punitive and negative. In most cases too it is self-financing and is not a drain upon public funds. The main question, however, is whether self-policing should be the only model of accreditation or whether it should complement and work alongside the monitoring procedures of statutory authorities.

Whichever model of accreditation finds favour it is clear that a good deal hinges upon the expertise and credibility of the inspectorate and it is of critical importance to attract experienced and trained staff into the job.

3 Information to consumers

The third important theme of the conference concerned the types of information which should be available to people who were seeking a place in a home and to their relatives. Some participants argued that the provision of good information was really the *raison d'être* of any accreditation system. The conference heard that a number of initiatives were already being taken in this area. Dianne Willcocks talked about the guide she was writing, *Living in Homes,* which provided information of a general kind for people intending to move from their own homes into residential care. Linda Challis described the research being undertaken at the University of Bath to provide homes with a standard format which they could use in producing their brochures. Conference participants also had before them copies of the Oxfordshire CHC guide to homes in the county. This contained factual information about the facilities offered in particular homes and the fees which were charged but it also included the comments of CHC observers on their feelings about the establishments. Some homes were described as having a 'homely atmosphere' and were 'clean, fresh and bright' while others were described as 'businesslike' and one was said to be 'more like a superior residential hotel than an old people's home'. Many speakers felt that this kind of subjective assessment by lay people was invaluable in helping potential residents to make their choices.

Elderly Accommodation Counsel Limited has just launched a national computerised register which contains information about sheltered housing, hospices and residential hotels as well as residential care homes and nursing homes. Proprietors pay an annual fee of £15 to appear on the register and potential consumers pay £6 for a computer printout of facilities available in their area. It is left to them to make the initial contacts with homes and to inspect them.

Linda Challis observed that information was important in raising standards because it helped to identify and to squeeze out poor performers. However, as other speakers pointed out, even where homes were known to be of a low standard they still managed to fill their beds. It was clear that, if information itself was to be a means of regulating standards, it had to be readily accessible and

easily comprehensible. Even so there would be some consumers who, because of mental impairment or frailty, could not understand or make use of the available information. Finally, if consumers were to judge whether they were receiving value for money they needed to know what to expect from a home (so as to compare actual practice with the claims which were made) and to have some sense of the alternatives available. A number of speakers remarked that the actual choices of residents in both the public and private sectors were very limited – usually to around two homes. The idea that the increase in the number of private homes had considerably extended choice was something of a myth.

4 Value for money

The major concern here was whether public money was best used in subsidising residents in private homes where the fee-paying authority (the DHSS) had little or no control over the product it was purchasing. Rudolf Klein remarked, in his introduction, that – in order to protect the public purse – it was necessary to ensure both that the charges were reasonable in terms of what was provided and that the appropriate people were receiving support.

This last point was taken up repeatedly during the discussion, with several speakers concerned that there was usually no assessment of the needs of residents going into private sector homes and that some, at least, were inappropriately placed. Because they referred themselves, in effect, they by-passed the normal assessment procedures which might be undertaken by health visitors, social workers, GPs, geriatricians and psychogeriatricians and this may be to their disadvantage.

Some speakers emphasised that it was only possible to judge whether social security payments to residents in private homes were really the 'best buy' if other alternatives, including non-residential care, were also explored. It is, indeed, a paradox that a Government so firmly opposed to institutional care and so committed to community and family care should have put more and more money into residential homes for the elderly (through indirect subsidy) in recent years, leading to such a rapid expansion of the number of institutions for the elderly.

5 Aspects of care excluded from, or inadequately covered by, existing legislation

Throughout the discussion it became clear that there were three areas of provision which were either not covered by existing legislation or which were inadequately covered. Sheltered housing and much of the residential accommodation housing the chronic mentally ill were not the subject of registration and inspection. Robert Bessell, Stuart Etherington and others felt that this was both

undesirable and illogical. Individuals in these types of accommodation could be amongst the most vulnerable and should be accorded the same protection as residents of nursing homes and residential care homes. As Malcolm Johnson pointed out, of the 2,500 or so builders who were producing sheltered housing very few have the skills to set up the supporting mechanism which is an essential part of the package. As far as the mentally ill were concerned, especially those in urban areas, they missed out almost entirely on the high care sector and often found themselves in squalid and unsatisfactory boarding houses or unregistered homes.

The position of private acute health facilities is somewhat different and although they are covered by the Registered Homes Act 1984 the legislation does not resolve the problems which this sector raises for regulatory agencies. The 1984 Act (and the Nursing Homes Act 1975 before it) gives only the sketchiest guidance to registration authorities on the monitoring and inspection of acute facilities. Both pieces of legislation were designed essentially for a nursing home sector which was made up of relatively small homes offering modest levels of nursing and convalescent care. However, the 1984 Act does also cover any premises which are intended to be used for:

> . . .the carrying out of surgical procedures under anaesthesia; the termination of pregnancies; endoscopy; haemodialysis or peritoneal dialysis; treatment by specially controlled techniques. . . (Section 20 (1c))

The hospitals and clinics offering these facilities are growing in number. The newer institutions, especially the American owned 'for-profit' hospitals, are larger and more complex than ever before and regulation under the Registered Homes Act is increasingly becoming an anachronism. They have little or nothing in common with the kinds of nursing home originally envisaged in the legislation and and an alternative means of regulating them may be required.[11]

4 THE WAY FORWARD

The main aim of the conference had been to consider the need for some type of accreditation system and to examine what form it might take. The view which came to predominate during discussion was that it was premature, at this stage, to think in terms of establishing a national accreditation agency. Most participants felt that the first priority was to implement existing powers of registration and inspection more effectively, and they were concerned about the burden of new responsibilities which had fallen upon registration authorities as a result of the 1984 Act. Some speakers expressed stronger views than this and regarded accreditation either as an irrelevance or as a luxury we could not afford. The general conclusion was that we should do better than we were already doing before going on to develop more refined techniques. Donald Dick, who had favoured some form of accreditation, felt that this did not preclude the sharpening of the tools to do the job and argued that, since quality assurance was coming by stealth, we needed to be ready for it. He maintained that we were at the stage of development rather than implementation.

As far as the role of the Fund was concerned in facilitating these changes, three clear possibilities (and other lesser ones) emerged.

1 There was considerable support for mounting a training course for inspectors in health and local authorities. The Central Council for the Education and Training of Social Workers was understood to be developing a course for local authority inspectors but the overlap of functions between the two is now so great (especially in dual registration) that there was no apparent logic in training inspectors separately. The Fund could perform a very valuable function in bringing together the two groups.

2 Many speakers had emphasised the need to improve information to consumers. It was important that the Fund look at experiments which already existed in this area – brochures, data banks, guides and so on – but there seemed to be scope for pilot projects which would test out different approaches to the provision of better consumer information.

3 Suggestions were made which could lead to experiments in good practice. There was Malcolm Johnson's idea of a 'consortium' to be responsible for monitoring. There was a proposal to try out techniques of quality control across the public/private divide and there was the suggestion that 'brokers' (or

placement officers) be employed to provide information on, and secure access to, different types of home.

These three options, together with some of the proposals outlined at the end of Chapter 3, seem to offer realistic opportunities for the Fund. While they do not constitute a strategy on accreditation they may qualify as 'tool sharpening' and may take us some way further down the road towards more satisfactory procedures for ensuring good standards of care in residential care homes and nursing homes.

APPENDIX A THE ACCREDITATION OF NURSING HOMES AND RESIDENTIAL HOMES FOR THE ELDERLY *

The problem

In recent years there has been a considerable growth in the number of private residential homes for the elderly and of nursing homes offering care for the frail and chronic sick elderly, including the elderly mentally ill (that is, the demented elderly). There seem to be two main reasons for this growth, one being the demand created by shortages in the NHS and social services statutory provision for this group of patients and the second being the increase in money available from public sources to enable elderly people to seek private care. There is no doubt that this is a very rapid area of growth, especially in retirement areas along the south coast. For example, there is one health district with a total population of 230,000, of which 66,000 are aged 65 and over, which has no NHS inpatient beds for the elderly mentally ill within the district (it is served by a neighbouring district). The district plan is to open only 66 beds for this group of patients, as opposed to the 200 that national norms might suggest, because of the very large numbers of private nursing places in the district which are already meeting most of the needs. The local managers believe that an NHS unit should serve firstly as an assessment point to decide on which nursing home is most suitable and secondly to manage the most severely ill who require intensive nursing and the technology of hospital. However, the managers are uneasy that they have no means of checking the quality of the private nursing homes to which they are sending the assessed patients.

Similar anxieties about the quality and value for money of private establishments are widely expressed, both by the health service and by social services. It is recognised that registered nursing homes and residential homes are checked for provision before they are licensed but such checking is generally limited to structural and staffing matters and has nothing to say about quality. It is possible that many residents are leading restricted lives of poor quality and little activity, for which the proprietor is receiving substantial sums. No doubt many are good but neither the proprietor nor the users have any real means of gauging performance or value for money.

* This was not intended by Dr Dick as a paper for publication. It is the hurried statement of a concern that was first expressed to the Secretary of the Fund and then set down in this way as both invitation and encouragement to action.

The need for a checking system

Like any system offering services to the public, the private homes need some means of checking on provision, quality and value for money so that those paying for the service can judge what they are getting. This will be increasingly true if public money is used to take over tasks that might otherwise be met by statutory bodies.

There seem to be two main characteristics of a checking system: first that it checks on the provision within the home – that is, the environment, staffing and basic activities; and secondly that it makes a judgment of the quality of what the home offers. Checking the provision seems to be the easier task. It is analogous to the AA or RAC star system. The presence or absence of stars tells one what a guest staying in a hotel can expect: for example, the number of rooms with their own bathroom, whether there is television, public rooms, times of meals, whether there is a night porter and so on. The judgment of quality, which in nursing homes has to be about dignity, privacy, self-determination and a high quality of life, is more difficult to estimate but the parallel here is in the awarding of rosettes or a similar mark by organisations that judge restaurants, such as the Michelin Guide, Egon Ronay or the Good Pub Guide. The star system requires that known, hard criteria are met, because they can be seen and counted. The estimation of quality requires a judgment against a set of principles by someone who knows how to discover whether those principles are being met and how to interpret the optimism and assumptions of staff and proprietors who are promoting their own establishment.

The objectives of establishing a checking system

A checking or quality assurance system that rates nursing homes and residential homes should enable those who use them or pay for private care to make judgments about value for private or public money. If such a system were widespread, it ought to be possible for a potential customer to be reassured that what he or she is paying for reaches an agreed standard. It should be as straightforward for the patient or his/her relatives as it is for a traveller who books himself in to a three star hotel, knowing that it will have assured standards or, in the case of a restaurant, that he will dine well.

Some characteristics of accreditation systems

It is essential that the checking system should be independent of the management of the homes. It would be pointless for a hotel chain to rate itself. The players should not be their own critics. The most successful systems of quality assurance in health care round the world seem to place much emphasis on their indepen-

dence from management, so that they can be free to criticise at any level. In hospital accreditation, for example, schemes are thought to be best if independent from Government or the financing organisation.

Voluntary accreditation systems seem better than those that are obligatory. If an establishment wants an external evaluation, leading to a certificate of approval or accreditation, it is likely to seek high standards both to gain and keep the certification. If *obliged* to obtain a certificate, it is likely to aim for minimum standards and an amount of whitewash. Obtaining a certificate should be a matter of pride, rather than of relief. Further, if certification is voluntary, it means that the establishment will be willing to pay for being visited, whereas it would expect an inspection system to be free and paid for by the funding agency. There is some evidence, especially from Australia, that the attempt to acquire a good approval rating is strongly motivating for the morale and excellence of service in a hospital or nursing home, being seen as an achievement for the whole organisation rather than a chore.

Some necessary steps

Before a universal accreditation system could be established, a number of preliminary steps would be necessary:

1 The criteria for provision would need to be described and published so that any establishment applying for accreditation would know exactly what it had to provide in terms of structure, staffing and basic activities in order to qualify for a grading. Gradings could be sub-divided, as they are in the Australian system, to take account of a range of size. For example, the criteria for what is offered by a six-bedded establishment would be different from those for an establishment of 30-40 places.

2 The principles of how the quality of life would be judged could also be written down as general principles, incorporating concepts like dignity, privacy and self-determination, with an interpretation of how they would be judged. The accreditation manuals of the joint commission on accreditation of hospitals in the United States serve as models.

3 It would be necessary to have a central organisation which was responsible for setting widely agreed standards, providing the visitors and training them in uniform standards. An appeal system would also be necessary.

4 It would be impossible to establish such a system without some initial financing and a pilot project, both to work out standard practice and gain

reputation and credibility. Nursing homes could not be expected to pay for accreditation if it had no meaning except to them.

5 Accreditation systems have more impact if the consequences of not being accredited are a disadvantage. For example, the withdrawal of approval from educational systems, nurse training schemes or restaurants can bring about urgent action which would not take place if there were no consequences. It might be that, in time, public funding for the elderly in private nursing homes or residential homes could be dependent upon the possession of an approval certificate.

Some possible effects

If a well organised accreditation system with clear criteria that took account both of provision and quality could be established throughout the country, it would be possible to ensure rising standards, reliable information for consumers and a means of ensuring value for money for those who pay. If it is both independent and self-financing, it will avoid being seen either as the heavy hand of bureaucracy or as a direct drain on public spending.

Some tasks

1 Writing the criteria for provision.

2 Describing the judgment of quality.

3 Finding finance to set up a pilot project.

4 Exploring the possibility of developing a national organisation if the foregoing are successful.

D H Dick
Consultant Psychiatrist

APPENDIX B LIST OF CONFERENCE PARTICIPANTS

Consultation on accreditation of residential care homes, nursing homes and mental nursing homes

Conference held on Friday 25 January 1985, at the King's Fund College, 21 Palace Court, London W2

Robert Bessell	Managing Director, Retirement Security Ltd (formerly Director of Social Services for Warwickshire)
Ms Linda Challis	Lecturer in Social Policy, University of Bath
Ralph Chapman	Principal Officer (Projects), East Sussex Social Services Department
Richard Clough	General Secretary, Social Care Association
John Cornelius-Reid	Council Member, Registered Nursing Home Association
Miss Sandra Curtis	Administrative Secretary, Grants Department, King's Fund
Dr Donald Dick	Consultant Psychiatrist (formerly Director of the Health Advisory Service)
Stuart Etherington	Director, Good Practices in Mental Health Project
Dr Colin Godber	Consultant Psychogeriatrician, Southampton
Dr Anthony Golding	District Medical Officer, Camberwell Health Authority
Mrs Sally Greengross	Deputy Director, Age Concern England
Dr Joan Higgins	Lecturer in Social Policy, University of Southampton
Professor Malcolm L Johnson	Professor of Health and Social Welfare, The Open University

Professor Rudolf E Klein	School of Humanities and Social Sciences, University of Bath
Robert J Maxwell	Secretary of the King's Fund
Professor Peter H Millard	Eleanor Peel Professor of Geriatric Medicine, St George's Hospital Medical School
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