THE LTC JOURNAL

Summer 2017 **The Long Term Care Community Coalition**

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Nursing Home Care Standards & Enforcement Under Attack

Federal Developments

In the face of heavy lobbying by the nursing home industry, the Trump Administration is taking steps to weaken and undermine federal minimum standards of care as well as both state and federal oversight. Following are some of the key areas of concern identified by LTCCC, as of August. [Note: There are, unfortunately, continuing developments in this area as the Administration carries out its plans to weaken regulatory requirements. Please follow us on Twitter and join us on Facebook for the most up-to-date information.]

1. **Pre-Dispute Arbitration**: Forcing Residents & Families to Give Up Their Constitutional Right to Ever Seek Justice in a Court of Law for Abuse or Neglect (No Matter How Heinous)

The nursing home industry has long sought to limit the ability of residents and families to hold them accountable in a court of law for abuse or neglect, even when the abuse or neglect results in a resident's death, by encouraging residents to sign pre-dispute arbitration agreements. These agreements effectively waive the resident (or family's) right to sue the facility in a court of law by requiring confidential and binding arbitration of any disputes. We agree with California Advocates for Nursing Home Reform that "[p]redispute arbitration clauses are, by their very nature, unconscionable because they insulate nursing homes from accountability for illegal and harmful acts and lead to worse care and health outcomes for residents."

In late 2016, the Centers for Medicare & Medicaid Services (CMS) issued regulations prohibiting this practice. However, just a few months later, operating under the new administration, CMS took a decidedly different view. On June 8, 2017, CMS proposed new rules which would not only allow nursing homes to put pre-dispute arbitration provisions in nursing home residency agreements; CMS went further than any previously existing regulation by proposing that nursing homes can mandate that a resident forfeit his or her rights to ever go to court as a condition of admission to the facility.

LTCCC, other advocates, many state attorneys general and a number of U.S. Senators have called for CMS to step back from its proposal to permit mandatory, pre-dispute arbitration agreements. The overwhelming majority of comments posted on www.regulations.gov in response to this proposed rule change likewise called for CMS to protect the rights of residents who have been abused. To read the comments that LTCCC submitted to CMS, in opposition to the proposed rule change, click here.

2. **Reducing Already Low & Infrequent Penalties for Substandard Care, Resident Abuse & Neglect.**

The nursing home industry's lobbyists have urged the Trump Administration to reduce penalties when facilities are found to have failed to meet minimum standards of care. In response, CMS announced that it will not allow states to issue any penalties for the nursing home regulations coming into effect in November 2017 for a full year. Facilities may be cited for failing to meet these minimum standards, but they will face no penalty. From LTCCC's perspective, this sends a

clear message to nursing homes that they can ignore these standards with impunity for (at least) another year.

In addition, in August CMS alerted stakeholders that, until further notice, it was no longer issuing both per day and per instance penalties in the same inspection – no matter how many violations a facility might have or the nature of those violations. LTCCC is concerned that this explicitly violates existing federal regulations (e.g., 42 CFR §488.440) and guidelines (e.g., the State Operations Manual, Section 7400.6.2, Category 2) and is advocating for a reconsideration and reversal of this policy.

3. **Grievance officer and policies**.

The 2016 standards for nursing homes mandate that every nursing home have an assigned grievance officer who must be responsive to resident and family complaints and concerns. We consider this to be an important provision since it, minimally, provides a chain of accountability for residents and families. In what appears to be another response to industry pressure, CMS issued a proposal earlier this year to change the regulation to weaken the requirements to have a designated grievance officer, to record complaints, and more.

4. **Discharge notice to LTC Ombudsman Programs**.

The 2016 standards require that nursing homes send a notice of discharge to the LTC Ombudsman Program when a resident is discharged. In 2017, CMS modified this to only apply when a discharge is initiated by the facility - not when it is initiated by a resident or resident representative. The problem with this modification, in our view, is that this assumes that facilities will engage in full and honest disclosure and would, for example, report that they are initiating an inappropriate or illegal discharge to the LTC Ombudsman Program for potential investigation.

NY State Developments

Regulatory Modernization Initiative

NY Governor Cuomo has embarked on a "Regulatory Modernization Initiative" the purpose of which is "to examine existing laws, regulations, and policies and recommend appropriate changes." According to the NYS Department of Health's website, the goal of the initiative, in respect to long term care, is to convene stakeholders to

> examine how to adapt current regulations on post-acute care management in order to better enable providers to deliver services that are known to reduce readmissions and lead to better outcomes for patients. In response to feedback that service need methodologies and compliance standards for nursing homes, adult homes and other long-term care providers are outdated, stakeholders will consider whether current regulatory approaches can be adapted to better allow for the provision of innovative models of care to meet the needs of communities.

The NY DOH website also provides a list of the individuals chosen to participate in the "Regulatory Modernization Initiative Work Group" that will be addressing long term care.

We have concerns about both the goals of this effort and the personnel entrusted with pursuing these goals. We strongly agree with – and support – the Governor's goals of improving care management and outcomes for consumers. Both of these goals reflect longstanding federal minimum requirements. Reducing hospital readmissions – so long as it is implemented carefully – is also a laudable goal. However, the idea of revising minimum safety standards is extremely alarming. Those standards provide the basis for decent care and life with dignity for New York's nursing home residents. As numerous studies over the years have indicated, if anything, better understanding and enforcement of existing standards is needed to ensure that the promise of decent care and life with dignity is realized for nursing home residents. Reducing or loosening standards could, in our view, be disastrous for those residents and their families.

Because these issues are so critical to the safety and well-being of nursing home residents, we also have concerns about the composition of the state Work Group. In addition to state government staff, the workgroup is comprised largely of representatives from the provider industry and the major provider lobbyist associations in Albany, including LeadingAge New York, NYS Association of Health Care Providers, Greater New York Hospital Association and the NYS Association of Health Care Providers. In fact, only one of the 30+ members of the Work Group is unaffiliated with either the state or the provider industry, and that individual announced that she was leaving her job and moving out of state the day before the first meeting of the Work Group.

Federal Alert: Procedures To Ensure Reporting of Incidents of Potential Nursing Home Abuse or Neglect Are "Inadequate"

The Office of the Inspector General's "Early Alert"

On August 24, 2017, the Office of the Inspector General for the U.S. Dept. of Health & Human Services (OIG) issued an "Early Alert" in respect to an audit it is conducting of potential abuse or neglect of Medicare beneficiaries in nursing homes. While the audit is not complete, the early alert was issued due to "the importance of detecting and combating elder abuse" and OIG's preliminary results, which indicate that a significant percentage of nursing home abuse may not have been reported to law enforcement, as federal law mandates. In addition, the OIG's memorandum to CMS Administrator Verma notes that "according to *Government Auditing Standards*, 'early communication to those charged with governance or management may be important because of their relative significance and the urgency for corrective follow-up action.'"

The OIG memorandum describes the methodology used by the OIG.

> We… reviewed the emergency room records for 134 Medicare beneficiaries with any of 12 primary diagnoses codes that explicitly indicate potential abuse or neglect. We also reviewed publically available Survey Agency reports for each [nursing home] covering

> the period when the incident of potential abuse or neglect occurred. In addition, we reviewed the Medicare exclusion database and interviewed CMS officials to determine whether the U.S. Department of Health and Human Services (HHS) had implemented and used civil monetary penalties or excluded from Federal health care programs any providers under section 1150B since its effective date of March 23, 2011.[1]

The diagnoses identified in the OIG sample, according to the memorandum, included allegations of rape, sexual abuse, physical abuse and sexual sadism.

According to the OIG memo, the preliminary findings indicate that

> [m]any of the incidents of potential abuse or neglect… identified may not have been reported to law enforcement. According to the records… reviewed, 96 of the 134 (72 percent) incidents were reported to local law enforcement. However, [OIG] found no evidence in the hospital records that the remaining 38 incidents (28 percent) were reported to local law enforcement despite State mandatory reporting laws requiring the hospitals' medical staff to do so. [OIG] also found that **the Survey Agencies substantiated 7 of the 134 [5 percent] total incidents in their survey reports**. [Emphasis added.]

The OIG "determined CMS procedures are not adequate to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported." According to the OIG memo, CMS informed OIG that, when a nursing home resident is sent to the emergency room, CMS does not match Medicare claims for an individual's emergency room services with those of his/her nursing home care "to identify instances of potential abuse or neglect. Furthermore, CMS has not taken any enforcement actions using section 1150B of the Act or used the penalties it contains since its effective date of March 23, 2011, to ensure SNF employees report incidents of potential abuse or neglect."[2]

Suggestions for Immediate Action

OIG determined that "[t]hese preliminary results combined with [OIG's] prior report results raise significant concerns that incidents of potential abuse or neglect at SNFs have gone unreported. Detecting and combatting elder abuse requires covered individuals, SNFs, MFCUs,

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[1] Editor's Note: Section 1150B of the Social Security requires all nursing home staff (including administrative and other non-care staff and contractors) to immediately report any suspicion of a crime against a resident of the facility. This requirement, originally part of the Elder Justice Act, was incorporated into the Affordable Care Act (so called "Obamacare") which became law in 2010.

[2] See footnote one, above, for information on Section 1150B.

Survey Agencies, and CMS to meet their responsibilities."[3] Thus, OIG's recommends that CMS take two immediate actions:

1. "[I]mplement procedures to compare Medicare claims for emergency room treatment with claims for SNF [nursing home] services to identify incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs and periodically provide the details of this analysis to the [State] Survey Agencies for further review…" and
2. Take steps to ensure appropriate enforcement of the federal requirements for reporting any suspicion of a crime against a nursing home resident to law enforcement (Section 1150B).

The OIG memorandum provides additional information of note, including previous reports addressing the persistence of nursing home abuse, a breakdown by state of incidents of potential abuse that they audited and examples of what they consider to be potential physical and sexual abuse.

In the first example, which was a case OIG considered to be potential sexual abuse, the emergency room record for "Jane Doe" indicated that "[n]ursing aides found the man on top of Ms. Doe squeezing and touching her breast and ejaculating on her. The emergency room record further noted that Ms. Doe's right breast was an "area of discomfort," and two silver-dollar-sized bruises were observed on her breast…."[4]

According to the memo,

> The Survey Agency reviewed the incident and cited the SNF for failure to:
>
> • immediately tell the beneficiary's doctor and a family member of the beneficiary of the incident,
>
> • report and investigate an instance of abuse,
>
> • develop policies that prevent abuse, and
>
> • provide care in a way that keeps or builds each resident's dignity.
>
> **The Survey Agency** did not cite the SNF for failure to ensure the Medicare beneficiary was free from abuse and **classified the incident as resulting in "minimum harm or potential for actual harm.**" [Emphasis added.]

[3] "SNF" is the acronym for skilled nursing facility, or nursing home; "MFCU" is the acronym for Medicaid Fraud Control Unit.

[4] This quote and the following description is excerpted from the OIG Memorandum. Available at https://oig.hhs.gov/oas/reports/region1/11700504.pdf.

LTC News & Briefs

Study: Patients Not Given Info on Quality of Nursing Homes When Discharged From Hospitals

A study, published in *Health Affairs* in August, assessed how hospital patients who need post-acute care after their discharge choose a nursing home for their care. According to the abstract published on the *Health Affairs* website, "Most patients described receiving only lists of skilled nursing facilities from hospital staff members, while staff members reported not sharing data about facilities' quality with patients because they believed that patient choice regulations precluded them from doing so. Consequently, patients' choices were rarely based on readily available quality data."

As noted in the abstract, "less strict interpretations of choice requirements" would enable patients to be referred to higher-quality facilities.

National Assisted Living Company Hit with Class-Action Lawsuit

McKnight's Senior Living reported (July 16, 2017) that "[a] set of disgruntled residents… filed what they believe could be the first class-action lawsuit against an assisted living operator to be brought under the Americans with Disabilities Act. Potential damages could exceed $45 million, according to one of the attorneys representing the plaintiffs."

The lawsuit was filed against Brookdale Senior Living Inc., which, according to its website, has over 1,100 facilities in 47 states. Allegations include understaffing, violations of the Americans with Disabilities Act and violations of the "Consumer Legal Remedies Act, committing elder financial abuse and fraud." According to the *McKnight's* article, the potential class of plaintiffs in this case is limited to Brookdale's California residents.

To find out if Brookdale operates your facility or facilities in your community or state, go to https://www.brookdale.com/en/find-a-community/browse-by-state.html.

Federal Government Launches Hospice Compare Website

The U.S. Centers for Medicare and Medicaid Services (CMS) has launched Hospice Compare, a web-based tool that, according to CMS, "allows patients, family members, caregivers, and healthcare providers to compare hospice providers based on important quality metrics, such as the percentage of patients that were screened for pain or difficult or uncomfortable breathing, or whether patients' preferences are being met. Currently, the data on Hospice Compare is [*sic*] based on information submitted by approximately 3,876 hospices."

Hospice Compare joins other "Compare" tools on the www.medicare.gov website, including: Nursing Home Compare, Physician Compare, Home Health Compare, Hospital Compare and Dialysis Facility Compare.

New York Nursing Home Co. Responds to Plunge in Star Ratings: "County should thank us!"

The Post-Star in Glens Falls, NY, reported (August 14, 2017) on a meeting between the newspaper's editorial board and the CEO and Vice President of Centers Health Care, which purchased the Warren County-owned Westmount Health Facility approximately a year ago. According to *The Post-Star* report, the nursing home's ratings were "downgraded from four stars to one star," with the new owners claiming that this is "because patients are getting better care."

The Post-Star report states that Centers' CEO Kenny Rozenberg gave several reasons in support of his assertion that care has improved while star ratings plummeted, including that "new patients are sicker" and problems are being better identified. However, As *The Post-Star* notes, Centers Health Care "has been dogged with poor inspections." The Bronx-based company owns nursing homes in New York, New Jersey and Rhode Island.

According to Nursing Home Compare, the newly named Warren Center has a two star overall rating, with two stars for health inspections and quality measures and three stars for staffing. Nursing Home Compare ratings range from 1 – 5 stars. It is important to note that, as of August 2017, a facility's staffing levels and most quality measures are self-reported by the facility and unaudited by either the state or federal governments.

The Post-Star report states that

> …officials insisted there were no problems with staffing.
> "More is not better. More is just more," Rozenberg said.
> The company staffs six to eight CNAs on the day and evening shifts, with four at night at Warren Center, said Director of Nursing Jennifer Burnham.
> That's enough to take care of the daily needs of the 80 residents because they are well-trained and dedicated, she said.
> "I can have eight people do the job wonderfully where 15 people couldn't do it," she said.

According to Nursing Home Compare, Westmount's CNA staffing is about equal to the state and national averages. However, its RN staffing is significantly lower. Westmount reports an average level of 38 minutes of RN time per resident day, while the state average is 45 minutes and the national average is 50 minutes. RN staffing in particular has been identified as a key indicator of a nursing home's quality and safety.

The Post-Star report states that

> [g]etting enough people on staff, including LPNs and RNs, has been difficult. The company often buys a house for new workers to share, or puts them up in a hotel, until they can find places of their own.
> "We have uprooted them from other parts of the state and relocated them to Warren County," [Rozenberg] said, adding with a laugh, "Warren County should thank us!"

Study Assesses Nursing Staff Perceptions of Antipsychotic Medication Use in Nursing Homes

A study reported on in *The Gerontologist* (May 30, 2017) assessed nursing home staff perceptions of antipsychotic medication use to identify caregiver perspectives on how to reduce inappropriate antipsychotic drugging. Researchers found that care staff recognized numerous benefits to reducing antipsychotic drugging,

> …with four primary themes: (a) Improvement in quality of life, (b) Improvement in family satisfaction, (c) Reduction in falls, and (d) Improvement in the facility Quality Indicator score (regulatory compliance). Participants also highlighted important barriers they face when attempting to reduce or withdraw antipsychotic medications including: (a) Family resistance, (b) Potential for worsening or return of symptoms or behaviors, (c) Lack of effectiveness and/or lack of staff resources to consistently implement nonpharmacological management strategies, and (d) Risk aversion of staff and environmental safety concerns.

The authors conclude that **"[a]chievement of further reductions in antipsychotic medication use will require significant additional efforts and adequate clinical personnel to address these barriers."** [Quotes from article abstract. Emphasis added.]

U.S. Agencies Announce Largest Federal Healthcare Fraud Takedown in U.S. History

In July, the U.S. Department of Justice and the Office of the Inspector General (U.S. Department of Health and Human Services) announced an "unprecedented nationwide healthcare fraud takedown." McKnight's reported (July 14, 2017) that the takedown "included more than 400 charged defendants as well as suspension of nearly 300 providers." The takedown targeted a range of service providers, including those involved in nursing home, hospice and home health care.

According to U.S. Attorney General Jeff Sessions, "**Too many trusted medical professionals, like doctors, nurses, and pharmacists, have chosen to violate their oaths and put greed ahead of their patients." The consequences are real: emergency rooms, jail cells, futures lost and graveyards**." [Emphasis added.]

Study Finds Significant Relationship Between Nursing Home Resident Choice & Satisfaction

A study published in The Gerontologist assessed the association between nursing home (NH) residents' perceived level of choice and their satisfaction with care preferences being met. As the article notes,

> Self-determination theory purports that autonomy is a critical psychological need necessary for personal growth, health, and well-being across the life span (Deci & Ryan, 2000). **Research demonstrates the importance of maintained autonomy for physical and psychological well-being and reductions in mortality** (Infurna, Gerstorf, Ram, Schupp, & Wagner, 2011; Langer, 1983). [Emphasis added.]

As the authors note, most prior research on this issue has focused on the perspective of nursing home staff, while "little inquiry has sought to understand how various dimensions of autonomy, such as perceived choice, are interpreted by NH residents. Consequently, a critical voice is missing from this dialogue." This study focused on the residents, utilizing "qualitative and quantitative data to examine NH residents' perceived level of choice in fulfilling care preferences." They found "a positive association between NH residents' perceived choice and feelings of satisfaction with their care preferences being met. Offering choices that are deemed favorable or solicited from NH residents is a fundamental step toward increasing resident satisfaction with NH care."

Texas Puts "Troubled Nursing Homes on Notice"

According to a report in the *Texas Tribune*, a new state law taking effect in September "will make it more difficult for long-term care facilities cited for repeat violations to avoid hefty fines from regulators." The law, championed by Texas State Senator Charles Schwertner, chair of the Texas Senate Health and Human Services Committee, "gives the state the ability to fine repeat offender nursing homes without first having a chance to fix violations."

According to the *Texas Tribune* report,

> His bill — eliminating a so-called "right to correct" loophole for the most serious offenses — passed the Senate but never made it out of the House, and eventually got attached as an amendment to another successful health care bill.
>
> Schwertner said in April that **the state "needs to send a clear and unambiguous message that we're serious about protecting our most vulnerable citizens from abuse and neglect**."
>
> "Whether it's children in foster care, individuals with intellectual or developmental disabilities living in long-term care facilities, or our parents and grandparents residing in nursing homes, our state needs to do a much better job of protecting those who cannot protect themselves," he said. [Emphasis added.]

"…a regulatory touch so light that the [nursing home] industry feels little consequence from committing repeated violations."

The *Texas Tribune* report notes that the law comes on the heels of two reports on nursing home care and oversight in the state. In January, AARP Texas released a report entitled *Intolerable Care: A snapshot of the Texas nursing home quality crisis*. Quoting an earlier report (July 2015) from the Texas Sunset Advisory Commission, which reviews the effectiveness of state agencies, AARP Texas states that "the Department of Aging and Disability Services 'needs to step up to the plate and more aggressively take on its role as a regulator.' But the commission also said that the department's power over long-term care facilities is 'a regulatory touch so light that the industry feels little consequence from committing repeated violations.'"

Save-the-Date: LTCCC's Annual Reception on September 27

LTCCC's Ninth Annual Cocktail Party and Reception will be held on Wednesday, September 27, 2017 from 6-8 pm in New York City. This year we will be featuring a very special Panel Discussion on the Present & Future of Long Term Care.

Panelists include: Valerie J. Bogart, Director, Evelyn Frank Legal Resources Program; Judy A. Farrell, MPA, VP, Government Affairs, GuildNet, Lighthouse Guild; Hon. Richard N. Gottfried, Chair, NYS Assembly Health Committee; and Mary Jane Koren, M.D., M.P.H.

Please join us, in person or as a sponsor, for an enjoyable and interesting program. For more information, please call 212-385-0355, email sara@ltccc.org or visit our website at http://nursinghome411.org/about-ltccc/ltccc-annual-cocktail-party-reception/.

Save-the-Date: Symposium on Nursing Home Care & Quality on November 13

With funding from the New York State Health Foundation, LTCCC will be hosting a symposium for nursing home residents, families, LTC Ombudsmen and those who work with them. ***Fulfilling the Promise: Resident Rights & Resident Care Under the New Federal Standards for Nursing Homes*** will feature speakers discussing relevant aspects of the new federal standards for nursing home care and other topics related to accessing the care and services that every resident deserves.

When: November 13, 9:30am – 2:00pm

Where: The American Red Cross, 520 West 49th Street, New York, NY

How: To register or for more information call 212-385-0355 or email sara@ltccc.org.

Nursing Home Residents, Families, Ombudsmen & Advocates

Limited slots are available for nursing home residents, families, LTC ombudsmen and advocates to attend at *no cost*. We will be sending out invites and invitations to the LTC Ombudsman Programs, Family Councils and other organizations in September. Please email sara@ltccc.org if you would like to receive an invitation.

Attorneys and Other Professionals Helping Nursing Home Residents & Families

We welcome your joining in this program. For attorneys, we anticipate offering CLE credits. Please email sara@ltccc.org for more information or an invitation.

LTCCC Resources For Residents, Families, Ombudsmen & Advocates

Free Programs for Residents, Families, LTC Ombudsmen & Advocates

LTCCC is pleased to announce that, with a generous grant from the NY Health Foundation, we are now providing free monthly programs on the new nursing home standards for residents and families and those who work with them.

Background: In November 2016 the federal government made comprehensive changes to the basic standards of care and dignity for all U.S. nursing home residents.

Why Attend?: It is crucial for residents, families and those who work with them to (1) know what their rights are and (2) be equipped to advocate for good care as the new standards are implemented. There may be a great deal of confusion as to what nursing homes are required to do to ensure that residents receive good care and are treated with dignity. Each month, participants will learn about a specific standard relevant to good care.

To Attend: Email sara@ltccc.org or call 212-385-0355 for information on the program schedule and how you can access via your phone or computer.

Get the Info: All of the fact sheets, PowerPoints and program recordings will be posted each month on our website's Learning Center: www.nursinghome411.org/learning-center.

Featured Fact Sheet: Nursing Home Transfer & Discharge Rights

LTCCC is building a library of free fact sheets on important nursing home regulations, dementia care and other standards relevant to residents and those who care for and/or help them. The fact sheet we are featuring in this issue is on the federal protections that limit the circumstances under which residents can be transferred or discharged from their facility. Involuntary discharge is a longstanding and growing problem. This fact sheet provides information on transfer and discharge protections, appeal rights and more.

LTC Ombudsman Program Seeks Volunteers in NY State

The LTC Ombudsman Program (LTCOP) is dedicated to ensuring that residents in long term care facilities have good care and are treated with dignity. Being an Ombudsman volunteer is both challenging and rewarding. Volunteers receive extensive training to advocate for, educate and empower family members and residents living in nursing homes, assisted living, and family type homes. They can make a big difference in the lives of some of the most vulnerable people in our communities.

The LTCOP is seeking volunteers who can contribute a minimum of two hours a week to help residents in facilities in their communities. The Hudson Valley LTCOP currently has volunteer

opportunities in Dutchess, Ulster, Orange, Sullivan, Columbia and Greene counties. To volunteer in the Hudson Valley, please call 845-229-4680 or email Gloria@hudsonvalleyltcop.org. To volunteer in another area of New York State, please go to the "Who is My Ombudsman" page on the NYS LTC Ombudsman Program's website: http://www.ltcombudsman.ny.gov/whois/index.cfm.

Nursing Home Enforcement Actions

LTCCC is in the process of transitioning our reporting of state and federal enforcement actions from our old homepage, www.ltccc.org, to our new homepage, www.nursinghome411.org.

The Nursing Home Information & Data page on www.nursinghome411.org includes a range of enforcement and other relevant data on nursing homes, including:

August 2017: US Nursing Home Citations

Nursing Home "Double G" Citations by State (2016)

August 2017: Comparative State Data Nursing Home Population, Citations, Staffing & Quality

The NY State Facility Information page on www.nursinghome411.org includes:

NYS Fines 2016

Federal Civil Money Penalties for Nursing Homes in NYS 2016

Selected Enforcement Actions Taken By The NYS Medicaid Fraud Control Unit 2016

Wherever possible this information, published in Excel format, has been formatted to make it as easy-to-use as possible.

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