Regulating nursing homes

Caring for older people in the private sector in England

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This is the last in a series of three articles

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Over half of all beds allocated for health care in the United Kingdom are in independent nursing homes for older people; this is a result of policies initially introduced to change the basis of social security payments[1] and now directed towards privatising long term care. Official statistics from the Department of Health indicate that between 1979 and 2000 the total number of beds in the NHS in England decreased from 480 000 to 189 000, while the number of beds in the independent sector, which is run mainly for profit, increased from 23 000 in 1983[2] to 193 000 in 2000.

Experiences in the United States and Australia have shown the lack of political will to promote the interests of residents against the interests of the industry and its shareholders.[3 4] In Australia the industry successfully lobbied to replace legally enforceable regulations with less effective accreditation schemes; this has had disastrous consequences. In the United States the industry successfully opposed the introduction of robust standards for minimum numbers of staff, and the result is continuously declining health outcomes for residents. The risks to residents of nursing homes in the United Kingdom are considerable as subsidiaries of large US multinationals enter the United Kingdom[5]; some of these companies have come under scrutiny in the United States for fraud and embezzlement of government funds and for abusing patients.[3] This paper considers whether the new regulatory framework for nursing homes in the United Kingdom offers adequate protection for patients.

Summary points

- Over half of the healthcare beds in the United Kingdom are in independent nursing homes for older people
- Little information is collected centrally about the needs for care or outcomes of services used by residents of nursing homes
- Research in Australia and the United States indicates that having an adequate number of qualified staff per resident is the key to delivering good quality care in nursing homes
- Since the mid-1980s the number of nursing homes has increased sevenfold but the number of inspectors has only tripled
- Little attention has been paid to what structures and mechanisms will be required to ensure that the National Care Standards Commission is accountable to users
- If new regulations are to protect patients they must be strengthened to ensure adequate staffing, monitoring, enforcement, and accountability

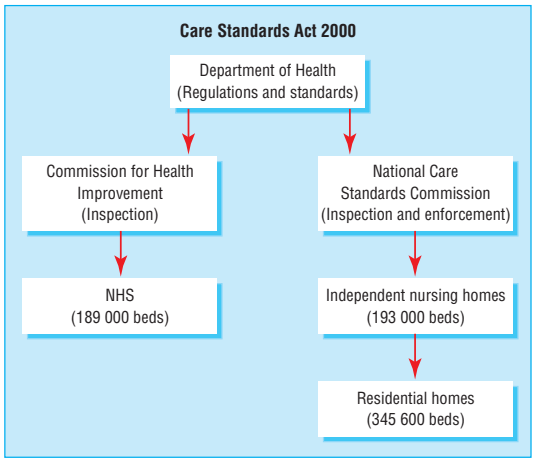
The new framework for regulation

The Care Standards Act 2000 and the Regulation of Care (Scotland) Act 2001 establish new regulatory frameworks for all care homes in the United Kingdom. Each act has three elements: regulations and standards, monitoring and inspection, and enforcement (figure). The responsibility for formulating standards and regulations will be retained by the Department of Health and the Scottish Executive. Standards are not legally enforceable, but failure to meet standards can be used as evidence in prosecutions for failure to comply with regulations.[8]

Under current legislation, individual health authorities are responsible for initially registering and inspecting nursing homes, and local authorities are responsible for registering and inspecting residential care homes. (Nursing homes are for residents who primarily need skilled nursing care. Residential homes are for clients who primarily need social care.) Under the new legislation, which comes into force in England and Scotland in 2002, the distinction between nursing homes and residential care homes will disappear. Responsibility for registering and inspecting homes and enforcing regulations will be transferred from health authorities and local authorities to the Commission for Health Improvement and three other new central organisations: the National Care Standards Commission in England, the National Assembly for Wales, and the Scottish Commission for the Regulation of Care. The National Care Standards Commission will have registration and enforcement powers that encompass not only care homes but also independent hospitals and other forms of social care.

Planning

The responsibility for ensuring that the services are appropriate to individual needs and are of high quality will remain with local authorities and NHS care trusts. However, the act does not provide a mechanism for determining the capacity of the sector and planning services to meet the needs of residents in each area. The act states that in England the remit of the National Care Standards Commission is simply to "encourage improvement in quality of … services" by ensuring that homes are registered and meet minimum quality standards. Although *The NHS Plan*,[9] which applies only to England, seems to mark a return to setting targets to increase the number of beds in the NHS acute sector and the intermediate care sector, this planning is absent from the approach to long term care. It is surprising that market forces and not patients' needs will be the key determinants of the capacity of this sec-



Departments and responsibilities for implementing Care Standards Act 2000 in England[6 7]

tor given that government funding accounts for 70% of the £9bn ($12.6bn) in annual revenue earned by the long term care sector.

Safeguarding the quality of care

Staffing

Research in the United States and Australia has shown that having low numbers of staff is associated with poor quality care.[3 4] The Regulation of Care (Scotland) Act 2001 allows local authorities to employ, fund, and determine the qualifications, skill mix, and number of nursing staff and to retain the ability to use publicly employed staff. In England local authorities may not fund, employ, or determine the number of nursing staff.

Despite the industry's poor record with respect to staffing, including having high turnover, offering low pay, and doing a poor job of recruiting,[5] the national minimum standards for care homes for older people in England have set no minimum requirements for the number of staff. Instead staffing requirements in each home are to be determined using a standardised assessment of each individual resident; the means of assessment is as yet undetermined. Inspectors will be responsible for calculating the number of staff needed using the current assessment of every resident[8]; this will be a time consuming, complex, and resource intensive task with room for dispute between the inspector and the care home.

Reimbursement and payment schemes

Nursing homes are reimbursed for each patient, but there is no mechanism for linking reimbursement to staffing and performance. The government has adopted a "traffic light" system for NHS trusts under which they are reimbursed on the basis of both their financial performance and the quality of care provided, but this approach is not being implemented in contracts with private nursing homes. In the United States, patients are assigned by staff to up to 66 categories of dependency,[3] and reimbursement is made using a measure of case mix. The effect of using risk adjusted capitation has been to encourage providers to manipulate the system by reporting higher levels of dependency for patients; however, there has been no requirement for providers to increase the number of staff.[10] In 1991, 4% of nursing home residents in the United States developed pressure sores, 15% developed contractures, and 47% developed bladder incontinence; in 1997 these proportions rose to 7% for pressure sores, 23% for contractures, and 50% for bladder incontinence.[11]

It has not yet been decided how reimbursement will work in England, but it is a cause for concern that the Department of Health is funding pilot studies of case mix reimbursement without having developed robust staffing standards.[12] In Scotland it has been proposed that reimbursement will be at a flat rate, but there is a risk that homes will try to select clients who need less care.[13]

Monitoring and accountability

Enforcement and monitoring by inspectors

The National Care Standards Commission's inspectorate will be responsible for monitoring and enforcing standards. Enforcement may be difficult, however, given that the inspectorate has relatively few resources. Since the mid-1980s the number of beds in nursing homes has increased sevenfold, but the number of inspectors has only tripled (table). Although the care standards commission will be provided with start up costs, in the long term it is expected to recover the costs of inspection from the care homes.[14] An under-resourced inspectorate will find it difficult to assess staffing levels and monitor compliance with other standards.

Persuading errant providers to comply with standards requires a regime of credible sanctions.[15] Apart from education and persuasion, the Care Standards Act provides the National Care Standards Commission with four sanctions with which to threaten providers who don't comply: formal notice of non-compliance; fines of up to £5000 for specific offences, such as failing to comply with conditions of registration; withdrawal of licence; and the exclusion of individuals from the industry. Although an enforcement notice might shame a home, if it fails to do so inspectors may be reluctant to take action that would lead to a revocation of registration. The disruption that revocation would cause to residents makes it an unpopular step and

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Changes in workload of nursing home inspectorate, England

	1983	1999*
No of homes	820	6 104
No of beds	28 000	196 000
No of inspectors	100	300
No homes/inspector	8	20
No beds/inspector	280	653

*1999 is the latest year for which nursing home inspectors can be identified.

unlikely, except in the most extreme circumstances. Intermediate sanctions—such as levying large financial penalties, barring new admissions, or taking over management—have not yet been made available to the care standards commission. These types of intermediate sanctions are considered essential tools for regulators in the United States,[3] in other sectors in the United Kingdom,[16] and in the NHS.[17]

Information and transparency

A keystone of the National Health Service and Community Care Act 1990 was the care plan, which focused on the care needed by an individual patient and the levels of service that were to be provided. An important deficiency of the act, however, was its failure to implement a standardised, routine data set for monitoring care plans. As a result, it is not known what type of care is needed by the 500 000[18] most vulnerable individuals in care homes and the services that are provided to them, and thus these needs and services cannot be scrutinised by researchers or government officials. Local studies have found that there are high levels of unmet need and that there is a lack of appropriate services in residential and nursing care.[19 20] The new regulatory framework does not improve this situation. Although the national minimum standards require that there is a care plan for each service user, there are no arrangements for collecting standardised information from the care plans despite the powers for collecting information that are provided by the Care Standards Act. Thus there will be no means of determining how much care is needed, what care is provided, and whether needs have been met.

Data could be collected about the performance of individual homes and their compliance with regulations, but comprehensive data are available only about the capacity of the sector. There is no standardised rating scale for homes, and the only information collected centrally is the total number of formal notices of non-compliance and prosecutions. This contrasts with the regulatory requirements for the public utilities in the United Kingdom and performance frameworks for public services, which include league tables for individual NHS hospitals and schools. In the United States, information about outcomes of care in nursing homes and regulatory deficiencies are presented on the Healthcare Financing Administration's website for each of the 18 000 nursing homes (www.medicare.gov/nhcompare/home.asp). These data are used by researchers, advocacy groups, and patients' representatives to highlight problems with care in nursing homes.[3] Unless the National Care Standards Commission makes major efforts to overhaul systems for the collection of data, any attempts by the public to hold it to account will be hampered by a lack of information.

Accountability

When pressure from the industry is not balanced by public involvement, regulations can be compromised. The industry now has the ear of government through the NHS concordat (an agreement between the Labour government and the independent sector which allows the private sector to deliver care that is paid for by the NHS) and its representation on the task force for better regulation (the body responsible for advising the government on regulatory policy). Yet the Care Standards Act has few requirements to involve the public.

The National Care Standards Commission has no statutory duties to consult users about the use of its powers.[21] Furthermore, no new requirements have been made for dealing with complaints about care homes, and the commission will continue to work with the same inadequate procedures used by health authorities.[22 23] The office of the Health Service Ombudsman, which investigates complaints about the NHS, will have no jurisdiction over the commission, instead complaints will have to be referred through a member of parliament to the office of the parliamentary ombudsman; this is a considerable barrier to independent review. Finally, although schemes to provide advocates for patients will soon be mandatory in the NHS, there are no arrangements for them to be centrally funded to assist frail residents in nursing homes in pursuing claims.

Conclusion

There are now two healthcare sectors operating in England. In the public sector providers in the NHS are accountable to the public through parliament; information about needs and performance is collected; capacity is planned; and the intent of policy is to provide services equitably on the basis of need and free at the point of delivery. The private sector, which comprises two thirds of all care beds in the United Kingdom, delivers care to frail elderly people and disabled people. In this sector, which is dominated mainly by profit making private providers, services are means tested; the need for care and the services provided are unknown; and there is no accountability for spending public resources. Although both sectors have difficulty delivering high quality care to elderly people,[24] the Sharman report recently highlighted the difficulty of accounting for public funds when care is provided by the private sector.[25] The report made clear that the government must ensure that it has robust mechanisms to safeguard all clients on whose behalf it is commissioning services even when some functions have been devolved to other authorities or to organisations in the private sector.

The needs of patients and communities have not yet emerged as a driving force in the supply and regulation of long term care in the United Kingdom. The regulatory system that is supposed to protect nursing home residents in England and Wales has flaws in the key areas of staffing, monitoring, and enforcement because of compromises made by the government with the industry. The National Care Standards Commis-

sion can only be held to account by the courts for the duties and responsibilities set out in the Care Standards Act.[26] The risk is that this will leave frail and vulnerable elderly people at risk of neglect and poor quality care.

In highly contentious political areas like health care and social care, the regulator, public bodies, and private providers must be directly accountable to the public and service users in order to maintain their trust.

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Two smokers and evidence based medicine

It was the autumn of 1969, and I was in the middle of my first house job. My consultant was lecturing one of his patients, who had pain at rest from peripheral vascular disease, on the importance of stopping smoking immediately. I nodded gravely in the background before we continued our tour of the ward. As soon as we had finished, my consultant lit up a cigarette and walked back up the corridor to Sister's office and then out to the car park. I returned to the ward to finish my post-round tasks and was waved down by the above mentioned patient, known to everyone as "Ginger" because of his red hair and many freckles. "I saw your guv'nor lighting up his fag after telling me not to," he told me with obvious glee. I was thrown off balance: would it be unethical to reveal that my "guv'nor" had had a coronary in his 50s because of his habit? Probably, so I just stuttered a repetition of his warning to Ginger to stop smoking or lose his leg. The instant I stepped into the ward the next morning, I knew something had happened. There was an abnormal silence, rather like that heard in a station during a train drivers' strike. I stuck my head into Ginger's four bed ward to see three men in their beds looking straight ahead and avoiding my gaze. Finally, one of them spoke: "At 10 o'clock last night, Ginger told us he would die during the night. He emptied his locker and gave each of us one of his belongings as a memento. At 4 am, the nurses came in and found he was dead."

A few weeks later, an elderly farmer came in as an emergency needing a laparotomy. His pyjamas, hair, and body reeked of cigarette smoke, his fingers were stained brown by nicotine, his chest wheezed with each respiration, and his head was almost permanently invisible in a cloud of thick smoke. "I think I had better take care of these," I declared with an all too obvious air of self congratulation and carried his cigarettes and matches in triumph to Sister's office.

Postoperatively, the old farmer made surprisingly good progress, and I was convinced his chest was the better for my therapeutic intervention. The only problem was his increasing confusion, which at times caused him to be aggressive to the nurses or anyone else who approached him.

One evening, a couple of days later, I was writing up notes in Sister's office when there was an apologetic knock at the door. A man came in who introduced himself as the old farmer's son and who was worried by his father's confusion. "I hope you don't mind me saying this," he said, "but I am a psychiatrist, and I have noticed that if elderly patients suddenly stop smoking they may become confused. Would you mind terribly returning my father's cigarettes?"

I hesitated. Where was my professional self respect if my treatment was dictated by relatives? Yet this request was so graciously made, it would be churlish to refuse. "All right," I muttered with, I hoped, obvious disbelief. The old farmer grabbed the cigarettes with the relief of a drowning man catching a life belt. His head again disappeared into a cloud of smoke, his racking cough returned with enough vigour to light up hope in a funeral director's breast, and his confusion disappeared.

What do these two smokers tell us about evidence based medicine? Nothing. They do, however, give us a clue as to why doctors have tended to pay more attention to anecdotal evidence than carefully compiled statistics. As long as patients have an infinite ability to amuse, fascinate, and sadden us and imprint themselves on our memories with their human foibles, epidemiologists will struggle to overcome our opinions with their science.

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We welcome articles up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to.