Frances Kent
ICES
Gateway House
Room 261 Level 2
Piccadilly South
Manchester
M60 7LP

23rd November 2003

Dear Frances,

Mike Clarke spoke at a Nursing Conference organised by the Registered Nursing Home Association on Wednesday last and I had the opportunity of discussing with him the draft report, "The Provision of Equipment in Care Homes" which I understand you will be finalising on Monday next.

I would wish to re-state my observations to you in my email of 9th August 2003 when I expressed concern that a National Reference Group had been set up by ICES with a range of interests represented, but which excluded any representative of the three National Associations representing care home owners. Would a similar enquiry into hospitals have excluded a representative from the NHS ?

My concern, and that of the Registered Nursing Home Association, is obviously focussed on the way in which the report addresses the needs of service users in Care Homes which provide nursing care. We are also concerned over the inclusion of presumptions which we believe are inaccurate and which could have been corrected had there been anybody representing the providers included in the Reference Group.

I detail below our principal concerns.

1. Altruism of the creation of ICES

Besides the obvious intention of improving the provision, administration, maintenance and return of a wide variety of community equipment, the inference in the announcement by Jacqui Smith, when Minister, was that individuals would get a better service. By implication, I believe that this goal was intended to apply to all of those in need of community equipment, rather than improving the lot of one group, at the expense of another.

The expectation for Care Homes to provide certain equipment means that the cost of providing that equipment is shared amongst some, or all, of the patients who are resident in the home. This, in turn, means that a function which in the community is

met and funded by the State, as part of the National Health Service, becomes limited or restricted when a patient becomes too frail to remain at home.

In such circumstances their needs for community equipment often increase at a time when they are suddenly disadvantaged, financially, simply by reason of the fact that their healthcare needs are such that they can only be met in a nursing home. Those needs remain the same whether they are at home, in hospital or in a Nursing Home - the only difference being that their residence in a nursing home results in their having to pay for that equipment.

2. Rights of Individuals

Service Users who are resident in Care Homes have always been entitled to all of the services to which they would be entitled if they lived at home. Residential Care Homes have always been considered to be part of the community. A point which is included in “2 Background” of the report, but which is lost in other parts of the report.

The ‘Coughlan case’ expanded the debate in relation to the provision of equipment which is specific to providing care which can only be described as meeting the ‘nursing needs’ of the patient. If a process is deemed a ‘nursing process’ then the judgement (and later reports by the NHS Ombudsman) indicate that the NHS are responsible for funding that process and, inter alia, any equipment which that nursing process requires.

Further, Department of Health Guidance on Intermediate Care indicates that everything associated with the provision of Intermediate Care will be at the expense of the NHS, which might create a situation where patients with similar equipment needs might be in the same nursing home but whilst the equipment will be free to some (those receiving Intermediate Care) others will have to pay for that equipment.

3. Self-funding clients

Whilst your text states “The principles contained in this paper should apply to everyone regardless of their financial status” I am not sure if the full connotation of this statement is understood. The costs met by any organisation must be identified and then shared amongst those in receipt of the service. The long term care sector was under considerable pressure during the 1980's to move away from the practice of invoicing patients for individualised care to one where there was a single fee, which is the current practice.

The disadvantages of this approach is best identified in respect of incontinence products, all patients in nursing homes share the cost met by the nursing home in the purchase of incontinence products whether they use them or not. Likewise, payment for the provision of any equipment which ICES deems should be provided by the care home is included in the costs of the nursing home and shared amongst

the patients - again, whether the individual patient is need of them or not.

There is an associated issue which is commonly misunderstood by Commissioners of services (either intentionally or otherwise) where there is a refusal to address the fact that in order to remain viable home owners must adjust their fees to meet all of their costs, this often results in self funding patients cross subsidising those patients whose fees are met by local authorities.

There is no alternative to this action, which is regretted by all home owners, where local authorities use their monopsony to falsely hold down the fees they are prepared to pay to below the economic level. Independent research by Laing & Buisson, commissioned by the Rowntree Foundation, has indicated that the average underpayment by local authorities is £75 per patient per week. The issue of who pays for the provision of community equipment will become more pronounced in those areas where local authority fees are lowest.

4. Who should provide the equipment

We believe that this section is fundamentally flawed for three reasons;

Reliance upon the National Minimum Standards - rather than the Care Home Regulations 2001.

the interpretation of 'Fit for Purpose'

Interpretation of 'provide' to mean 'fund and provide' as opposed to 'make available or provide access to'

It is, however, firstly necessary to identify that the Government's response to the Royal Commission Report - in respect of NHS Funded Nursing Care initiative - is universally rejected by independent commentators as being penny pinching and unworkable. Its application is also being challenged by the NHS Ombudsman in her report on a number of cases she has considered.

The inconsistency of RNCC assessments is pronounced in regions, let alone nationally. We have examples of nursing homes where the RNCC assessment provides a total payment for all of the patients within the home which is less than the salary of the single nurse who has to be on duty to provide that nursing care.

The setting of eligibility criteria by commissioners is being challenged by the NHS Ombudsman. The inclusion of a requirement for a nursing home to include in the fee it receives from the social care commissioner nursing equipment which is the responsibility of the NHS was clearly excluded by HSG (92) 50 and LAC (92) 24:

> *When, after April 1993, a local authority places a person in a nursing home after joint HA/LA assessment, the local authority is responsible for purchasing services to meet the general nursing care needs of that person, including the cost of incontinence services (eg laundry) and those incontinence and nursing supplies which are not available on NHS prescription. Health authorities will be responsible for purchasing, within the resources available and in line with their priorities, physiotherapy, chiropody and speech and language therapy, with appropriate equipment, and the provision of specialist nursing advice, eg continence advice and stoma care, for those people placed in nursing homes by local authorities with the consent of a DHA.*

Whilst pressure relief equipment was not specified in HSG (92) 50, it was commonly held at that time to fall within the definition of 'specialist nursing equipment'.

The requirement to provide an Assessment of Service Users (Regulation 14), the provision of a Service User's Plan (Regulation 15), Facilities and Services (Regulation 16) and Fitness of Premises (Regulation 23) are all predicated on the statement within the requirement to produce a Statement of Purpose (Regulation 4) which states:

> *" a statement as to the facilities and services which are to be provided by the registered person for service users"*

and not the presumption which the paper makes;

> *"For care homes providing nursing care equipment is highly likely to include amongst other things, equipment such as pressure reducing and relieving overlays and replacement mattresses to maintain tissue viability (static and dynamic systems). That is, if a client in a care home providing nursing care is assessed as requiring preventative care for pressure ulcers, the care home should provide for that client"*

Firstly, it is thus possible for a care home providing nursing to exclude from its Statement of Purpose the provision of pressure relieving equipment. Secondly, a care home could indicate that it provides such equipment for a percentage of its patients.

The structure of the Care Standards Act and the Care Home Regulations passes the requirement to determine the services which will be provided to care home owners, rather than to permit the National Care Standards Commission to prescribe what will be provided. There are obviously safeguards built into to the system to ensure that standards are maintained - but not the power to prescribe.

In this way, it should be identified that the role of the National Care Standards Commission is to ensure that Regulation 4 (Statement of Purpose) is complied with,

not to comment upon the content of the statement or prescribe what will be provided.

Therefore, 'Fit for Purpose' is not to be seen as some external presumption of what should be provided by all care homes, but rather, a responsibility placed upon individual care home owners to be 'fit' to meet the 'purpose' they have stated.

Finally, as has already been identified by the NHS Ombudsman, there are some legal responsibilities placed upon the NHS which cannot be avoided by introducing a form of words which appears to place the responsibility elsewhere. HSC 2001 / 015 : LAC (2001)18, which addresses Continuing Care: NHS and Local Councils' responsibilities, includes at paragraph 23;

> *Health Authorities and PCTs are responsible for arranging for the following services for residents of nursing homes;*
>
> *access to GP and other primary care services (including community* nursing)
>
> *the provision of other nursing advice, eg continence advice and stoma care*
>
> *physiotherapy , occupational therapy, speech and language therapy, dietetics and podiatry*
>
> *from October 2001, continence pads and other related equipment (further details on this will be provided over the summer)*
>
> *specialist medical and nursing equipment (eg specialist feeding equipment) normally only available through hospitals*
>
> *palliative care*
>
> *and access to hospital care, which should also be arranged whenver it is arranged.*

The use of the word 'provide' should, therefore, not be presumed to mean 'fund and provide', but, rather, to mean 'make available or provide access to'

5. Assessment

I would not want to rehearse all of our deep seated concern over whether there is any real determination on the part of Government to do anything other than pay lip service to assessment. Suffice it to say that we continue to be disappointed that lessons have not been learnt by Government over giving the right to assess access to a service to a budget holder.

In 1993 Local Authorities were given the responsibility to assess the needs of individuals for community care, and the budget to meet those needs. The White Paper, 'Caring for People', which introduced those reforms, had as one of its Key Objectives "making proper assessment the cornerstone of good quality care". Sadly, the budgetary constraints meant that assessment was always compromised by the ability to pay.

More recently we saw the NHS Funded Nursing Care initiative, again, provide the budget holder - the PCT - with the right to determine how much each patient will receive. In one case we have evidence that the PCT is passing on a little over £1400 per week to a nursing home from a budget allocation of £1800 per week.

Our genuine concern is that, yet again, decisions will be made - may have already been made - over eligibility criteria which will favour the budget over the needs of the patient.

6. Working in Partnership

I have already commented on the poor start to the issue of partnership working with the providers of nursing home care in relation to this guidance. We have similar concerns that, despite the best of intentions, we are unlikely to see a national consistency between agencies over their policies on working in partnership.

We would hope that ICES will, firstly, undertake some monitoring role over the 130 individual equipment stores around the country, particularly in respect of eligibility criteria. Further, that either ICES or the Department of Health might be able to exert some influence over those who stray too far from a national average.

Annex C

I will resist the temptation to analyse the sample equipment provision guide given at Annex C, but would comment that, even at this late stage, if there could be some genuine dialogue between the national representatives of the providers with ICES then there would be a greater chance of securing agreement with individual providers around the country. Nursing Home owners need to feel a sense of ownership of any agreement, rather than having one foisted upon them.

Conclusion

It is always the case that representatives of providers of long term seem to be making reference to the confidence of the sector and its ability to provide a continued capacity, that is because we seem to be the only ones with a finger on the pulse. Any adverse circumstances - and there have been plenty in recent years - are identified as likely to result in more home closures. With homes continuing to close

at the rate of two per day, even the Minister will have soon to accept the situation as being a reality.

In relation to the provision of community equipment this lack of confidence is likely to have two consequences. Firstly, the obvious issue of the proposals being just one 'straw too many, which breaks the camel's back'. More pertinently, however, is that the reducing capacity is likely to make Annex C unworkable. In certain circumstances where nursing home owners have already used their stock of pressure relief mattresses, they will simply refuse to take a patient unless there is an increase in fee to cover the lease of a mattress, or, alternatively, the commissioner provides a mattress. As capacity continues to fall, it will be more difficult for the more dependant patient to find a place in a nursing home at the fees which the local authority is prepared to pay. At the same time it will be easier for nursing home owners to become more selective as to who they offer to provide care to when a room becomes vacant.

As a consequence, any insensitivity in the introduction of this paper is likely to have an adverse effect on the occupancy levels of hospitals. The Delayed Discharge legislation is unlikely to be able to cope with this additional difficulty and may lead to targets within the NHS Plan becoming more difficult to achieve.

Finally, we should remember that, at the end of the day, however it is phrased, it is ultimately patients who pay for all equipment which is provided by nursing homes

Yours sincerely

Frank Ursell
Chief Executive Officer