7.13

The Registration of Private Homes and Nursing Homes

May 1986

HEALTH NEWS BRIEFING

Association of Community Health Councils for England and Wales
Mark Lemon Suite,Barclays Bank Chambers • 254 Seven Sisters Road, London N4 2HZ • Tel 01 272 5459 01 272 5450

THE REGISTRATION OF PRIVATE HOMES AND NURSING HOMES

Report of a conference jointly organised by ACHCEW and the King's Fund Centre on 11th March 1986.

The day was divided into four sessions: one each for the two invited speakers; a panel discusson; and a summary of the day's proceedings.

"Private nursing homes and mental nursing homes: trends and issues"
STUART HAYWOOD, Health Services Management Centre, University of Birmingham

Mr.Haywood's intention was to persuade his listeners of the continuing need for a "mixed economy" in residential care provision. The level of demand for places in residential care makes this inevitable. Such a "mixed economy" has to be seen in the context of the close connections that already exist between the NHS and the private sector: the private supply of goods and services to the NHS; private beds inside and outside the NHS; private health insurance; NHS contracted beds in private facilities.

Once the need for a "mixed economy" is established, the question arises how best to manage this mix of private and public sector provision so as to maximise the benefit to those people who are in nursing homes. What should be aimed for?

Only a minority of the population over 65 years lives in residential care (3.64% according to the last census). The majority of these are in public sector homes - 66%; and 34% are are provided for by the private and voluntary sector. 10% of the total, though placed in the private sector, are paid for out of public funds.

The private sector is growing. The number of beds in private nursing homes increased from 18,197 in 1982 to 26,500 in 1984.

Should such a trend continue, by 1990 40-45% of all continuing care for the elderly will be provided by the private sector. This prediction involves three assumptions:

1. There will be little or no increase in NHS provision for continuing care.

2. Age specific demands for residential and nursing care will not diminish.

3. The arrangements for public finance will not change in any radical way.

It is because these assumptions are likely to be correct that it is best to adopt a pragmatic approach towards the private sector - accept its existence and seek to improve the way this "mixed economy" works for the benefit of all. Those who are totally opposed to the private sector should bear in mind the overwhelming demand that would fall on NHS provision should it be abolished or seriously restricted. Furthermore, given the succession of public inquiries into NHS hospitals, there are no grounds to suppose that public ownership is a guarantee of high standards.

Any mix of provision between the public and private sector should satisfy certain key conditions:

1. Full consideration should be given to the preferences of the "consumer" or relative, particularly in respect of location and ease of access.

2. Provision should be appropriate to clinical needs.

3. It should treat the individual with dignity and show respect for and flexibility towards his or her needs.

4. It should offer value for money.

If the private sector can satisfy these conditions, then it should be acceptable.

What is the role of the public authorities in regulating the private sector? As well as ensuring that minimum standards are met, they should also be seeking to improve overall standards. Firstly, it is necessary to monitor "results". Are the standards of health care adequate? What are the nursing levels? How frequent are medical visits? What are the paramedical services like? A similar kind of checklist could be compiled around the idea of personal dignity e.g. personal clothing, memorabilia, bedtime flexibilty, menu choice etc. How satisfied are the patients themselves with all these arrangements? There should be more effort to develop training for staff in the private sector. The authorities carrying out regulatory checks need to develop their own skills further. Secondly, the public authorities have a role to play in reinforcing the market

mechanism. There should be sufficient information available for consumers to make knowledgeable choices. Competition should be encouraged in the interests of the consumer.

Finally, it should be noted that the majority of DHAs have little or no connection with private homes. 30 DHAs have no such homes in their area; 50 have only one or two; and another 50 have only three or four.

Discussion:

A number of points and questions were raised in discussion.

1. Are the monitoring arrangments adequate? Should it be the NHS or some independent body that undertakes regulation? Is there not a need to control the geographical distribution of homes? Present variations in standards could perhaps be overcome by the co-ordination of registration by RHAs.

2. How can existing NHS provision be expanded? Private sector rates were beyond many people's ability to pay. How would the process of competition deal with this? Were not the present public financing arrangements inadequate? There were areas such as the South East where levels of provision were inadequate.

3. How should standards be monitored in homes that were closing down or in non-registered homes i.e. those with less than four patients/clients?

4. CHCs have a right to visit private homes where there are DHA sponsored patients. Yet it was often difficult for them to exercise this right. This reflected a general dissatisfaction over the arrangements for the protection of the consumer.

.....

"Registration and inspection"
LINDA CHALLIS, Lecturer in Social Policy, University of Bath

The speaker intended to look at the questions of registration and inspection in the light of two issues: the problems of dual registration and consumer information and choice.

The distinction between residential care homes and nursing homes was a historical one. It had happened to develop that way and often failed to reflect the true needs of the people using the facilities. The purpose of dual registration was to make up for this failure by providing some continuity of care. It would obviate the need for moving increasingly frail individuals to different homes with nursing provision. There are, however, problems in satisfying the requirements of dual registration and hence in being able to provide this desired continuity. To satisfy both DHA and SSD regulations is difficult - there are discrepancies between them. As a result, proprietors of residential homes could well decide that the additional expense

and bureaucratic effort involved in satisfying DHA regulations were simply not worthwhile. These obstacles in the way of dual registration and the provision of proper continuity of care constitute a serious problem, which needs to be looked at closely.

The speaker's own recent research into private homes had disclosed that only 50% of those contacted provided any literature or brochures. Only 40% entered into written contracts with their clients for the services and facilities to be provided. One of the local authorities she had contacted refused to give information or advice on private homes. This state of affairs should be corrected.

It was clear that there was a need for more information for people considering entering care. This should include information on the kinds of provison available: NHS, Social Services, private and voluntary sector. Prospective users should know what the regulations governing residential and nursing homes are. They should know what to expect, not only in respect of the "hotel" services offered in any given home, but also in respect of its philosophy of care. Are there any rules they should know about? Is there anything they may have to give up? Privacy? Autonomy? Control of their own finances? How secure is their tenure?

Perhaps local authorities could produce a blueprint for what should be included in a brochure. Community Health Councils could produce information on pre-care considerations as well as regulations and statutory requirements. Contracts should not be optional; all residents should have one. Personal and independent advice on the choice of a home should be available.

The speaker concluded by emphasising the need to maintain a sense of proportion in the standards to be enforced. They should not have the consequence of causing a decline in the level of provision by private homes.

Discussion:

1. It was felt that there should be closer liaison between DHAs and SDDs in order to develop a common language.

2. Residential care homes should be required to give details of arrangements made between themselves and Family Practitioner Committees regarding the availability of medical care.

.....

PANEL DISCUSSION:

AUDREY DERRICK, Registration Officer, Somerset SSD

The speaker described the procedures used in Somerset. There is a contract between the County and private providers. Initial advice and access to training facilities are given. There was a 3-day

training course for new proprietors.

Somerset respond immediately to any complaint. However, before private owners are criticised, the County needs to look very closely at its own provision. There should be liaison with FPCs and GPs locally. Somerset have prepared a package to be sent out to people who are thinking of opening homes. Less than 10% of these actually go ahead. Somerset have never de-registered a home. On the other hand, Lancashire have de-registered six. Special arrangements are made for change of ownership and should be made for dual registration.

JOSEPHINE BARRY-HICKS, Ealing CHC

Ealing has a lot of acute nursing homes and the largest abortion clinic in London. Its proximity to Heathrow means that there are many people from abroad making use of the private sector, particularly for abortion and sterilisation. There are no arrangements for ensuring that these people have enough money for their stay - or even enough to return home. The problems connected with private nursing homes are not confined to long-stay patients such as the elderly, the mentally ill and the mentally handicapped. Young disabled people from overseas had been abandoned in nursing homes and the fact that they were young enough to be taken into care created additional problems. There are many changes of ownership at the bottom end of the market. Infractions of regulations tended to be serious - e.g. missing fire escapes. The de-registration of such homes was considered in the public part of the DHA meetings, thus ensuring that the press got to know. If problems arose with acute cases in private homes, the DHA had to pick up the case immediately, which puts a lot of extra pressure on HA acute beds. NHS contractual beds are being withdrawn from the voluntary sector - which means a depletion of middle-range facilities. Pressure is put on people to transfer from the public to the private sector in an effort to free beds, and they are not being properly informed of all the implications. Most importantly, they are not told that DHSS coverage of their fees excludes laundry and incontinence pads. Elderly people going into private nursing homes need to be assessed so that their clinical needs are clearly understood. Dual registration had been costed and was found to be both time-consuming and expensive. There was no funding for inspection in Ealing and 8 WTE inspectors were necessary for effective inspection.

MARGARET BURFORD, Blackpool CHC & EDGAR EVANS, Weston CHC

Both speakers came from areas which attracted large numbers of retired people. In Blackpool 25% of the population are elderly. The very large number of homes is a problem in itself because of the demands placed on support services. (In Blackpool 22 nursing homes and 250-300 residential homes: the CHC had been invited to visit one-third of them, but had been opposed by the DHA). The

popularity of both areas had often led to an "upgrading" of the market and a consequent rise in fees, thereby causing problems for the poorer section of the elderly community and contracted NHS patients. People moving into these areas from other parts of the country often remained unknown to the HA and the LA for a long time. FPCs were, for instance, slow to send records to Weston. In Weston both the DHA and CHC visited registered nursing homes and quality of care was expressed in advertisements "as visited by the CHC."

There were occasional problems with non-registered homes. A halfway house for drug addicts requires social living - people benefit from sharing rooms. But this means they cannot register as the rules require single rooms.

MARGARET MARTIN, Cambridge CHC

The speaker concentrated on the problems that had been encountered with Kneesworth House, a private mental nursing home owned by AMI. It accommodates "difficult to place" patients, many of whom are under compulsory detention. Twenty-three of the patients had been placed there by five DHAs. DHAs can send individuals to Kneesworth without informing their CHC and hence not all CHCs are exercising their rights to visit the facilities at Kneesworth.

The CHC had not been able to find out which DHAs had placed patients there. Apart from the statutory inspection and visits from the Mental Health Commissioners, it is therefore questionable whether there is adequate public monitoring of this commercial venture. The DHA has not come up with any solutions to the problems of registration and monitoring. The CHC role was weak, even though they have negotiated to visit four times a year. There was no role for the Local Ethical Committee. MIND do not have access.

Such a facility as this is contrary to national policy, which advocates local units. It also has to be recognised that because it is a commercial venture, patients may not be discharged at the earliest appropriate time. How do patients in such a unit as this exercise their consumer rights?

The same company, AMI, plan to build another "national facilty" for brain- damaged patients and "difficult to manage" mentally handicapped people.

Participating CHCs were urged to write to their DHAs regarding Kneesworth.

The suggestion was made that Regional Associations of CHCs should organise conferences on this subject.

.....

An important point that emerged from the panel discussions was

the diversity of private nursing homes and the range of problems this created for registration and inspection. Acute nursing homes, abortion clinics and facilities for drug addicts are instances of this. It was felt that CHCs should have the right to enter all such homes.

.....

RAY JOBLING, Chairman, Cambridge CHC

Stuart Haywood's picture of the buyer in the market-place made one want to say Caveat emptor! The day's discussions had raised issues of the respective roles of market forces and planning and regulation. Was it the case that cheaper always meant better? Might not investor's decide that health care was no longer the place for smart money - and what would happen when the funds started flowing out of the sector? If the growth of private nursing homes continues to accelerate, the burden of monitoring could become too great for DHAs. If CHCs succeeded in gaining admission for inspection, they too could find themselves with obligations they were unable to discharge. Should there not be a national inspection team paid for out of registration fees - or perhaps, Regional inspection teams? The problems were considerable and it was open to question whether or not the present situation was one of partnership between the public and private sectors - or a "takeover".

Ken Howse 15.5.86

ACHCEW would like to thank all the CHCs who sent us their reports on the conference.