Nursing in Care Homes

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Second edition

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Dedication

To Ed, as always, for his help and encouragement and to Rachael and Sam

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Preface

Nursing homes have come a long way in the last 20 years. They have moved from being an often ignored cottage industry to becoming an integral part of government's vision on health care. As you can see from Figure P.1 there are now more beds in the nursing home sector than there are in the NHS[1].

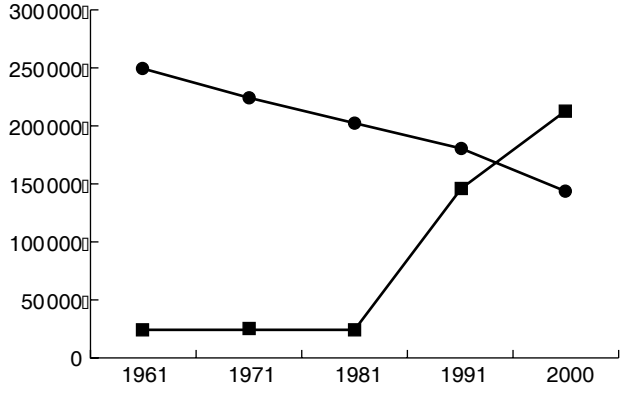

Fig. P.1 Number of beds in the NHS ● and nursing home sector ■.

As I write nursing homes are on the threshold of the greatest changes they have ever experienced, with a series of government initiatives being introduced. In April 2002 the Care Standards Act was introduced; now all homes are known as care homes – the legislation makes no mention of nursing homes. All homes will be regulated by a single body, the National Care Standards Commission. All homes will have to meet national minimum standards.

Older people in differing UK countries are now eligible for different levels of assistance with nursing home care. In England nursing home residents who fund their own care are being paid an allowance towards the care delivered by registered nurses, this allowance is only paid after assessment. In Wales residents receive a non-means tested allowance if they are self-funding. In Scotland nursing home residents are to receive a large contribution towards the costs of nursing and personal care.

In the past, people with continence problems who lived in residential homes had pads supplied by the NHS, but people who lived in nursing homes did not. This situation is now changing and people with nursing needs will be entitled to free incontinence pads.

The Department of Health insist that nursing homes are separate from

the NHS but the people who are cared for in homes receive NHS care from General Practitioners (GPs) and other NHS staff either in primary care or within hospitals. Changes to primary care such as Primary Care Trusts will impact on the care nursing home residents receive. New initiatives such as the National Service Framework for Older People outline primary care targets for GPs and identify good practice. GPs will implement this guidance for all of their older patients and targets such as reducing the risk of falls are particularly relevant within nursing homes.

In the 1990s the NHS underwent considerable change – nursing homes quietly developed as nurse led units. Now nursing homes are about to undergo far-reaching change because of new regulation and changes to the way NHS services are delivered.

This second edfition of the book (previously called *Nursing in Nursing Homes*) aims to guide you through the new regulations and to update your knowledge of key issues in the care of older people. It aims to enable you to continue to care for older people in a sensitive and humane way and to offer holistic care. It aims to help you to use research and good practice to provide high quality care.

Nursing in Care Homes has been written so that each chapter is self-contained, giving the information on a particular topic in one place without the reader having to flick between chapters to find all the aspects of the subject. Each chapter also has its own references and further information. Each chapter can thus be used to update your knowledge, or as the basis for further study or teaching sessions. I hope that this approach works for you and I would appreciate comments and feedback.

Nursing remains crucially important to an older person's quality of life. It makes the difference between an older person living life to the full in the remaining months or years of life or feeling as if life is not worth living. It is a real privilege to be able to make a difference and I hope that this book will help you to avoid some of the pitfalls of nursing home nursing and enjoy the rewards.

If you have any suggestions or comments you can send these to linda.nazarko@blueyonder.co.uk

Reference

[1] Department of Health (2000) Shaping the Future NHS: Long Term Planning for Hospitals and Related Services. Consultation Document on the Findings of the National Beds Enquiry. Department of Health, London. This document can be found on the Internet at: http://www.doh.gov.uk/pub/docs/doh/nationalbeds.pdf

Chapter 1

The Legal Framework

Introduction

In April 2002 the legislation that homes in England must meet in order to remain registered changed. The Registered Homes Act of 1984 was repealed and the Care Standards Act 2000 was enacted[1].

This chapter aims to enable you to:

- Understand the main provisions of the Care Standards Act
- Understand how these changes will affect the way homes are regulated
- Be aware of how inspection will change
- Understand the role of the National Care Standards Commission
- Develop an understanding of national minimum standards

The Care Standards Act 2000

The Care Standards Act was introduced in April 2002. It replaced the Registered Homes Act 1984. It aims to end the current fragmented and muddled regulation and the differing standards that health authorities and local authorities use to regulate care. The Care Standards Act does not just apply to nursing and residential homes. It is a massive piece of legislation regulating:

- Children's homes
- Independent hospitals and clinics
- Care homes
- Residential family centres
- Independent medical agencies
- Nurses' agencies
- Voluntary adoption agencies

The Act also:

- Regulates and inspects local authority fostering and adoption agencies
- Establishes a General Social Care Council in England and a Care Council for Wales
- Makes provision for the registration, regulation and training of social care workers
- Establishes a children's commissioner for Wales
- Makes provision for the registration, regulation and training of those providing childminding or day care

- Makes provision for the protection of children and vulnerable adults
- Amends the law about children looked after in schools and colleges

The Act has 123 sections in nine parts and one supplement. The relevant sections are outlined in the rest of this chapter.

Regulation of homes

Under the old system, residential and nursing homes were inspected and regulated separately. Dual registered homes were inspected by two different bodies and expected to comply with different standards. Under the old system local authorities were providers, purchasers and inspectors of residential homes.

National Care Standards Commission

The Care Standards Act establishes the National Care Standards Commission. The Commission takes over from the 95 health authorities and 150 local authorities that currently carry out inspection. This means that one independent body inspects all homes to the same standards. Homes will no longer be inspected by different authorities to different standards. The National Care Standards Commission will inspect to national standards.

How the National Care Standards Commission functions

The National Care Standards Commission (NCSC) is based in Newcastle. It has a chair who works 1–2 days a week. A full time chief executive, Anne Parker (formerly of the Carers National Association), has been appointed. A board consisting of 14 members drives the Care Standards Commission forward. The board consists of lay and non-lay members. Non-lay members are providers or purchasers of health or social care. Lay members have knowledge and/or experience of the sector and of change management and methods of evaluating performance. Box 1.1 outlines the functions of the NCSC.

The work of the NCSC can be divided into four main areas:

(1) Inspection and regulation
(2) Improving the quality of services
(3) Providing information and investigating complaints
(4) Informing and advising government on the range and quality of care services.

Legislative timetable and infrastructure

In April 2002 the Care Standards Act was introduced and old legislation such as the Registered Homes Act 1984 was repealed. Shadow inspection teams developed to the infrastructure for the National Care Standards Commission between April 2001 and April 2002. There are eight area offices. Each area office has a regional director and support services. The NCSC has around 2500 staff. Most have transferred from old inspector

Box 1.1 Functions of the NCSC.

- Advise the secretary of state how to establish offices in specific areas or regions. Inspectors currently work out of 800 offices and the Commission hopes to reduce this.
- Organise staff into divisions. Currently local authority and health authority staff work in separate offices and have their own management structure. The Commission will integrate these structures and establish a new management structure.
- Inform the secretary of state about the availability of provision and the quality of services. The availability of homes varies from area to area. Some areas are well provided for whilst others have an underprovision. The Commission will monitor this, the first time such monitoring has happened. The quality of services varies and the Commission will have a responsibility to monitor quality. It is likely that this will involve introducing a quality audit tool at some time in the near future.
- Encourage improvement of quality and services. This will require the adoption of a nationally recognised quality audit tool.
- Advise the secretary of state on changes required to improve quality. This may involve benchmarking and setting standards.

posts. CCETSW, the Central Council for Education and Training in Social Work, are setting up a post qualification award in inspection, and inspectors will, for the first time, have a relevant qualification.

Regulation of care workers

The Care Standards Act sets up mechanisms to regulate care assistants. They are to be known as 'social care workers'. The Act defines a social care worker as 'a person engaged in the provision of personal care for any person'.

In England social care workers are regulated by the General Social Care Council, and in Wales by the Care Council for Wales. Moves to educate and regulate care assistants are welcome. The precise definitions of a social care worker are:

- Engaged in relevant social work 'social work required in connection with any health, education or social services provided by any person'
- Employed at a children's home, care home or on the premises of an agency
- Supplied by a domiciliary care agency to provide personal care in their own homes for people with a disability, infirmity or illness or who are unable to provide it for themselves.

The following people could also be included in the definition 'social care worker':

- Persons engaged in work for social services
- Persons employed as inspectors of children's homes.

Registration

Social care workers are required to register with either the English or Welsh Council. Each council is required to promote high standards of conduct and

practice and promote high standards of training. Each council is required to maintain a register of social care workers. In order to register, social care workers must meet the following conditions:

- Is of good character
- Is physically and mentally fit to perform the work
- Satisfies any rules imposed
- Satisfies training requirements.

Each council will maintain a list of unsuitable persons.

Conduct

Registered Social Care Workers (RSCWS) must abide by a code of conduct. RSCWS will abide by occupational standards – these are to be drawn up by the relevant councils. RSCWS will be required to meet practice standards. RSCWS will meet initial and ongoing training requirements. A person who breaches standards of conduct, practice or the code of conduct will be called to a hearing. If the charges are proven the person may be suspended or removed from the register. There are provisions for restoring people to the register.

The general social care council for England and the care council for Wales will approve courses and make grants and allowances for training. It is not clear if nurses working in homes would be able to access such grants.

Management of homes

Government will require all managers of homes to have relevant management qualifications by 2004. The minimum qualification will be an NVQ level 4 in management or a recognised management qualification. Nurses with relevant expertise and qualifications should be able to use systems such as APL (Acreditation of prior learning) and APEL (Acreditation for prior experiential learning) to help enable them to gain qualifications. This requirement has far reaching implications for homes and nurse managers. For the first time nursing home managers will be required to have a management qualification and experience in working with older people in homes.

These standards will have cost and time implications. Already advertisements for managers are stating that candidates with NVQ level 4 in management are preferred. Who will be expected to fund management qualifications? The introduction of management qualifications will reduce the available pool of managers and increase wage costs – what resources will be made available to meet these increased costs? What will happen if a home is unable to recruit a suitably qualified manager?

Powers of inspection

Homes are required to comply with national minimum standards. These were released in draft form as *Fit for the Future* (1999)[2]. The final stan-

dards have now been released. The Minister for Health will have the power to review and amend these standards at any time. Government consider national minimum standards to be a floor below which no home can fall. Government plan to raise standards over a period of time. Many nurses are anxious about what they fear may be a process of continual change.

The Care Standards Act gives regulators a greater range of powers. These powers are:

- Require manager to provide any information concerning the establishment that the inspector requires
- Inspect at any time
- Make any examination into the state of management of the premises and treatment of persons cared for
- Inspect and take copies of records
- Interview manager in private
- Interview person cared for in private if the person consents
- Examine person cared for if the person consents, to ensure the person is receiving proper care; only doctors and nurses may examine the person cared for
- Inspect any medical records
- Seize and remove any document or material thing when there are reasonable grounds to believe that this may be evidence of failure to comply with any condition
- Take such measurements and photographs or recordings as he considers necessary
- Access computer records.

Individual rights

The Act gives inspectors the right to interview any manager, member of staff or resident privately. Managers, staff and residents could feel intimidated by such an interview – the Act does not specify that the person being interviewed has the right to a friend, advocate or supporter.

Offences

The Act specifies offences and lays down penalties for failure to comply with the Act. Offences are:

- Managing an establishment without being registered
- Failure to comply with any condition
- Guilty of an offence under the regulations
- False statements
- Intent to deceive
- Failure to display registration certificate.

Inspectors will have the right to apply conditions to registration, for example they may specify that a particular door is kept locked. The Act lays down penalties for offences. If the manager (or presumably someone who the manager is responsible for) breaches the Act, the manager may be fined up to £5000 or even imprisoned for six months.

National minimum standards

Two years after government released the consultation document *Fit for the Future*, national minimum standards have been released. The responses to *Fit for the Future* have been incorporated into the new National Minimum Standards for Care Homes for Older People.[3] These standards are the *minimum* standards that homes must meet in order to retain registration. The Care Standards Act gives the secretary of state the power to introduce new standards at any time without any further legislation.

Government have announced 38 standards, each with a number of elements. These standards cover seven areas:

(1) Choice of home
(2) Health and personal care
(3) Daily life and social activities
(4) Complaints and protection
(5) Environmental standards
(6) Staffing
(7) Management and administration.

Choice of home

Standards 1 to 6 concern the choice of home. These standards make it clear that the home must justify claims to have the ability to care for a specific client group. If a home claims to care for people with dementia it must clearly state what specific features of care and facilities meet the needs of older people with dementia; for example, if you provide a multisensory room this must be stated in the literature provided to residents. If the manager or other staff have specialist training in dementia care this must be stated. It is not clear what the implications would be of stating that you have a level of expertise and then having key staff leave.

Standard 1

Standard 1 requires homes to produce a statement of purpose setting out the aims, objectives, philosophy of care services and facilities. The home must provide a 'service users guide' written in plain English. The required content of the service users guide is:

- Description of accommodation and services
- Relevant qualifications and experience of the registered manager, provider and staff
- Number of places and special needs or interests cared for
- Copy of most recent inspection report
- Copy of complaints procedure
- Copy of residents' survey
- Information on how to contact the Care Standards Commission, social services and the local authority.

Each home will have to prepare a service users guide. Copies of this could be made available at a central point in the home. The costs of developing and

providing such detailed information are substantial. Inspection reports can be 30–40 pages long. It is unclear what the legal position is if you prepare information and some aspect of it becomes outdated.

Standard 2
Standard 2 relates to providing the resident with a contract. The contract must state the room to be occupied, and the resident is issued with details of rights and obligations. The only potential problems relate to moving a resident from one room to another.

Standard 3
Standard 3 requires the home to carry out comprehensive assessment using 13 care categories including falls and continence promotion. Homes must carry out a comprehensive assessment prior to admitting a resident. This is good practice but could prove difficult in certain circumstances. If the person is in Liverpool and wishes to enter a home in London to be near relatives, how will assessments be carried out? What will happen in the case of emergency admissions? The home is (for the first time) legally required to maintain care plans. This has long been good practice but has never been a legal requirement.

Standard 4
Standard 4 requires the home to demonstrate its ability to meet assessed needs and to deliver care that is based on good practice and clinical guidance.

New standards such as *Good Practice in Continence Services*[4] must be adhered to. New standards such as those on prescribing and older people contained in the *National Service Framework for Older People*[5] must be met. Failure to meet such standards could result in loss of registration.

Standard 5
Standard 5 specifies that homes should offer trial visits, and this standard should present few problems. There are provisions for emergency admissions.

Standard 6
Standard 6 relates to intermediate care and is an important standard for homes. The main requirements are:

- Dedicated facilities must be provided for intermediate care
- Rehabiltation facilities must have equipment for therapies and treatment
- Staff have appropriate classifications and training to deliver intermediate care
- Specialist services are provided in sufficient numbers and delivered by competent and skilled professionals
- Intermediate care residents are not admitted to long-term care unless appropriate assessment has taken place.

This standard is significant. Intermediate care (short term care aimed at discharging the individual back to their normal place of residence) is only

beginning to come on stream and most contracts are short term and small scale. This standard effectively restricts provision of intermediate care to providers who have the ability to provide dedicated units and specially trained staff. There is a danger that homes will find it impossible to provide such services in the absence of long-term block contracts. Providers may be unwilling to contract with small homes. In such circumstances people could have no option but to move to a corporate home that has a block contract for intermediate care.

Health and personal care

Standards 7 to 11 relate to health and personal care. The aim of these standards is to improve the level of record keeping, assessment and care planning within the home. It is clear that inspectors will use care assessments and care plans to make judgements on the quality of care delivered within the home. These standards make it essential that nurses plan and document care accurately.

Standard 7

Standard 7 duplicates and reiterates standards 3 and 4. Additional requirements are:

- Care plan must detail actions to meet assessed need
- Care plan must meet relevant clinical guidelines
- A risk assessment in relation to prevention of falls must be carried out
- Care plan must be reviewed at least once a month to reflect changing needs
- Care plan must be drawn up in consultation with resident
- Care plan must be accessible to resident
- Care plan must be signed by resident if capable; if not capable must be signed by representative.

This standard is significant. Registered nurses do not generally excel at record keeping. Homes will need to spend significant amounts of time training and supervising staff to ensure that these standards are met. Some residents need their care plans to be updated monthly but others have needs that remain unchanged for years. This standard will increase the time nurses spend completing paperwork and it risks removing them further from the bedside. NHS staff are not required to meet such standards. The issue of preventing falls is becoming more important – this is also emphasised in the National Service Framework for Older People.

Standard 8

Standard 8 is a comprehensive standard relating to maintaining health. The issue of assessing pressure sore risk and prevention and treatment of pressure sores is emphasised. The issue of preventing falls is again emphasised. Homes are required to carry out comprehensive nutritional assessments and to take appropriate action to prevent malnutrition.

These standards are significant in that for the first time homes will be inspected not only on the basis of the facilities they provide but also the

quality of care they deliver. Eventually the information held in assessments and care plans will be used to benchmark homes. This means that each home will be measured against others, and its ability to prevent pressure sores, malnutrition, incontinence, falls and other negative care outcomes will be available to the public. This level of scrutiny is unprecedented and provides a real impetus to improve care. Homes that are unable to deliver positive outcomes of care will find it much more difficult to maintain occupancy.

There is a danger though that homes will 'cherry pick' residents to enable them to meet standards. As the number of homes falls, those that remain will find that demand exceeds supply. So homes will be able to choose who to admit. If a person is immobile and has a pressure sore, a home may be reluctant to admit them. If a person is incontinent and has dementia the home may be reluctant to admit them because the presence of dementia makes continence promotion difficult. If a person has Parkinson's disease and a history of falls the home may fear increasing its fall rating by admitting them. When benchmarking is eventually introduced results will have to be interpreted with great sensitivity to prevent such problems.

Standard 9

Standard 9 relates to medication and states that the registered person will ensure that there are suitable procedures for receiving and handling medicines (see Chapter 4).

Standard 10

Standard 10 relates to privacy and dignity when health care and personal care are delivered, and it merely reflects current good practice.

Standard 11

Standard 11 relates to death and dying. It specifically states that the person should be able to die in his or her own room unless there are strong medical reasons to prevent this. It merely reflects current good practice. Residential homes may find it difficult to meet this standard because of staffing implications. There is no mention of providing increased resources if the home has a number of people who are dying. It is possible that regulators will increase staffing requirements in such circumstances, but that homes will lack the resources to meet increased levels of need.

Daily life and social activities

These standards demand that the home comply with good practice in relation to dignity and choice.

Standard 12

Standard 12 requires homes to demonstrate that routines and activities of daily living are flexible and reflect the needs and aspirations of residents. For example, a home that forced residents to rise at 6AM would not meet this standard. A home where staff stated that every resident chose to rise at 6AM would not meet the standard. The only way to demonstrate that you meet

this standard is to specifically state the person's preferences on their care plan. The care plan should state, 'Mrs Jones wishes to get up at 7:30AM . . . She prefers to shower rather than bathe. She prefers to shower before breakfast or in the evening'.

Standard 13

Standard 13 requires homes to offer open visiting, which is standard practice. Visitors and friends are to be given written information about the home's policy on maintaining their involvement. This standard will be easily met.

Standard 14

Standard 14 requires homes to enable residents to manage their own affairs, have access to advocates and bring personal possessions to the home. Residents are to have access to their personal records. This means that staff must be careful how they document care and complete daily records. Imagine how you would feel if you read 'Difficult and demanding' in your records. Nurses will have to write carefully and use examples to back up their assertions. For example, 'Mrs Jones appears anxious and needs lots of help to settle into the home. Rang the call bell ten times this afternoon wanting someone to sit with her'.

Standard 15

Standard 15 relates to meals and nutrition. Most of this merely reflects good practice. The items that may require attention are:

- Intervals between meals must be no more than five hours
- The time between the last meal and breakfast should be no more than 12 hours.

If you live in your own home and decide to eat dinner at 7PM, lie in and have breakfast at 10AM the next day, that is fine, but in care homes it is contrary to national minimum standards.

Complaints and protection

Standards 16 and 17 relate to complaints and protection. Most of these merely reflect good practice. The items that may require attention are:

- Complaints procedure should state who deals with the complaint and must give details of how to refer a complaint to the National Care Standards Commission
- Complaints must be responded to within 28 days.

Protection

Standard 18

Standard 18 requires homes to protect residents from abuse and to have policies that state this. A whistle-blowing policy is required. The home must comply with *No Secrets* guidance on prevention and protection of vulner-

able adults from abuse. Further details of this are given in Chapter 9.

Environment

Standards 19 to 26 deal with the physical environment of the home.

Standard 19

Standard 19 relates to maintenance and will cause few problems.

Standard 20

Standard 20, the most controversial of the standards, has been considerably diluted in the consultation process. The time-scales have also been extended. The requirements can be summarised as:

- Communal space of 4.1 m^2 per resident by 2007 for existing homes
- Total of 14.1 m^2 of space provided per resident. If room is larger than 10 m^2, communal space can be reduced to 3.7
- Outdoor space accessible to wheelchair users.

Standard 21

Standard 21 details toilet, washing and bathing facilities. From 1 April 2002 all newly-built extensions and first time registrations must have a minimum of an en suite toilet and washbasin. En suite facilities are provided in addition to minimum space requirements in the person's room.

Standard 22

Standard 22 deals with assessment of facilities by suitably qualified persons including an occupational therapist to ensure adaptations are made to enable residents to function to capacity. This specifically refers to adaptations to meet the needs of people with dementia.

In practice few homes employ occupational therapists. There is a national shortage of occupational therapists and community resources are limited. Many NHS community trusts concentrate on using occupational therapists to enable people to remain at home. People living in homes are considered low priority for assessments and services.

Standard 23

Newly-built and adapted rooms must be 12 m^2 by April 2002. All single rooms must be at least 10 m^2 by April 2007 and by that date 80% of rooms must be single rooms. Single rooms accommodating wheelchair users must have at least 12 m^2 of usable floor space. National minimum standards do not define a wheelchair user. This means that we do not know if an immobile person is classified as a wheelchair user. If all people who are immobile are classified as wheelchair users then 78% of new rooms should meet the 12 m^2 standard.

Standards 24, 25 and 26
Standards 24, 25 and 26 detail furnishings, heating and hygiene requirements and are not problematic.

Implications of physical standards

The most significant and unclear standard is that wheelchair users must have rooms with 12 m^2 of floor space. As the standards do not define what a wheelchair user is it may be left to individual inspectors to try to determine what the standard really means. Hopefully the NCSC will issue guidance to clarify this issue.

The costs of adapting and changing rooms so that each meets new physical standards may be significant and are certain to force the closure of some homes. There is evidence that individual providers are closing homes and providers with more than one home are closing smaller homes. This is because when some homes, especially smaller homes, have been reconfigured, it is no longer possible to run them cost effectively.

Staffing

Standards 27, 28, 29 and 30 deal with staffing matters, the most significant of which are:

- 50% of care assistants to have NVQ level 2 qualifications by 2005
- 50% of agency care assistants to have NVQ level 2 by 2005
- Formal recruitment, references and police checks for volunteers
- Formal recruitment, references and police checks for staff
- Formal six month induction for staff
- Three paid training days a year for all staff.

The implications of these standards are far-reaching. The standards will considerably add to the costs of providing care. Meeting a 50% NVQ target within four years will be difficult for many homes and may prove too expensive for some providers, who will leave the market. Some government assistance with costs of NVQ training has been announced.

Management and administration

Standards 31–38 deal with the management and administration of the home. The only one that may be difficult for most homes is standard 31, the qualifications and competency of the registered manager. The key points are that the manager must:

- Have at least two years experience in senior management in a relevant care setting. This will mean that managers become more sought after and will be able to command higher salaries
- Have an NVQ level 4 or equivalent qualification in management by 2005

- Be a first level nurse if the home is registered for nursing
- Have expertise in caring for older people.

It is unclear what the situation would be if the registered manager left and the home could not find a suitable manager.

Conclusion

Government healthcare policy is changing rapidly. The National Care Standards Commission took over responsibility for regulating care homes on 1 April 2002. On 18 April 2002 the Secretary of State for Health announced plans to merge the National Care Standards Commission, the Audit Commission and the Commission for Health Improvement to form the Commission for Healthcare Audit and Inspection. At the time of writing the date of this merger has not been announced.

The aim of national minimum standards was to provide a clear regulatory framework that ensured that all homes were regulated to the same standards. It now appears that some standards will be applied nationally but others will vary from region to region. The costs of providing care will rise but there are no indications that government intends to provide additional resources to meet these costs. In the short term the introduction of national minimum standards will lead to a reduction in the number of homes.

Further information

The National Care Standards Commission have a useful website: http://www.doh.gov.uk/ncsc/index.htm

References

[1] Care Standards Act 2000. The Stationery Office, London. Copies can be obtained from: The Stationery Office, PO Box 29, Norwich NR3 1GN. Order through the Parliamentary Hotline Lo-call: 0845 7 023474. Fax orders: 0870 600 5533. E-mail: book.orders@theso.co.uk website: http://www.ukstate.com

[2] Department of Health (1999) *Fit for the Future?* Department of Health, London.

[3] Department of Health (2001) *National Minimum Standards for Care Homes for Older People*. The Stationery Office (details above). Also available on the Department of Health website: http://www.doh.gov.uk/ncsc

[4] Department of Health (2000) *Good Practice in Continence Services*. Department of Health, London.

[5] Department of Health (2001) *National Service Framework for Older People*. Department of Health, London.

Chapter 2

Needs Assessment and Funding Care

Introduction

Ten years ago needs assessment had not been invented and funding was fairly straightforward. Now a range of government iniatives and national variations have made everything more complex. Increasingly older people and their families turn to nurses for advice.

This chapter aims to:

- Explain the background to recent policy changes
- Outline current assessment criterion
- Examine new developments
- Update your knowledge of funding
- Explain about national variations in funding

In the 1980s the long stay hospitals that once provided care for older people who required nursing care were closed. The number of places in nursing homes increased dramatically and in 1988 there were for the first time more beds in nursing homes than in NHS geriatric hospitals. Figure 2.1 illustrates

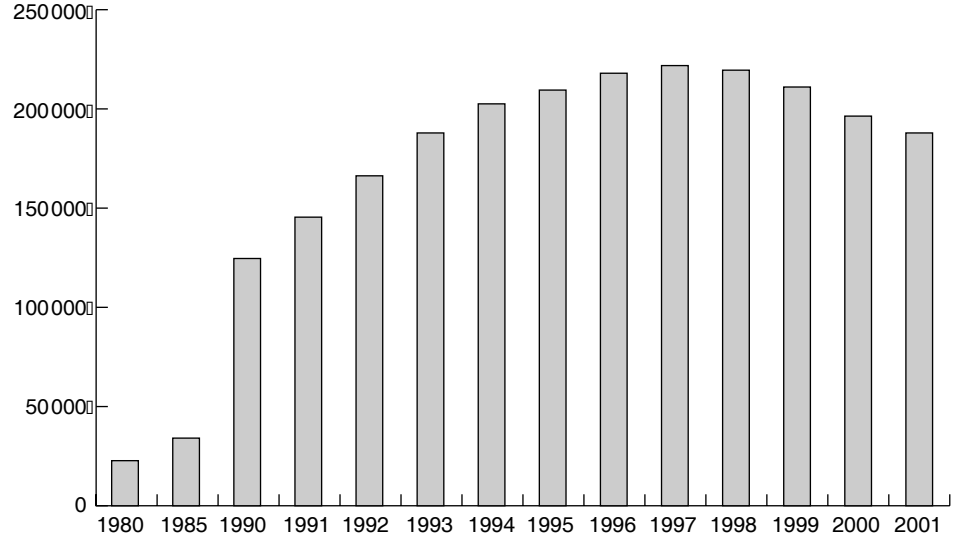

Fig. 2.1 Growth of nursing home beds (compiled from data taken over several years, the most recent being *Care of Older People* (2001) by Laing & Buisson, London).

the growth in nursing home beds. As the number of nursing home beds increased the costs of providing nursing care also rose. The government of the day asked Sir Roy Griffiths to examine the way nursing and residential care was provided. In 1990, as a result of his advice, the NHS and Community Care Act was passed.

The Community Care Act

The Community Care Act was introduced in England, Scotland and Wales in 1993. This gave social services departments in local authorities 'lead responsibility' to assess older people's needs for care. Local authorities were also given budgets to enable them to purchase that care from providers in the independent and voluntary sector. Local authorities had a number of roles:

- Providing care in local authority run homes
- Purchasing from independent sector
- Assessing need for car
- Inspecting residential homes to determine their ability to provide care
- Determining fees for care.

Local authorities were inspectors, assessors of need, providers and purchasers of care. Soon problems developed. Social services departments developed individual assessment criteria to determine whether a person required nursing or residential care. There were concerns that assessment criteria focused more on the person's ability to pay for care rather than the care required[1]. There were also concerns that social services assessment criteria did not meet government standards. Research shown in Figure 2.2 confirmed this[2]. There were also concerns that inadequate assessment and eligibility criteria were preventing older people from receiving the right level of care in the right home[3]. People who required nursing care were being

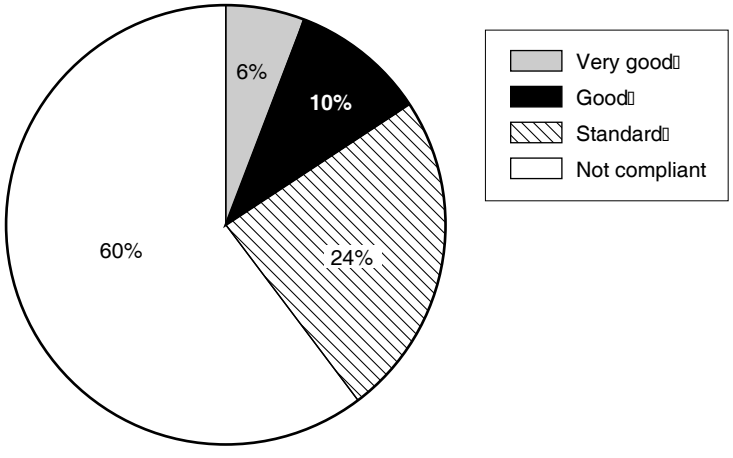

Fig. 2.2 Quality of local authority eligibility criteria. Data from Challis *et al.* 1997[2].

sent to residential homes[4]. People who required complex packages of care were being provided for without reference to district nurses or GPs. An influential report by the Clinical Standards Advisory Group found that 'care packages are financially driven rather than needs led, inappropriate decisions placing people needing nursing care in residential homes rather than nursing homes because it is cheaper[5]'.

The system of community care was discredited and following the 1997 general election the Labour government set up a Royal Commission to examine the funding of long-term care.

The Royal Commission on the funding of long-term care

In the past older people requiring continuing care were cared for in hospital, in long stay geriatric units. The standard of care was often poor and staffing levels were often abysmally low. The standard of accommodation was very poor by today's standards. People were cared for in the old 'Nightingale style' wards. There was little in the way of recreation. But nobody paid. If you needed continuing care you were admitted to a geriatric hospital and the state met your needs. Nursing homes were a very small part of the continuing care sector. Nursing home care was mostly restricted to those who had the means to purchase continuing care. It was a little like private education: you could have it if you wanted to or could afford to but there were always the state schools.

In the 1980s all that changed. Firstly, social security changes made it possible for people of modest means to enter nursing homes. People voted with their feet and nursing homes boomed. The geriatric hospitals were largely closed down and then the problems began. Nursing home care was means tested. If you had more than the income support threshold, you had no option but to pay. That meant spending your life savings and selling your house. Every year 40 000 people were forced to sell their house to pay for nursing or residential home care.

The Royal Commission was asked to examine the options for sustainable funding of long-term care for elderly people, bearing in mind the expectations of older people for dignity and security. Privately, government acknowledged that the current system was a nightmare. Why bother to save for your old age if you would have to spend every penny funding care in your old age? The aim was that the Commission examine ways to fund long-term care.

How the Royal Commission investigated the problem

The Royal Commission held regional meetings throughout the UK to hear the views of the public. The Commission also heard evidence from nurses, and groups such as Age Concern, the Royal College of Nursing and the Alzheimer's Society.

Recommendations of the Royal Commission

Three volumes of commissioned research evidence accompanied the Royal Commission report, which weighed 4 kg[6]. The main recommendations are:

- Free personal care for people living in nursing and residential homes
- Means testing the 'hotel services' element of care
- Increasing the eligibility threshold for means testing to £40 000
- Separating the assessment and purchasing aspects of nursing and residential care
- Establishment of a national care commission to monitor trends including demography and spending and to ensure transparency and accountability; and to set national standards now and in the future
- Enable more people to stay at home
- Increased availability of rehabilitation services
- Allow each individual 12 weeks grace to enable them to recover before a decision is made to place permanently in nursing or residential care.

Minority report

Two members of the Royal Commission disagreed with the report and published a note of dissent that is appended to the report. The dissenters stated that they felt that the NHS should only meet the costs of providing the care delivered by registered nurses and not that delivered by care assistants. They estimated that the registered nurse component of nursing care could be delivered for around £100 a week.

Government response to the Royal Commission

The government response to the Royal Commission report was published a year later[7]. The main points are:

- NHS to pay only for the care delivered by a registered nurse
- Value of person's home disregarded for the first 12 weeks of admission to homes
- Older people no longer forced to sell their homes to pay for care. Loans schemes to enable older people to borrow money from the council and the loan to be paid back when the person dies
- Residential allowance premiums that encouraged placement in independent sector homes abolished in April 2002
- National Commission for Care Standards established.

The importance of assessment

Assessment becomes crucial under national minimum standards. Managers are responsible for ensuring that they can deliver the appropriate level of care to the resident. If the person requires nursing care he or she should not be admitted to a residential bed where this care is not available. If the person requires specialist care because of mental illness it would be inappropriate to admit them to a non-specialist nursing home staffed by nurses who lack qualifications in mental health. The person with dementia may require care in a residential home, a nursing home or a dementia unit but it is rarely possible to determine this merely by talking with family or a social worker.

Many homes now offer both residential and nursing care. Assessment enables you to work out what level of care the person requires and decide

which part of the home that care can be delivered in. Assessment enables you to meet the person, find out what specialist equipment and what level of care is required, and decide if you can meet those needs.

Case history

According to the referral letter Mrs Dora Johnston's needs could easily be met in the home and little specialist equipment was required. When Sarah Orem carried out the assessment she found that Mrs Johnston had complex care needs. Mrs Johnston was an overweight lady who had suffered a severe stroke. She was depressed and not able to help nursing staff to move her. She had severe pain that was unresponsive to analgesia. The only way to control the pain was to change Mrs Johnston's position hourly. Mrs Johnston liked to sit out of bed but had fallen out of her chair on many occasions because of poor posture and muscle control following stroke. She had pressure sores to her sacrum and heels that required daily dressings. Mrs Johnston also required supervision while eating because of swallowing difficulties.

In order to meet Mrs Johnston's needs the home needed to supply an electric bed, an alternating pressure mattress replacement, a special chair and additional slings for the hoist. The referral letter gave no indication of these requirements or the relative's expectation that they be supplied. If Sarah had not carried out an assessment, Mrs Johnston could have been admitted without appropriate equipment and without appropriate funding levels having been agreed.

The aim of assessment is to enable nurses to meet the person and to check if the home can meet that person's care needs. Sometimes the home will not be willing or able to meet an individual's care needs and will decline to admit. Older people and their families can choose homes but homes can also choose which residents to admit and which not to admit. In the past, homes have tended to adopt a policy of 'if in doubt admit'. National minimum standards place increased emphasis on the home being able to provide for specific client groups and sometimes homes will have to decline to admit certain individuals because the individual has specialist care requirements. Sometimes homes will decline to admit a person because the person's behaviour could affect the quality of life of other residents living in the home. Sometimes staff within the home do not have the skills to meet that person's care needs.

Nurses sometimes feel upset when they decline to admit a person – they feel inadequate because they feel they ought to be able to care for every person who seeks a place. Sometimes social workers, hospital staff and relatives are angry and rude if you decline to accept a possible resident. It is important to be realistic about the level of care you can offer. Nursing homes are just that; they are not acute general or psychiatric hospitals. Nursing homes normally care for frail older people. Nursing homes are ill equipped to care for acutely ill older people requiring high levels of specialist care and high levels of medical input. Nursing homes are also ill equipped to care for people with acute mental health problems requiring specialist care. Under national minimum standards, the manager will be required to demonstrate staff ability to care for people with specialist care needs.

The single assessment process

At the moment local authorities assess a person's needs for care using local assessment criteria. This means that an older person in Bournemouth may

have different access to community care services and to a bed in a care home than an older person in Bolton. Current assessment criteria are inequitable and unfair because they treat people differently depending on where they live. The assessment criteria for social services do not match up with the assessment criteria for continuing care paid for by the NHS, so people can find that they fall between the gaps in services. The Department of Health is now working with professional groups to develop national assessment criteria so that all older people receive coherent assessment that enables them to access care.

Funding care

At present continuing care remains means tested. If an older person meets the local health authority's continuing care criteria she is entitled to have all the costs of care met by the health authority. In the future, Primary Care Trusts will hold 75% of the NHS budget and will be responsible for commissioning all NHS services. Health authorities are to be abolished and 28 strategic health authorities will be created. Primary Care Trusts will take over many of the functions of health authorities in the near future and funding arrangements will change. At the moment, although there are many highly dependent residents in nursing beds who appear to meet continuing care criteria, health authorities fund few of them.

People who have savings above income support levels have to pay for their care. In order to qualify for local authority support in meeting nursing home or residential care costs a person must have capital of £19 000 or below. Capital includes the value of a previously occupied property subject to the following rules.

Disregarded property

Property to be disregarded will include:

- The value of a resident's dwelling if their stay in residential care or nursing home is temporary and they intend to return to the dwelling and the dwelling is still available to them
- Only one dwelling can be disregarded in these circumstances.

Where the resident's stay is regarded as *permanent* their former dwelling can be disregarded for 12 weeks, or totally if it is occupied in whole or part by:

- The resident's former partner (who is not estranged or divorced from the resident)
- A relative of the resident who is aged over 60 or is incapacitated.

The local authority also has the discretion to ignore the property in special circumstances, for example if it is the sole residence of a previous carer of the resident who gave up their home in order to care for the resident. In such circumstances the property will be taken into account if the carer were to die or move out. The benefits agency does not have this discretion for income support purposes.

Jointly owned property

Where a property is jointly owned by the resident and another person whose joint ownership does not enable the property to be disregarded as above, the local authority will take the resident's share into account. However, in doing so it is the value of that interest which is taken into account bearing in mind:

- The resident's ability to re-assign the beneficial interest to somebody else
- There being a market, i.e. the property is saleable.

It may well be construed that because a joint owner has a right to occupy the property it is unlikely that there would be a willing buyer prepared to share in that right to occupy it. The only person who may be interested in purchasing the share would therefore be the joint owner and effectively the 'market value' could be nil. Legal advice should be sought in these circumstances.

The rules for income support purposes are very similar in this respect. Following a Commissioner's decision (CIS/15936/1996) it was held that the valuation of jointly owned property should be based on the actual market value of the claimant's share, and this value may depend on whether there would be a willing buyer of the claimant's interest in the property. If there is a disparity between how the local authority and the benefits agency value the property, which results in the resident not being entitled to the income support element contributing towards their care costs, the amount to be paid by the local authority is that much more. Where the local authority is unsure about the resident's share, or their valuation is disputed by the resident, a professional valuation should be obtained. The name on the deeds of property should establish ownership; however, if ownership is disputed and a resident's interest is alleged to be less than seems apparent from initial information, the local authority will require written evidence on any beneficial interest that the resident or other parties possess.

12-week property disregard

This is effective for all people who enter care homes permanently after 9 April 2001. The local authority will disregard the value of property for 12 weeks and residents will only have to contribute their assessed income less £16.80 personal expenses towards the care home fees. To be eligible for this funding:

- The resident must be assessed as needing *permanent* residential accommodation which can be in either a local authority or an independent care home
- Other capital apart from the value of the property must be below £19 000 and income must be inadequate to meet the full cost of the care.

The 12-week property disregard is mandatory and local authorities are under a statutory obligation to apply it once they are aware of a resident to whom it applies. Delays by local authorities in providing this funding do not affect the resident's entitlement to it and could render them liable to reimburse residents who have consequently paid a higher contribution towards their care costs than they should have during this mandatory disregard period.

NHS nursing care contribution

Residents of nursing homes entitled to a contribution towards their nursing care from the NHS will undergo an assessment for the NHS contribution, which will be paid after the twelve-week property disregard period has expired. During the 12-week disregard period the difference between the local authority's standard rate for the nursing home fees and the resident's assessed charge will be met by the local authority. This is explored in greater detail later in this chapter.

Top-ups for more expensive accommodation

Local authorities would normally pay only their standard rate for accommodation, which is likely to be less than care homes normally charge. In these circumstances residents entitled to the 12-week property disregard will be entitled to top up the local authority contribution from disregarded income, earnings or capital with the proviso that:

- The top-up during the 12-week period must not exceed the lower capital limit, i.e. at the time of writing £11 750 (equivalent to £979.16 per week)
- The level of tariff income assessed (at the time of writing, £1 for each £250 of capital between £11 750 and £19 000) remains the same even though the capital may reduce as a result of topping-up during the 12-week period.

Beyond the 12-week period – the deferred payments agreement

From 1 October 2001 individuals who have not been able to or do not wish to sell their homes to pay for their care may enter into a deferred payments agreement with the local authority. The contribution from the local authority will be secured against the value of their property. This facility is open to those who do not wish to or cannot sell their home and where their other assets are less than the upper capital limits and their income is not sufficient to cover their fees. Local authorities have discretion over whether to operate this scheme, for example they may not wish to enter into an agreement whereby the cost of the chosen care may not be affordable by the individual over the long term.

The possible advantages of an individual accepting a deferred payments agreement are that any growth in the property value will contribute towards the loan, they may be able to let the property and contribute the income towards the fees and the decision to sell the property can be deferred while all options are being considered. However, there are also possible disadvantages, for example:

- The loan is only deferring a liability repayable from the eventual proceeds of the property
- The property will require maintaining and insuring
- Letting property can often be troublesome and rental income is taxable
- The level of local authority funding may restrict the choice of accommodation unless a top-up is affordable over the long term
- Interest will accrue on the loan 56 days after the resident dies
- Councils may ask residents to cover, up front, the costs of land registry searches and any other such legal costs

- If it is intended to sell the property it is probably not to one's advantage to accept a deferred payments agreement if the resident has other capital of below £16 000 and is entitled to an attendance allowance. If the property is *not* on the market it is *not* disregarded for income support purposes. However, if after the 12-week property disregard residents decide to place their property on the market and fund their care independently, they will be entitled to income support with reinstatement of attendance allowance. At the time of writing this is worth an additional contribution of up to £64.65 per week during the period following the 12-week property disregard. Figure 2.3 illustrates this.

(Benefit rates 2002/03)	**Local authority deferred loan** **(£)**		**No local authority deferred loan Property on the market** **(£)**	
Cost of care per week		350.00		350.00
Attendance allowance (not means tested)		(56.25)		(56.25)
Income support (means tested)				
Severe disability premium			42.25	
Pensioner premium (60 and over)	–		44.20	
Personal allowance	–		53.95	
	–		140.40	
Less pension	–		75.75	
Net income support benefits		–		(64.65)
Pension state	75.75		75.75	
Personal expenses allowance	(16.80)		(16.80)	
		(58.95)		(58.95)
Local authority charge against property/shortfall				
First 12 weeks local authority funding		Nil		Nil
Second 14 weeks shortfall		234.80		170.15
Overall cost from capital over 26 weeks		3287.20		2382.10

If it took 26 weeks to sell the property, the current saving by not accepting a deferred payments agreement could therefore be up to £905.10 plus land registry search and legal costs.

Fig. 2.3 Funding options.

Fee plans

Increasing numbers of older people now fund their own care. Around 50% of people in the south-east of England and 30% of people in the remainder of the UK fund their own care. A person with a property to sell could sell the property and purchase an Immediate Need Care Fee Payment Plan liability to pay fees over the long term. Remaining capital can be invested to yield tax-free income and may offer potentially higher capital growth to regenerate the estate.

Top-ups for more expensive accommodation

As with the 12-week property disregard period, individuals who choose more expensive accommodation than the local authority would normally pay for may be entitled to top up their fees from:

- Disregarded income, earnings or capital
- Other capital resources, including the value of the property that is subject to the deferred payments agreement, with the proviso that the resident must be left with total capital resources of no less than the means test lower capital limit, i.e. £11 750. Where the top-up is part of the deferred payments agreement, it is eventually repaid when the property is sold. Local authorities may be reluctant to enter into such agreements if they are not satisfied that the resident contribution including the top-up can be met for the duration of the person's stay in the care home.

The ability for individuals to provide their own top-ups only applies to those benefiting from the 12-week property disregard or the deferred payments scheme. In other circumstances where the local authority is funding the care costs, a top-up may only be paid by a third party who the local authority considers is able to cover the duration of the third party agreement.

NHS nursing care contribution

Residents of nursing homes participating in the deferred payments scheme will, subject to assessment, be entitled to a contribution towards their nursing care from the NHS as if they were normal self-funders. Every case must be considered on its own merits taking into account life expectancy, the property market, the possible loss of benefits, the feasibility of letting against selling and investing in alternative financial products, and the family's wishes to remain independent from state provision.

Before considering whether to be totally independent of the state, there are some important factors residents should bear in mind:

- During any period of interim funding, while the property is on the market the care home fees are likely to be greater than the person's income. How will this shortfall be paid? Can a relative afford it or will the home owner allow it to accrue over the long term if the property does not sell quickly?
- How much will the property sell for and will this provide sufficient money to meet care costs for life? If not, and the capital falls to below £19 000, will the person qualify for help from the local authority (i.e. be assessed as needing the level of care they have chosen at a price the local authority are prepared to pay)?
- Will the home owner agree to keep somebody as a resident in the same accommodation if their capital falls to £19 000 and they can only pay what the local authority offers?

It is sensible to discuss these points with the social services department and the home owner if the resident wishes to follow this course.

Placing a charge on property

Where a resident has a beneficial interest in land that is not disregarded and fails to pay an assessed charge for his accommodation, or chooses to participate in a section 55 deferred payment agreement, from October 2001 the local authority can place a charge on the property to pursue the debt and recover the cost of the accommodation paid on behalf of the resident. In arriving at the value of the property to be treated as capital, the local

authority will allow 10% of its value as notional selling costs. The balance of the value will be treated as notional capital and the charge against the property will continue to accrue until such time as that notional capital after deducting the charge is deemed to be below £19 000 and the authority can begin to provide financial support.

Interest can only be charged on the sum due to the local authority under a deferred payment agreement from 56 days after the death of the resident for whom accommodation has been provided.

Property rented

Property rented out will be treated as a capital asset and any rent received will be disregarded as income although it could be paid to the local authority towards the standard charge.

The marital home

For the purpose of the financial assessment, when one member of a couple enters residential accommodation, the value of his or her home is disregarded as long as it is occupied in whole or part by his or her partner. Should the spouse who remains at home decide to sell the property and move into smaller, less expensive accommodation, the resident's 50% share of the proceeds could be taken into account in the charging assessment. However, should the resident wish to make available part of his or her share of the proceeds to the spouse to enable the purchase of the smaller property, the local authority guidance states that it would be reasonable for this amount to be disregarded, leaving only the surplus of the partner's share to be taken into account.

If one member of a couple enters a home the couple should seek professional advice (often obtainable free of charge). Professional advisers should consider whether jointly owned property should be held as a joint tenancy or as tenants in common. The latter would enable a spouse at home to leave their share of the property to an alternative beneficiary rather than to a spouse in a nursing home or residential home who would need to use the value of the property to pay for care costs. Either party can carry out the change in status of ownership without consulting the other.

Seek advice

The financial and legal implications to be considered when paying for care are wide, and require careful planning. Older people or their relatives should seek specialist advice before taking on any commitment that they are unsure of being able to afford. They should seek advice on what their entitlements are from the state, what legal matters they should attend to and how best to use their capital and income to meet ongoing care costs and possible changing care needs.

'Free' Registered Nursing Care

The way that the costs of registered nursing care are met varies across the UK. Older people living in England, Scotland and Wales all have different

eligibility criteria because of devolved government. In England government introduced a complex system that it claims meets the costs of registered nursing care in English nursing homes.

The Health and Social Care Act 2001 defines nursing care in a care or nursing home as 'the registered nurse contribution to providing, planning and supervising care in a nursing home setting'. The NHS will pay this component of nursing care when an NHS nurse has carried out an assessment. The NHS will not cover personal or social care costs or the costs of accommodation for residents. However, the NHS will continue to fund the care of residents who meet the criteria for continuing NHS health care where the resident has a primary health need.

Assessing eligibility

In England, Primary Care Trusts have appointed nursing home co-ordinators. In areas where Primary Care Trusts have not yet been established, the health authority will appoint a nursing home co-ordinator. The co-ordinators will be registered nurses. Although some co-ordinators are experienced and well qualified in the care of older people, co-ordinators are not required to have any specific expertise or educational qualifications in the care of older people.

The co-ordinators have received training materials and an assessment tool to enable them to determine the level of nursing need. They also receive one day of training. The tool aims to pay not only for care delivered by a registered nurse but also the time a registered nurse spends teaching, supervising and documenting care[8]. The assessment, a tick-box form, bands care into three categories: high, medium and low[9]. Box 2.1 gives details of the three bands.

Box 2.1 Three bands for registered nursing care (from Health and Social Care Act 2001).

- *Low – £35 per week* 'For those whose care needs can be met with minimal registered nurse input. Assessment indicates that care needs can be met in a setting other than a nursing home, but the person is funding their own care and has chosen to enter a nursing home.'
- *Medium – £70 per week* 'The average amount of care provided (delegated, supervised and planned) by registered nurses in nursing homes.' The person will require RN care on at least a daily basis and may need access to a nurse at any time. Needs are stable and predictable and likely to remain so if existing treatment and care is delivered.
- *High – £110 per week* This is based on the finding that 'the average amount of care provided for those with complex or enhanced nursing needs is 55% higher than for those with standard needs for care'. This level of funding is for people who have unstable and unpredictable nursing needs. The person will require frequent intervention and assessment by the RN throughout the 24-hour period.

The assessment process takes from 10–45 minutes per person. It is not yet clear how many people will fall into each band. Jacqui Smith, the minister responsible, has indicated that around 10% of people will fall into the lower band and most other residents will fall into the medium band.

Government estimates that the higher level of allowance will pay for ten hours of registered nurse care per week.

Timetable for introduction

People living in nursing homes who are funding their own care were assessed from November 2001 onwards. There are an estimated 42 000 people funding their own care in England so there may be a backlog of assessments. People admitted to nursing homes after 1 October 2001 have their nursing needs assessed if they are self-funding. People who are funded by social services will have their nursing needs assessed from April 2003. This has just been put back a year because of concerns over the number of assessments required.

If the person, or his or her family, is unhappy with the banding for nursing care they are advised to raise their concerns with the home manager. The manager will be responsible for liaising with the nursing home co-ordinator. The person who has been assessed can request a further assessment from the nursing home co-ordinator. The co-ordinator may change the assessment. If the person is still not satisfied then the assessment can be referred to the health authority continuing care panel.

The nursing home co-ordinator will be responsible for making sure that the scheme runs to budget. The system is cash limited – there will be £80 million to spend between October and April 2002. It is unclear what will happen once the budget is allocated. Will people be forced to join waiting lists for registered nursing care? Will people be expected to remain in hospital because the Primary Care Trust is over budget?

Respite care excluded

People who enter nursing homes on a short-term basis are excluded. If a person comes into a nursing home for six weeks or less they will not benefit from free registered nursing care. Older people who live at home with a carer and go into homes for short-term respite care may be eligible for state funding for up to 12 weeks of care. In order to obtain funding the person has to agree to a full financial assessment. Some older people who fund their own care are not aware of the complexities of funding[10].

National variations

In Wales all nursing home residents will receive a flat rate of £100 a week. Nursing home residents will not be assessed individually for nursing care. The Welsh Assembly believes that people who are living in nursing homes are there because they require nursing care. They recognise that £100 a week does not meet the full costs of registered nursing care and hope to be able to increase the allowance each year so that it does at some point meet the full costs of registered nursing care.

In Scotland the Scottish Executive plans to meet the costs of most nursing and personal care for people living in nursing homes[11]. Eligibility will be on the basis of a single holistic needs assessment. The Scottish Parliament hopes by early 2003 to have in place the system to meet these costs. Northern Ireland is expected to follow the English system.