The Registered Nursing Home Association is pleased to respond to the consultation document on the proposed draft supplementary guidance on NHS Funded Nursing Care.

The Registered Nursing Home Association is, uniquely, the only national association which exclusively represents the interests of nursing home owners. Its membership consists of both single operators and corporate operators and, in total, our members own more than 25% of all of the nursing homes in England.

Background

We would wish to point out that our experience of the implementation of the NHS Funding for self payers was that it was not as successful as is claimed in the consultation document. This is evidenced not only by the media coverage of claims of NHS funding being withheld by providers and the statement by the Minister, Jacqui Smith that Regulation 5 is to be tightened up, but also by the hundreds of telephone calls received at our head office. This, together with concerns over the requirement to enter into contracts with PCTs, has all created a background against which nursing home owners have many reservations over the way in which the proposal to extend NHS funded care to local authority funded patients is to be implemented.

Whilst it is acknowledged that there was a stakeholder consultation group set up to address the introduction of NHS funded care to 'self payers', that group did not meet after April 2001. This was, in our view, a significant oversight in that there was no provider input into the key logistical issues surrounding the implementation in October 2001. Had there been a continuation of this consultation, many of the anxieties of providers could have been raised and may have been prevented.

The Registered Nursing Home Association would wish to place on record that the same lack of consultation surrounds the extension of NHS funded care to local authority contracts. Whilst the Department of Health has been consulting with the Association of Directors of Social Services (ADSS), the Local Government Association (LGA) and the NHS Confederation, the involvement of providers in this final stage consultation is too late in a process which will require significant good will on the part of providers if the initiative is to be introduced smoothly.

Amongst the major issues not adequately addressed in the application of 'free nursing care' to self payers was the simple timetable difference between the existing method, whereby patients paid for their care, and the self determined way in which HAs / PCTs made 'free nursing care' payments. The vast majority of self paying patients pay for their care monthly in advance by Standing Order. The NHS funded care element was paid weekly in arrears. The consequence of this mis match has meant that there is a bureaucratic burden to be borne by home owners in administrating and accounting for these two different pay periods.

Further, providers have been incensed by the knowledge that in transferring funds to HAs/PCTs the Government made funding provision for the administration of the initiative, but none of that administration funding has been made available to providers. In many cases extra part time staff have had to be employed and the

additional cost can be identified and measured.

Case Study

A 50 bedded nursing home in one of the Home Counties with 34 patients who are in receipt of RNCC has calculated that they now have to employ an additional administrator for a minimum of three days per month to undertake the additional work in relation to:

- *Preparation of schedules*
- *Liaison with the PCT*
- *Verifying payments are received*
- *Issuing individual cheques to those patients who pay by standing order for the RNCC received*
- *Preparing individual invoices for the other patients*
- *Creating credit control and an audit trail*

At an hourly rate of £10 this equates to £240 per month, or £7.00 per patient per month.

As negotiations with PCTs have failed to secure any funding for the cost of administration, that cost has to be passed on to those in receipt of NHS funded care. It is inappropriate to aggregate that cost to all patients as this would mean that local authorities would be bearing a cost which specifically related to self paying patients. Post April 2003 this situation will continue for self paying patients unless there is recognition by the Department of Health of the need to instruct PCTs to make a payment for the cost of administering this government initiative.

Principal amongst our concerns is that neither the NHS / PCT nor the local authority truly understand the cost basis for the provision of nursing home care. Few PCTs, when meeting the cost of continuing healthcare in nursing homes, are prepared to pay more than £500 per week, whilst the cost of such provision in hospitals is more than twice this figure (*"average cost of a seven day stay in hospital for the speciality of elderly medicine is £1,015"* - Jacqui Smith, Hansard 9th December 2002). Indeed many will only pay the fee agreed by the local authority for nursing home care.

Local authorities, for their part, whilst often having a range of social care fee levels for increasing dependency, invariably only have one fee level for nursing care. There is genuine concern that the additional costs of staffing and the more specific facilities provided in nursing homes are not properly recognised, and thereby costed, by local authorities.

Finally, the implementation of the NHS & Community Care Act, by giving the responsibility to local authorities to fund those patients who are unable to pay for their own nursing care, has created a two tier market within the provision of long term care. The fee levels paid by local authorities have failed to keep pace with the simple inflationary costs of providing residential or nursing care and this has resulted in the need for cross subsidisation of public funded patients by those who pay for their own residential or nursing home care.

Providers are forced into this approach by the pragmatism of having to ensure that their home remains financially viable (now a legal requirement of the Care Standards Act). Local authorities and Ministers and officials in the Department of Health are aware of this situation and their complacency over securing a long term solution does not help. In producing guidance to local authorities on the extension of NHS funded care, the Department fo Health needs to display considerable sensitivity over ensuring that they do not, inadvertently, create a scenario which might lead to widespread concern being expressed by self paying patients or, worse, to a legal challenge.

The Registered Nursing Home Association does recognise that the Government has committed to introducing NHS funded care to all patients and is keen to work with the Department of Health to ensure that this is achieved with the minimum of inconvenience to patients and providers.

Principal areas of Concern

We perceive there to be five specific areas of concern which we would wish to see incorporated in guidance on NHS funded nursing care:

a) A recognition by local authorities of three bands of nursing home care with increased personal care and accommodation costs associated with each band.

The experience of our members over the past ten years of local authority funded care is that whilst local authorities may go through some form of local consultation over fee levels, the ultimate decision is theirs and relies upon the monopsony they enjoy as a single commissioner of nursing home care. Independent analysis by William Laing of Laing and Buisson has identified that during those ten years, the fee levels enjoyed by nursing home owners have fallen behind the cost of providing nursing home care by £76 per week. *(Calculating a Fair Price for Care).*

The publication of the document *Building Capacity and Partnership in Care* by the Department of Health in an attempt to arrest the falling capacity of the long term care sector has, largely, fallen on deaf ears. Although in the past year we have seen some movement towards higher fees, the fundamental requirement within the document to recognise the true cost met by providers has yet to be acknowledged.

Against this background, the nursing home sector is not convinced that local authorities will have procedures which are sufficiently robust to ensure that the individual needs of patients will be adequately met. Our fears are that there will be a move to identify a simplistic single fee level for the 'personal care and accommodation' elements of nursing home care, to which will be added the NHS funded care contribution.

It is a fallacy to believe that by some process of 'swings and roundabouts' the provider's income will be protected. More pertinently, this approach does not properly address the assessed needs of the individual. As an individual's nursing

stability may change so may his/her personal care needs increase. What we do not want to experience is a local authority determining that there is a single personal care and accommodation fee level which is common to all patients.

We believe that in each local authority there should be three distinct levels of fees for the three bands of nursing care which are currently defined . The fee levels to be agreed in the usual negotiating process between providers and commissioners and to be based upon the principles embodied in *Building Capacity and Partnership in Care*

Recommendation

We would request the Department to insert an additional paragraph after the first principle of Commissioning to read

"Councils should note that the costs associated with the provision of nursing care will be different from the costs associated with providing residential care without nursing and hence should agree with care homes providing nursing three total fee levels reflecting the different band of RNCC along with a mechanism for providers to utilise when the equivalent level of income is not maintained, when compared with 2002/3."

b) Funding arrangements to continue to be from a single source, preferably local authorities, with NHS funding being passed by PCTs to local authorities.

This is the procedure outlined in the Model A contract. We are concerned that there are few local authorities who have Partnership Agreements in place, which is a qualifying requirement for using the Model A contract.

We do not want to see a repeat of the disarray which has followed the implementation of this initiative for self paying patients with funding being from two different sources at two different time scales.

We have, over the past ten years, developed useful relationships with local authorities, with their various assessment, finance and policy departments. This relationship should be used to good effect to ensure that the provision of care in any given home is not endangered by any breakdown in cash flow.

The qualification in the guidance of the need for partnership agreements to be in place must be addressed without delay. It must be within the capabilities of the Government to facilitate a fast track approach to ensuring that sufficient safeguards can be developed to meet the governance principles which are embodied in the use of public funds.

It is noted that the guidance indicates that local authorities are not to receive any funding for their administration costs. It necessarily follows that as the funding for administration is only going to the PCT, then the assessment of individual nursing needs and the administration of the payment process must be undertaken by the

PCT in as cost effective manner as possible. The payment of a single amount per month to a local authority, who will then continue to pay individual homes by their current payment arrangements seems to be eminently admirable.

Local authorities already have in place arrangements to cater for emergency admissions and the funding for same. It will be necessary for PCTs to agree a figure which will be incorporated into the fee paid by local authorities for such admissions. We presume that this figure will be based upon the middle funding band.

c) Contract control and quality assurance to be vested in the local authority.

The long term care sector is now the most regulated of any United Kingdom business sector. In addition to the usual regulatory compliance to be found in all businesses from organisations such as Planning Control, Building Control, the Health & Safety Executive, the Environment Agency and the Environmental Health Department, providers are also subject to regular inspection by the National Care Standards Commission, contract control by local authorities and a range of other government driven initiatives such as '*No Secrets'.*

The Registered Nursing Home Association has, on behalf of its members, previously raised concerns over PCTs becoming involved in quality assurance matters in relation to the model contract for self paying patients. The issue is a fundamental one of who are the principle parties to the contract and who has the overall right to determine whether the service element of the contract is being discharged to the satisfaction of the user.

We are already seeing some cross over of contract / quality assurance control with the new, more stringent, powers now being exercised by the National Care Standards Commission. The local authority, being a party to the contract on behalf of the patient, has always exercised these controls for the patient.

The Registered Nursing Home Association believes that each entity should have a specific role to play on behalf of all of the partners so that the focus of our care - the patient - receives the outcome of that care with the minimum of upheaval. We would advocate the following in respect of those patients whose care is funded by local authorities.

The principle parties to the contract are the provider and the local authority. The local authority acts on behalf of the patient and the PCT. The principle responsibility for each party is :

Local authority	Assessment of an individual's care needs Contract arrangements with providers Quality assurance of contract matters Making payments to providers 'No Secrets'

PCT	Assessment of an individual's NHS Funded care element Assessment of an individual's continence needs Transfer of the individual's funding to local authority
National Care Standards Commission	Regulation of Care Homes providing Nursing Monitoring of standards of care provided by the nursing home. Undertaking a complaints procedure Regulatory and enforcement action when necessary.
Provider	Provision of services to an individual in accordance with the assessed needs of the patient Meeting the standards necessary to satisfy the Statement of Purpose and Service User Guide Maintaining standards of care such as to ensure continued registration by the National Care Standards Commission Maintaining such financial records as will provide an audit trail

The Registered Nursing Home Association believes that separation of individual responsibilities of each party, but with joint commitment to working together, will bring about the intended outcome for the patient with continuing protection for the individual.

This model should determine the way in which the future long term care for older people is secured. In particular, the Registered Nursing Home Association believes that the Department of Health can satisfy its discharge of 'providing' NHS funded care by a simple extension to the contract between local authorities and providers. Such extension need do no more than recognise that the local authority also represents the interests of *x* PCT.

Recommendation

> *The Department of Health should adopt this model and include the model within the guidance as directions to each party as to their responsibilities. No change in legislation or regulation is required, simply a determination to 'make it work'*

d) Genuine needs based assessments and provision of incontinence aids by the PCT.

There is a long history of irritation on the part of providers over the provision of incontinence services to patients in nursing homes. Not only have such patients been denied a service which has been provided freely to residents in residential care

homes, but nursing home operators have had to bear VAT on incontinence products. This despite the fact that the individual concerned is entitled to VAT relief were the supply to be individually purchased. Clearly nursing home operators are far more concerned over the well being of their patients than are (successive) governments or the Custom and Excise Department in that they continue to purchase such products collectively and, thereby, incur the VAT charge - which, of course, is then passed to the patients in their fees. Again, because of this background this is an area in which sensitivity is required in relation to new arrangements.

To date incontinent services have been made available to individuals at home and in residential care homes. The introduction of a payment for incontinence products to self paying patients from October 2001 has been piecemeal and, at times, derisory.

The other alternative, that of providing incontinence products has also highlighted the, often, unthinking nature of the NHS continence service whereby individuals are required to store 4, 6, or even 8 weeks supply of these products. When this approach is applied to nursing homes the logistical problem of storage is very real. Our current arrangements, via our local suppliers, is usually weekly based. It would be impossible in many nursing homes to find safe storage for even 4 weeks supply of incontinence products.

This storage issue also impacts upon the whole question of control of the products. If they are to be made available to individuals following an assessment of that person's needs then are they to be restricted to use by that person ? If so, how are we to monitor control of the issue of products ? Are we to store them in the patient's room? Eight weeks supply at a time would probably take up most of the remaining floor space in a patient's room

Few nursing home providers have found the allocation of either supplies or funds meets the level of supply or expenditure they have been providing to patients prior to the introduction of the service. In particular, providers have been unable to reconcile the service their patients are being offered, especially a rationing process of, usually, three pads by day and one by night, with the advice to be found in the Department of Health publication *"Good practice in Continence Services"* especially:

> *Pads should be provided in quantities appropriate to the individual's continence needs. Arbitrary ceilings are inappropriate. Guidelines should be developed for the Primary Health Care Team to aid product choice, but these should not be seen as rules." (Appendix 2 - supply of products).*

The Registered Nursing Home Association believes that there is a potential legal action, on the lines of the Pamela Coughlan case, in respect of the way in which this part of the 'free nursing care' initiative has been introduced. We urge the Department of Health to review the funding of this aspect and to ensure that there is sufficient money available to meet the advice it has published.

Recommendation

The Department of Health is requested to place additional guidance in the circular after paragraph 25 stating that
"Whilst it is accepted that continence products are managed within PCT budgets, an individual patient should have the supply of continence products based upon their individual needs and allowing for changes in the daily condition of that patient. Arbitrary local limits to the supply of continence products are, therefore, not appropriate."

e) Community equipment which meets the assessed nursing needs of the patient to be provided by the NHS / PCT.

As with the provision of incontinence products, this is an area which providers of nursing home care believe patients in nursing homes have been disadvantaged and they are pleased that there is to be some recognition of the rights of patients in their care to community equipment.,

There are two fundamental issues which the Registered Nursing Home Association would wish to make on behalf of providers of nursing home care.

- Since 1993 the care of patients in nursing homes has been paid from the social care budget. Social Services departments have, over this period, been reluctant to provide or pay for equipment which they have deemed to be 'specialist' or nursing in nature. At the same time they have been depressing the fees paid for nursing home care such that nursing home providers are unable to provide that equipment themselves.

  Fees which are determined by personal care based contract negotiations do not take into account the costs for equipment met by nursing home providers. The equipment which is presumed to be provided as part of the usual facilities of a nursing home should not extend to the type of specialist healthcare equipment which might be expected to be found in hospitals or other healthcare locations.

- There should be some clearer directions on what is expected to be found in nursing homes than is to be found in the current draft guidance. The extension of NHS funded care to local authority patients is to a group of patients where the local authority determines the fee it will pay. In these circumstances it is not possible to assume that such patients, at the lowest fees paid, will necessarily provide sufficient funding for the provision of equipment more easily afforded where an appropriate fee is paid.

Recommendation

We would ask the Department to make the guidance more specific by including a further paragraph as follows:

"Where the needs of an individual patient necessitate the provision of equipment which is unlikely to be able to be used for any other patient (for example because of the design size or weight, or intensity of need of the patient) then the obligation to provide will usually rest with the NHS. However where equipment is of a generalist nature then the Home offering care with nursing should be required to provide that equipment."

Conclusion

The Registered Nursing Home Association urges the Department to take account of the serious issues raised above. These issues come from those providers who work, live and breath this provision of care in a hands on manner on a daily basis.

The comments are made with greatest authority and knowledge. As such they are practical comments on areas which will seriously affect the market for Nursing Care in the coming years.

The greatest risk which the Department of Health faces in respect of the extension of NHS funded care to local authority funded patients is that if it is not undertaken sensitively enough, the only consequence will be a further reduction in capacity. Nursing homes are, arguably, the only establishments to which patients in hospital in need of nursing care can be discharged.

The Secretary of State recently identified that the capacity of the long term care sector has already fallen to a level which is less than is desirable and has indicated that an additional 6000 beds should be commissioned by 2006.

The patience of nursing home owners is stretched, care needs to be taken not to create such a funding nightmare that it will break.

The ethos behind Free Nursing Care is very commendable and supported by us all. Let us endeavour together, for once, to enable this benefit to reach some of the most vulnerable citizens in our community.

Frank Ursell
Chief Executive Officer