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SOCIAL AND ECONOMIC DIMENSIONS OF AN AGING POPULATION

LONG-TERM CARE IN TURMOIL

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SEDAP Research Paper No. 13

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Abstract

The reformulation of the regulation of long-term care seen in the recent White Paper and Royal Commission in the UK has led to topical debates on long-term care for older people. Given that there are over 500,000 people in residential nursing and dual registered homes across the country, there has, until now, been remarkably little research on the role of managers in the long-term care sector, the various tasks they undertake in the day-to-day operation of a care home, and the qualities and qualifications they bring to their work. This study investigates the range of tasks which managers of long-term care homes perform, and the skills they should possess to do their work. The opening chapter reproduced here provides a critical analysis of the current confusion which besets UK policy on long term care.

LONG-TERM CARE IN TURMOIL

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Long Term Care is in turmoil - again. Since the great expansion of the early 1980's fuelled by the release of public funds and demographic pressures, there has been a succession of anxieties, atmospheres of collective grievance and claims of injustice. The introduction of the 1984 Residential Homes Act, the associated Code of Practice *Home Life* and the creation of the Tribunal; generated alarm and dismay. Proprietors worried, in public and private about locks on residents doors, ensuite facilities, single rooms, room sizes, night staffing, nurses in residential homes and registration fees. Then it was differential fees, payments for high dependency, different inspection standards, the Fit Person and the problems of dual registration. More recently the focus has been on the competing expectation of higher standards with driven down prices, often below the costs of provision. Local authorities in their attempts to manage capped budgets for purchasing care have frequently placed older people in the cheapest rather than the most appropriate care.

Little wonder that those who own and run what is now termed the Long Term Care industry are challenging the government to match its emergent package of policy changes with fair and adequate funding. In the interim the stock market values of the increasingly influential corporate sector continue to fall and as a consequence new investment has declined. Some parts of the charitable sector continue to flourish and grow on the proceeds of effective fund-raising. The main body of small 'cottage industry' proprietor led homes (still the core provision) mostly struggle to survive. Local authority homes, twenty years ago the largest sector has dwindled to become the smallest. All too frequently these are places of last resort

for the discerning consumer, but given preferential treatment by purchasers from the public purse.

Despite these vicissitudes it is not difficult to conclude that the past fifteen years since the 1984 Act have seen an overall rise in quality for the older people who are residents. They have more privacy, personal space, dignity and care. But the average rise, embraces vigorous innovation and excellence as well as facilities and personal services which are intolerably sub-standard. Inspectors and Registration bodies are increasingly skilled at enforcing good care standards. Yet they do their task, largely understaffed, so that the regular monitoring they are charged to undertake is widely neglected. Perhaps most discomforting to providers is the significant variation in the way standards are interpreted and applied. The government the industry and the registration bodies all have collective voices to express their disquiet. So too have the nurses and the doctors who have all but abandoned old people in homes. The constituency rarely heard even in times where consumer consultation and Charters are in great evidence, are the half million increasingly frail old people who pay an average of over £15,000 a year to live in a residential or nursing home.

Residents do at least have a range of pressure groups to speak as their unchosen proxies. Age Concern, Help the Aged, the Relatives Association and others draw public and political attention to failures in the system which come to their attention. The group which is completely submerged in the clamour is staff. RCN speaks out for the qualified nurses; but the huge workforce of poorly paid, mostly part-time, unqualified female carers and domestic staff are virtually unrepresented. Nor, significantly do we hear from their managers. Mostly working in single establishment homes with no organised body to represent them managers are often isolated from their peers; engaged in an undoable portfolio of activities and yet bearing central responsibility for the effectiveness of a vital service.

Managers and Staff

This study begins from the premise that the greatest net gains to be achieved in the quality of long term care over the next decade will be through improving the effectiveness and skill of staff. There are other domains of improvement which will be complementary - assessment, personal living space, new regulatory frameworks and more equitable public funding - but none will match the efficacy of sound investment in staff. Enhancement of their skills, knowledge, professional self confidence, assessment and recording capability and ability to use knowledge - based practices, will pay high dividends. Yet, given the depressed levels of funding and the poor return on capital across the industry, there can be little prospect of the

necessary level of training budgets, to lift the competence quotient significantly above present levels. Even £100 a year per member of staff spent on training would cost the sector more than £60 million. Whilst such a modest training programme would require only the equivalent of £3 per bed per week (or one per cent of average turnover) it is unlikely to materialise at a national level.

Within such a restricted expectation of investment in the workforce it may make more sense to devote a higher proportion of training resource to raise management effectiveness. Reliable estimates of the numbers who might be termed managers are unavailable. In part this is due to the lack of overall workforce statistics in an industry dominated by low paid, part-time and rapid turn-over of workers. But even a simple approach produces large numbers. If each home has a manager or matron who takes overall responsibility for the establishment there must be at least one deputy who oversees staff during the second day time shift. In most homes there will be at least one other responsibility post. Add to these, the managers employed by the larger groupings and companies who are senior, with Chief Executive or area responsibilities. On the basis of 31,000 registered homes, there is likely to be around 100,000 operational managers.

As the rest of this volume reveals, the tasks of management extend far beyond the oversight of care staff and caring work. Rotas, training, finance, purchasing, food and hotel services, building maintenance, health and hygiene, legislative and regulatory compliance and marketing all feature in a diversity of job descriptions. The range of tasks is greatest in the smallest businesses, where the composite of proprietorship and management is common. More specialisation is possible in the larger corporates where conventional line management on functional lines is the norm.

Remarkably little is known about this key body of staff. Previous enquiries provide sketchy information. Official statistics are strongest on residents, their age gender and dependency levels. Staff are usually described loosely and collectively, but not enumerated. The Audit Commission's *The Coming of Age* (1997) report on care services for older people is much concerned with issues of cost, value and quality, but presents no data on staff and only addresses management in terms of processes and procedures. The Royal Commission on Long Term Care (1999), looks at the whole field as well as focusing on its given task of funding. It too pays no attention to staffing or management. *Modernising Social Services* (1998) provides a chapter on Improving Standards in the workforce. Its concerns are largely with training standards and qualifications for social services professionals. Plans are laid out

for the new General Social Care Council which will set training standards and regulate the training system to be lead by the National Training Organisation. Clearly this is closer to the staffing of homes for older people; but at this stage the attention is drawn more to the establishment of qualification routes for social workers and other professionals. The untrained army in long term care is part of the planned framework, but still a long way down the line. Managers are equally invisible in this emerging system.

The neglect of staff and management in the institutional care system is as old as the system itself. Long term care has over a century of history of being out of sight and out of mind. Our long stay mental hospitals were staffed with 'orderlies' whose tasks were defined by their title. Custody and control was also the principal task of the poor law institutions out of which local authority residential homes grew. Despite the alarm which was provoked by Peter Townsend's *Last Refuge* (1962) and the staff revelations in *Sans Everything* (1967), the care of the old, the infirm and the poor has never attracted public funding for trained, caring staff. Even the efforts of the Gatsby Group led by Barabara Kahan to improve training in childrens' homes, had only a moderate influence. It resulted in the closure of homes and the abandonment of collective care rather than its improvement. With older people, the 'Home' in its various formats, is one permanent feature of the landscape of support. So attending to the qualities of care staff and the quality of those who manage them is a vital project.

In later chapters we examine the nature of the management function, the present characteristics of home managers and what informed opinion believes we should do to raise standards. In this opening sequence, we now turn again to the kaleidoscope of change which infuses every aspect of the lives of residential and nursing homes in Britain.

Public Policy in Transition

Fifteen years after the Registered Homes Act 1984 and the accompanying Code of Practice *Home Life* (1984), the institutions and practices which they established are seen to be in need of serious revision. Moreover there is a declared intention on behalf of government to produce a more equitable and better organised set of arrangments for residential and nursing homes. As the public purse currently meets almost seventy per cent of the total costs, it is a matter of expectation that resources are spent well. At the same time it is a matter of concern that demographic pressures and practice trends are increasing the annual spend. Thus advances are being made both on the framework for regulation and quality and on establishing future patterns of public and private contributions to the costs of care in homes

for older people.

Two key documents were published within a few months of each other. The White Paper *Modernising Social Services* (1998) and the Report of the Royal Commission *With Respect to Old Age* (1999). The White Paper had been long awaited so its principal areas of interest and its proposals were widely discussed, before its publication. Whilst much of the expectation was met, it sets long term care in wider context than many anticipated. The government has wisely seen the need to set all residential and nursing care provision within the same regulatory arrangements. But it has also included homes for children, those with learning disabilities and mental health problems. In public policy terms this embracing of the whole spectrum makes good sense. Yet in placing services for very different clienteles together, it generates the need to recognise differences of practice whilst stewarding the same standards.

The Single Registered Care Home

The current distinction between nursing and residential homes is based on an historical split between professionally defined models of 'medical' and 'social' care. The regulatory system embodied in the Registered Homes Act 1984 is determined by these two professional models. The current provision for dual registration might have led to the development of a more unified type of provision. In reality, differing regulations, guidelines and procedures followed by health and local authority inspectors have often placed unreasonable regulatory burdens on homes seeking to provide a wide range of care. In consequence, the successful establishment of dually registered homes has been limited.

Resulting from an earlier Rowntree funded study Malcolm Johnson and Lesley Hoyes (1996) proposed an organisational and regulatory framework which would facilitate a broad spectrum of styles of provision enabling a degree of mobility between different styles, which reflects the changing needs of individuals over time. This was not to advocate a single category of care home catering for any person with support needs. There are powerful arguments against a general mixing of different age and client groups within residential settings. However, instances of couples being split up because of differing care needs are clearly unacceptable and could be avoided with a single registered home.

Equally the proposed system does not imply that all homes would be expected to provide for all levels of dependency. Providers must be able to choose the type of care they are prepared

to offer and residents must be able to choose the type of home they wish to live in. The concept of a single care home is about enabling flexibility, not about imposing a universal model of provision.

The aim is a continuum of long-term care, from small family placement schemes for individuals with support needs, through care homes offering a home for life, to establishments caring almost exclusively for frail or sick people with substantial nursing needs. Along this continuum, providers could opt to offer a range of care, some quite narrow, some very broad, which would be clearly set out in their brochures and information for prospective residents.

The detailed proposals are summarised below:

Arguments for a single registration include:

- The distinction between nursing and social care which underpins the current separate systems of provision is no longer tenable as residents become older and increasingly frail. Dual registration has not succeeded in bridging the regulatory gap.

- A spectrum of care homes registered under a single system would offer a range of care along a continuum.

Key elements of the proposed model are:

- *The setting of nationally agreed criteria for initial and on-going assessment of health and social care needs*. Individual care plans would specify assessed needs and would also trigger changes in the level of care. Assessment would be linked to a scale of fees based on provision for individual needs rather than type of home.

- *A level and mix of staffing in each home dependent upon the assessed levels of needs of residents*. Accredited training courses, producing a wider skill mix amongst care staff, would enable a more efficient use of qualified nurses.

- *The development of 'Gerontological Nurse Specialists'* who may work as established staff in homes or be based in support agencies, allowing the flexible and appropriate use of specialist nursing skills.

- *The establishment of an independent and broadly self-financing National Office for Standards of Care* to oversee the setting of national standards and the registration and inspection of all care services.

- *The development of a regionally based registration and inspection system,* with a multi-

disciplinary core of staff, supplemented by panels of 'lay experts', including service users and carers.

- *The appointment of an Ombudsman* to deal with complaints.

Implementing the White Paper

The ramifications of changes of this order are considerable, both for the shape of the sector and the way staff and facilities are managed. However as the White Paper has already clearly signalled the establishment of Regional Care Commissions (based on existing NHS Regions) and plans are laid to set them up from 2001 and operational from 2002 (DoH: Modernising Social Services, Implementation Diary LASSL (99)L), the new systems must be anticipated. The Commissions for Care Standards (CCSs) will cover all residential and nursing homes. They will function within a framework of new guidance and regulations which were also scheduled in the Implementation Diary. Prominent among these are:

- National Standards - for Care Homes (produced by the Centre For Policy on Ageing).
- National Standards for Domiciliary Care.
- National Training Strategy.
- Policies on Best Value / Performance Management.
- Plans for Partnerships across the NHS / Social Services divide and with Primary Care Groups.
- Long Term Care Charter.

Whilst some of these protocols will be advisory others will either take the form of Regulations or develop - as *HomeLife* did - a quasi-legal standing, which CCS's will feel able to use as authoritative standards, in the regulatory process.

The White Paper extends the range of regulation, through the CCSs, to include domiciliary care and the provision made by Social Services Departments themselves - including their residential homes for older people and children. In doing so the system will embrace boarding schools and Residential Family Centres.

On the subject of the Single Registered Home the White Paper said:

'In due course it may be sensible to move to a single registration category for all care homes, and we intend that the legislative framework should be flexible enough to allow this possibility (p.80).

With or without a single category, the range of provision is already diversifying giving rise to the need for more appropriate skill mixes to meet the needs of a more differentiated clientele and niche marketing on behalf of owners. As a result homes will become more complex organisations as some tasks require more experise. Managing a more heterogeneous work force will become commensurably more demanding.

Assessment and Care of Older People: The Way Forward

The Government promises in the White Paper 'services that are suited to the needs of people not the convenience of providers'. The foci for improving this 'suiting' are empowerment of consumers and better commissioning. But there is no mention of the critical underpinning needed to make these improvements work - assessment/care mapping/review. Nor does it address the absence of shared assessment tools and records for the many workers and providers who now attempt to sustain and improve the quality of life for people in the fourth age.

The diverse and often seriously deficient assessment schemes used by doctors, nurses, social workers, psychiatric nurses, care workers, physiotherapists and occupational therapists have two damaging consequences for older clients. The first is that they are beleagued by professionals doing assessments, absorbing vast amounts of potential care delivery time and energy. The second is that professionals have no shared assessment tools and therefore no trust in the assessments of others. Nor is there any central file on an individual to which all carers refer and contribute.

Far too much of the already inadequate service to old people is being squandered on poor and often wrongheaded judgements about need. Lack of integration is the fundamental weakness not commissioning - much as that needs attending to. In short old people needs are being neglected. Old people are dying of assessment.

A major problem at present is the lack of a universal means of matching long-term care funding to services and outcomes. Thus there is no way of measuring cost-effectiveness. The relationship between costs, services, standards and quality of care is important and potentially informative, yet presently the precise terms of that relationship cannot be established. (Challis et al 1996). Arguably, comprehensive care provision is only possible through the work of multidisciplinary teams capable of performing specialised tasks. Older people often have multiple needs - medical, psychological, pharmacological and social - which cut across service boundaries. However the multiagency, mixed market system is poorly integrated. This results in: poor and highly differentiated services to clients; wasteful duplication; low cost effectiveness. The lack of a structured and systematic application of standards and quality and regulatory control hinders effective provision and effective monitoring . A common regulatory framework subscribed to by all professionals is needed (Johnson 1996; Johnson and Cullen 1998).

At present there is thus a wide variation in acceptable standards and quality of care. The 1984 Act speaks in broad unquantified terms about quality, adequacy and sufficiency which are open to interpretation. National guidelines do not extend to practical outcome measures or recommendations of skills mix and staff ratios for long-term care homes (Johnson 1996; Johnson and Cullen 1998). The lack of uniformly applied standards renders the measurement of care quality impossible: this obstructs the very processes - building models of best practice, rewarding quality, transferring expertise, promoting cost-effectiveness - by which a better service can be created. (Bowman 1997). But new Regulations if they are to be effective must provide a common framework for assessment and recording.

The Continuous Assessment and Review system (CARE) is used to assess clinical practice in long-term care establishments. The Royal College of Nursing assessment system is concerned with the measurement of qualified nursing and costing of care time. *Inside Quality Assessment* devised by the CESSA encourages residents to identify areas in need of improvement. These represent a small step toward increased monitoring of the care environment. However, none is readily transferable outside the narrowly circumscribed milieu of the hospital or nursing home to the vital other services provided by external agencies. Evidently, a rapprochement between service providers is necessary to ensure the most efficient and cost-effective services. This would entail: (a) the universal adoption of the same assessment tool to establish the needs of older people; (b) the adoption of the same principles governing the care of older people; (c) a centrally coordinated management, information and financial system; (d) the creation of a corpus of evidence-based practice for the care of older

people. The key to this coordinated approach is the universal assessment tool linked to agreed quality standards. Given this, the different agencies responsible for care could become part of a structured and integrated framework of care provision. The characteristics of such an assessment instrument would be a standardised link with care planning, providing a holistic account of an individual's need and his or her past medical and social history (Carpenter and Calnan 1997). The *Resident Assessment Instrument* (RAI) operated in the United States meets this criterion. It relates an elderly person's individual needs to an agreed care plan which is benchmarked according to a national standard for quality and outcomes. For the first time care can be costed, and its quality determined at all levels from the individual to the nation. Indicators verifiable against agreed standards have been set (Fries et al 1997).

All the different agencies responsible for care have access to a set of evidence-based criteria by which their input is governed, and their precise role within the multiagency context is made clear.

When an older person enters nursing or residential care his or her needs are assessed according to a set of indicators of functional ability which covers all aspects of mental and physical health. This standardised assessment is enshrined in the *Minimum Data Set* - a matrix of all possible care needs of an older person. All care providers understand and use the same assessment. The Resident Assessment Protocols (RAPs) are a crucial accompaniment. These indicators guide the assessor in working out a care plan by flagging up what kinds of functional problems are likely to benefit from what kinds of care intervention. They act as an aid to goal-setting and care planning. While not normative, they are admonitory. Thus if the RAPs were to recommend a particular intervention and an assessor did not follow the recommendation, s/he would have to justify this in terms of the specific individual needs of the client.

Benefits of instituting integrated care on the basis of a standardised assessment instrument

Strengths	Weaknesses	Opportunities	Threats
modularity means components may be changed without major restructuring	may inhibit innovation of services	creation of an integrated care service and the pooling of budgets	potentially bureaucratic, inflexible and difficult to administer
facilitates collaboration of different agencies by providing a recognised benchmark for care	standards may be set at the minimum possible level	epidemiological research: standardised data on needs of older people	risk of a normative, reductive approach unless elderly clients and their advocates are widely consulted
can be uniformly applied over any area	may be used to drive down costs and quality	IT - create a powerful research tool	innovativeness may incur resistance to change (wide consultation needed)
combines top-down and bottom-up approach	may provide perverse incentives against rehabilitation	involves older people in their own care planning	rising costs due to demand for higher quality of care
standardised assessments linked to care plans		regulates standards through a unified training programme for care staff	closure of private care homes unable to meet standards
seamless linkage between assessment, care plan and costs		evaluate and budget in advance for long term care costs	demand for higher or lower national budget commitment to the care of older people
individual-centred		develop a more biographical link with care planning	care staff and professional interest resistance to change

As the table shows, the adoption of a universal assessment instrument linked to accepted protocols for devising care plans has the potential to iron out many of the present inequalities in service provision. Further, by relating uniformly assessed need to actual provision, the system would automatically bring cost into the equation and therefore enable cost-effectiveness and value for money to be judged. Transparent *audit trails* for expenditure on staff and other resources would become possible.

The aims of the present proposal are to:

- an improved means of uniformly assessing - on an individual basis - the needs of older people resident - or likely to become resident - long-term care establishments in the UK
- relate needs to practicable and achievable standardised actions or care plans

Cost, Value and Price

Since the transfer, by the last Government, (commencing April, 1993) to residents in long term care homes, from the Department of Social Security to local authorities, there has been a growing downward pressure on fee levels. The shift of this component of social security payments - which now amounts to more than £7 billion a year - to Social Services Departments we soon accompanied by a capping of the budget. This has simply meant that the growing number of older people needing to enter care has (a) been restricted by the unavailability of funds - waiting for the beds of claimants who have died, and (b) lead to attempts by local authorities to pay below national rates for care to provide for more people (c) resulted in policies to place elderly people wherever possible in lower cost residential rather than higher cost nursing homes.

The local authorities were placed in a situation which required them to do more with less. In the contemporary world this is a familiar challenge. It immediately, requires the pressed budget holder to consider whether better value can be obtained from the expenditure. Almost immediately the commissioning units began to explore the possibilities of better deals for their block purchasing power. New rules were constructed around the country which placed residential and nursing homes in new forms of price competition. Fairly rapidly it became necessary for proprietors to accept publicly funded residents at below current Department of Social Security (DSS) rates. Initially such reduced rates were exceptional and set within packages of substantial business delivered by the local authority.

As the movement for Best Value, sponsored by the Audit Commission and the National Audit Office was diffused into local authority Commissioning' practice, the national guideline prices were increasingly breached. The 'set price' practice which had prevailed for many years was quickly diluted by local Commissioners anxious to demonstrate their negotiating skills and to maximise the number of older people accommodated within the capped budgets.

Special arrangements were made in the Community Care reforms in 1993, which gave 'preserved rights' to existing residents who had access to a higher rate of income support. This group (initially 84,000 people) has been diminishing by about 20-25,000 persons a year. But for the rest of the resident population and those who entered after April 1st of that year, the tariff of prices has become something of a managed lottery. Those whose costs are met by the local authority may be placed in homes at prices below the marginal cost i.e. at a loss. Proprietors are increasingly left with the option of taking loss making residents or risking the

loss of their contracts with the local authority. In other cases residential homes feel obliged to accept residents whose case needs would properly place them in a nursing home - but the placing social workers are under instruction to avoid placements in higher cost nursing homes as far as possible. the same social workers were also required to place as many as possible in local authority or block contracted homes previously owned by the LA to ensure maximum occupancy rates - despite the much higher costs in many of these establishments.

A report for the London Government Association (Kenny, 1997) *Influencing the Market: Negotiating fees with Independent Homes*, highlights the impact of the cost containment strategy. Overall, the average prices paid for residential and nursing home places were within the upper and lower DSS rates for residential homes in 1996 when the survey was done this range was £207 to £221 per week. However these averages contain very wide disparities, with some highly specialised cases costing £2000 a week and some at the lowest end alarmingly and irresponsibly low.

For example in the Midlands the average fee for residential care was £221; the highest was £436. But the lowest end was £83. The lowest paid to a nursing home was £190 - both. In Thames and Anglia the comparative lowest figures were £97 (residential) and £175 (nursing). Whilst some of these low fees may be otherwise 'profitable' contracts, there is evidence that smaller homes are at the receiving end of these exploitative fee rates. It can only be inferred that either the homes will go out of business or the standard of care will become unacceptably low, as a result of enforced savings on staff, food, laundry. cleaning, heating etc.

A wider consideration of disparities in market rates for state funded residents was carried out by William Laing for the Joseph Rowntree Foundation (Laing, 1998). He draws attention to the circumstances above, but adds that 52% of residents with preserved rights have to pay top-ups to meet the disparity between the fees payable and the DSS higher rate. Of local authority supported residents 14% have to find top-up funds. Laing estimates that these top-ups for the poorest residents on a state funding cost £80, million a year.

It is almost standard practice across the industry to charge private payers a higher rate than is accepted for state supported residents. Thus those who are paying from their personal savings or from the equity from their house are systematically subsidising the majority.

Laing's reasonable conclusion is that there is a overall under funding of long term care, over and above the shortfalls which result from the diversity of fee levels. His estimate that a

further £600 million a year is needed to re-establish proper rates of return to what is now a predominately private sector industry.

Price and Quality in Tension

There is good reason to further raise quality standards in homes, through regulation, audit and training. It is also right that those who work as care staff should be properly paid and provides with appropriate employment facilities. The introduction of the minimum wage will not affect most of the bigger providers, whose lowest pay rates are already above the £3-60 minimum. But many homes have employed staff at less than £3 an hour and the legislation will Laing and Buisson estimate that following its introduction in April 1999, there will be an addition to industry costs of £90 million a year.

Commissioners and purchasers as well as a better informed clientele are driving up expectations of quality. Following the drive for single rooms and ensuite facilities, there is pressure to demonstrate staff training and the capacity to deal with increasingly dependent residents who are likely to experience progressive dementia and memory loss. Activities and the introduction of complementary therapies are also more demanded.

From government there is a significant assortment of new requirements in the making, most of which are listed earlier in this chapter. Amongst the ones which are troubling providers is the *National Required Standards for Residential and Nursing Homes For Older People* prepared by the Centre for Policy on Ageing for the Department of Health. Focus has already gone onto minimum room sizes - 12 square metres for new build homes and 10 square metres for existing homes. Reaching the required size for existing homes will add considerable costs and in some cases will lead to closure.

Changes in legislative requirements personnel regulations, training and quality are not peculiar to long term care. Nor is the need to respond to the market. But care services for the vulnerable old are not ordinary businesses. rapid turnover of staff, home closures and underfunding are matters of public policy and widespread social concern. So these changes present those who own and run homes with complex and difficult tasks. Perhaps this explains why in his 1998 market review Craig Woolam (1999) reports that one in four home owners plan to quit the market within the next three to five years.

Managing in the Turmoil

This account of major change imposed from outside the home which impacts on the lives of older people and those who care for them is only partial. There are other influences not mentioned here. The changing professional roles of doctors, nurses and other professional practitioners are a continuing and unresolved dynamic. So too are issues concerning ethnicity, death, personal finances and the voice of the consumer. All these find themselves on the desk and the mind of the Manager - the Head of care, The Matron and those who share their responsibility.

In earlier, simpler times, it was the common practice to appoint one of the core staff to 'run things'. Indeed such practices remain remarkably common, as we reveal in Chapter 5. But the sheer bulk of knowledge required and the ability to oversee care staff with skill and experience, demands a more serious recognition of the management function. With the honourable exception of The Residential Forum and some innovators within the industry, there has been all too little progress. It was in recognition of this needful situation that JRF commissioned this study.

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