Health Service Commissioner

Fifth Report for Session 1995–96

Investigations of Complaints About Long Term NHS Care

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Introduction

1. In January 1994 I made a special report (HC 197) on a complaint about the failure by Leeds Health Authority to provide long term NHS care for a brain damaged patient. That report raised issues of general public interest. Since then I have received other similar complaints about failure by the NHS to provide continuing inpatient care in nursing homes or hospitals.

2. This is a second special report on the same topic. It includes the full texts of reports of five investigations (with the identity of the complainants anonymised to preserve confidentiality) which have been completed since September 1995. Two other such reports (case numbers E.264/94–95 and W.71/93–94) were published in a volume of selected investigations completed between April and September 1995, HC 11.

3. In February 1995, taking account of my first special report, the Department of Health issued new guidance, (HSG(95)8 reproduced as Annex A to this report) on NHS responsibilities for meeting continuing health care needs. The complaints included in this report all arose before that guidance was issued but many of the matters raised remain relevant as the new guidance is being implemented.

Issues arising

4. The complaints about provision of continuing care received since 1994 have rarely involved such a clear failure in service as in Leeds, where the Health Authority's policy made no provision for continuing inpatient care. In some cases investigated authorities were making some provision for long term inpatient (or intensive outpatient) care for certain severely disabled patients, but not for the patients referred to in the complaints. Some of those authorities did not have clear written eligibility criteria for NHS funding of such care. That made it difficult both for the complainants and for me to judge whether the NHS should have been providing it for the patient. Where eligibility criteria existed they proved to be often complex and restrictive. My investigations revealed other problems such as poor arrangements for arranging discharge from hospital. Implementation, in April 1993, of parts of the NHS and Community Care Act 1990 enhanced and clarified the role of social services departments (whose actions are not within my jurisdiction but within that of the Local Government Ombudsman) in assessing and funding community care. Even after that date some hospitals failed to refer to social workers patients needing long term care. The result was that the patient did not receive comprehensive assessment and advice before discharge.

5. Under the new guidance authorities had to develop by April 1996 local eligibility criteria and to set up independent panels to review contested decisions about eligibility. It is too soon to say, from the evidence of complaints I have received, whether those and other measures will be effective in increasing public understanding of and confidence in the equity of decisions about continuing care. I note that the Department of Health's own review of progress (EL(96)8 reproduced at Annex B to this report) on implementation of the new guidance identified a number of areas where proposed eligibility criteria could be too restrictive. Health authorities are to review their eligibility criteria by April 1997, taking account of further guidance which will follow a national review of the operation of the criteria to be completed by October 1996.

6. The eligibility criteria seek to determine where a sharp dividing line ought to be drawn between those who, regardless of their financial circumstances, have the costs of their long term care in a nursing home (or in a hospital) paid for by the NHS and those who should be liable to pay the costs themselves, unless they qualify for means-tested funding. Since April 1993 that

funding has been from the local social services department. Some health authorities' attempts to tackle the problem of drawing that line have involved setting up innovative funding arrangements. In case E.672/94–95 in this volume, before April 1993, partial funding for some patients was made through a grant to a charitable organisation. In case E.787/94–95, after April 1993, considerable efforts were made by one health authority to develop arrangements for joint funding of care for certain patients with the local social services department. However when the complainant refused to provide all the information requested by social services, for the purpose of means-testing the care not funded by the NHS, the result was stalemate. Despite the best efforts of the health authority (who sought advice from the Department of Health) that stalemate was not resolved. The patient was not discharged from hospital to a nursing home, although all involved agreed that that was in his best interests. The patient died without matters being resolved.

7. Previous guidance (HC(89)5, quoted in Annex C) from the Department of Health said that patients being discharged from hospital to a private nursing home should be told *in writing* whether the health authority would pay the fees. I have seen too many examples of that guidance being ignored. That is simply not good enough. While often the lack of written information in itself resulted in no injustice, because the patient or relative was given the information orally, sometimes by a social worker, in future proper regard should be paid to the similar requirement in the new guidance. Paragraph 25 of HSG(95)8 (Annex A to this report) places responsibility on hospital staff (as well as those from social services) to make sure that patients receive a written statement about which aspects of their continuing care will be funded by the NHS. Poor communications with relatives and among professionals about discharge plans are still too common. Examples are given in the complaints covered by this volume.

8. In the three cases where I upheld the complaint I suggested that the relevant authority should make an *ex gratia* payment. That was not as compensation for unnecessary expenditure, because I was unable to say whether the authorities concerned were under a duty to pay for the patients' care, but as redress for unfairness or distress caused by other failings identified. In two of those cases a suitable payment was made: in the third case Bristol and District Health Authority (since succeeded by Avon Health Authority) did not make a payment.

Conclusion

9. The arrangements for long term care pose difficult and important questions. The Health Select Committee of the House of Commons published in November 1995 the results of the first of two phases of an inquiry into the subject. It is not for me to intervene in policy but, when I receive complaints, I am concerned with how it is implemented or in some cases not implemented. My aim in publishing these cases, and previous ones, is to illustrate the issues involved and to indicate how mistakes can be avoided. I hope that the cases in this volume will demonstrate some of the administrative problems, and the difficulties which can be caused for individuals involved.

June 1996

W K Reid
Health Service Commissioner

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Matters considered *Discharge arrangements—undue pressure to accept financial responsibility for private nursing care.*

Body complained against East Kent Health Authority

Summary of case and findings In September 1993 a woman was transferred to the Royal Victoria Hospital, Folkestone. At the time the hospital was managed by South East Kent Health Authority (later succeeded by East Kent Health Authority) but since 1 April 1994 has been the responsibility of South Kent Hospitals NHS Trust. In November 1993, although the woman had suffered strokes in hospital, nurses told her daughter that she would have to be discharged from NHS care. In December the daughter met the consultant and other staff responsible for her mother's care. The consultant said that despite the woman's severe disabilities she did not fulfil the Authority's criteria for NHS-funded continuing care. The daughter felt intimidated by the way the case conference had been arranged and felt under pressure. She was aware that she would have to pay for nursing home care but thought there was no alternative. The woman was discharged to a private nursing home in December and died in March 1994. Contrary to Department of Health guidance the woman's daughter was not told in writing of the financial consequences of her mother's move to a private nursing home. The Authority's system operated on the assumption that the social services department (SSD) would inform patients and carers about financial matters, but the woman's daughter was never formally referred to them. Staff had adopted an unacceptable procedure of neglecting to refer to the SSD patients who might need nursing home care if they thought those patients were ineligible for financial help. A joint assessment form was not fully completed, and the SSD, the community liaison nurse and the woman's daughter were not involved in the assessment. The daughter was denied the opportunity to explore other options for her mother's care. If the correct procedure had been followed the woman's daughter could have been involved in discussing the joint assessment and the reasoning behind any recommended action; but the outcome—discharge to a nursing home with the costs borne by the patient—might have been the same. The Authority's failures to follow procedures amounted to maladministration. As a result the woman's daughter was denied a proper discussion and considered advice. I upheld the complaint.

Remedy The Authority apologised for their shortcomings. They agreed to make the woman's daughter an *ex gratia* payment in recognition of the injustice and distress caused by mishandling her mother's discharge from hospital.

Case No. E.672/94–95

Matters considered *Discharge arrangements—advice to family about cost—responsibility for funding*

Body complained against North Cheshire Health Authority

Summary of case A man aged 74 was admitted to Halton Hospital in October 1992 after a stroke. His wife complained that she was made to arrange his discharge to a nursing home a month later without being given adequate advice about the costs of care. She also complained that the health authority should have funded his future care. At the time the hospital was administered by Halton

Health Authority, since succeeded by North Cheshire Health Authority. On 1 April 1993 it became the responsibility of the Halton General Hospital NHS Trust. The woman was referred to a charitable organisation which received a grant from the Authority and provided advice and help with nursing home placements—but only to those eligible for income support. It was therefore unable to help the complainant. As a result she had no proper advice about alternatives to and the cost of nursing home care. The Authority had no long term care beds for the elderly. Their grant to the charitable organisation covered some of the cost of care for some patients eligible for income support.

Findings I upheld the complaint that the woman was given no written information about plans for her husband's discharge and that she had little or no discussion with Authority staff about options for his care. Their practice of making a grant to the charity was not a source of injustice to the complainant but was no substitute for a proper mechanism for determining eligibility for NHS funding for continuing health care, regardless of the financial means of the patient. Because of the time which had elapsed I could not judge whether the costs of the man's care should have been borne by the Authority in 1992.

Remedy The Authority apologised and agreed to make an *ex gratia* payment to the woman in recognition of the distress she had been caused by their maladministration. All cases where a discharge to nursing home is considered appropriate are now referred to the local authority social services department for advice.

Case No. E.787/94–95

Matters considered *Delay in deciding on provision of long-term health care*

Body complained against Oxfordshire Health Authority

Summary of case A woman complained that Oxfordshire Health Authority took an unreasonably long time to decide on the provision of long term health care for her husband who suffered from Alzheimer's Disease. She believed that the NHS should meet all the costs of her husband's nursing home care. The Authority acknowledged that they had a duty to fund some of the care which the man needed and the SSD were prepared to meet other costs (subject to a formal agreement). However, because the woman refused to be financially assessed, the SSD could not arrange care. The woman's husband received until he died inpatient care in a NHS community hospital which was the second option in his assessment and there was no failure to provide a service which it was a duty of the NHS to provide. His death left matters unresolved.

There were two reasons for the delay in arranging nursing home care. First, there was a dispute about whether the husband qualified for nursing home care fully funded by the NHS, the woman believing that the NHS ought to meet all the costs, while the Authority considered that his needs were below the threshold which would qualify him for *all* the costs to be met by the NHS. The Authority acknowledged that they had a duty to fund the health care support which he needed, over and above his routine daily care, and their discussions with the SSD concluded that the SSD should meet the other costs of his care. The second reason for the delay was that the woman believed the NHS had a duty to finance her husband's care, and refused to be financially assessed by the SSD, though that was a necessary part of the assessment of her husband's means. The SSD could not arrange care without a financial assessment. The Authority argued that it would be inequitable for them to finance all the man's home care without doing the same for other patients in similar circumstances. They accepted they could not force him to enter a nursing home and clinical advice prevented his discharge home. Care in a community hospital was the solution which the Authority funded.

Findings I found that the Authority acted reasonably in the circumstances. I did not uphold the complaint.

Case No. E.615/94–95

Matters considered *Discharge arrangements and duty to provide for care.*

Bodies complained against Avon Health Authority and Bristol Healthcare NHS Trust

Summary of case In April 1993 a woman was discharged to a private nursing home from Bristol General Hospital, which is managed by the United Bristol Healthcare NHS Trust. The woman's son complained that staff at the hospital failed to complete the necessary forms correctly, and failed to inform his mother or her family in writing of the financial consequences of her discharge. In November 1993, he wrote to the Trust seeking clarification of the Trust's responsibility for his mother's continuing nursing care. The Trust advised him to write to Bristol and District Health Authority, which he did in February 1994. After an exchange of correspondence, the chief executive of the Authority told the woman's son in July 1994 that they would not accept financial responsibility for his mother's care. In April 1996 the Authority was succeeded by Avon Health Authority.

Findings I upheld the complaint about the completion of the forms, although I found that no injustice or hardship was sustained as a result of the errors. I did not uphold the complaint that the Trust had failed to inform the woman or her family about the financial consequences of her discharge. I made no finding on the complaint that the Authority should have funded the woman's care in the nursing home. However, I considered that the Authority's stated policy at the time of not purchasing any continuing care beds in hospital or in nursing homes was unreasonable; and that it was unfair that their lack of criteria for access to such care effectively excluded the woman from consideration. I invited the Authority to consider making an *ex gratia* payment to the woman's son.

Remedy The Trust and the Authority agreed to make sure that all health needs assessment forms were completed fully in future. The Authority also undertook to agree explicitly with local hospitals and the SSD arrangements for informing patients or their relatives about the financial consequences of discharges. The Authority decided not to make a payment to the son.

Case No. E.118/94–95

Matters considered *Patient obliged to pay for continuing care.*

Body complained against Buckinghamshire Health Authority

Summary of case A man aged 91 was registered blind, was deaf and had difficulty walking. He was admitted to Stoke Mandeville Hospital after a fall. In February 1993 he was discharged to a nursing home where he remained until his death in 1994. The man's sister-in-law complained that he was obliged to pay for continuing care which should have been provided free of charge under the NHS. At the time of his discharge the hospital was administered by Buckinghamshire Health Authority, but on 1 April 1994 it became the responsibility of Stoke Mandeville Hospital NHS Trust. The family had not been given written information about the need to pay for nursing home care (as they should have been) but they were told about it by a social worker. The Authority who managed the hospital at the time provided NHS continuing care in hospital for some patients. There were no written criteria for determining eligibility for NHS funding of continuing care but the consultant considered that the man did not come within the category of patients who required long term care as provided in the hospital. The Authority said that a decision taken now on such a patient would be no different.

Findings I could not tell whether the outcome would have been any different if the family had received the information in writing. I did not see evidence of a failure in service, but criticised the fact that the eligibility criteria being applied were unwritten. That made it difficult to explain or scrutinise them. I did not uphold the complaint.

Full texts of reports

Case No. E.685/94–95

Background and complaint

1. The background provided by the complainant was that on 17 September 1993 her late mother, was transferred to the Royal Victoria Hospital, Folkestone. At the time the hospital was managed by South East Kent Health Authority (the Authority), now East Kent Health Authority, but on 1 April 1994 it became the responsibility of the South Kent Hospitals NHS Trust (the Trust). Although the complainant's mother had suffered strokes while in hospital, nurses told the complainant in November that her mother would have to be discharged from NHS care. A ward sister told the complainant that any nursing home fees would have to be paid by the complainant's mother or if appropriate, the social services department. On 1 December the complainant attended a meeting with the consultant responsible for her mother's care and other hospital staff. She found the meeting intimidating and felt under pressure to arrange for her mother to be admitted to a private nursing home. The complainant was not informed in writing, as required by Department of Health circular HC(89)5, whether the Authority would pay the home's fees; nor was there any liaison with the local social services department over her mother's discharge from hospital. The complainant's mother was discharged to a private nursing home on 3 December 1993. She died on 6 March 1994.

2. The complaints which I investigated were that:

(a) the arrangements made for the woman's discharge did not accord with Department of Health guidance; and

(b) undue pressure was placed on the complainant to arrange, and accept financial responsibility for, her mother's placement in a private nursing home.

Investigation

3. I obtained the comments of the Authority and examined relevant papers. My officer took evidence from the complainant, and from staff of the Trust. Evidence was also obtained from a care manager employed by the local authority social services department, whose actions are outside my jurisdiction.

Policy context

4. A circular, HC(89)5, issued in February 1989 by the Department of Health provided advice to health authorities on the discharge of patients from hospital. Guidance in a booklet issued with the circular says that procedures should provide for:

> 'liaison with social services .... about alternative arrangements, if it appears likely the patient will not be able to return to his/her current place of residence .... Such arrangements must be made in good time and be acceptable to the patient and, where appropriate, the patient's relatives .... They should be fully aware of the nature, purpose and likely consequences of them .... Where a person moves from hospital to a private nursing home, it should be made clear to him/her in writing before the transfer whether or not the health authority will pay the fees .... No NHS patient should be placed in a private nursing .... home against his/her wishes if it means that he/she or a relative will be personally responsible for the home's charges.'

Hospital discharge procedure

5. The hospital's own discharge procedure includes:

> '*Responsibilities of ward managers and nursing staff*
>
> 5.1 Plans for discharge should commence as soon as possible after admission.
>
> 5.2 Discuss with patient, responsible relatives .... before decisions are finalised.
>
> '.... if the patient requires an assessment of their social care needs a referral should be made to social services at the earliest possible moment.
>
> *Responsibilities of social services department*
>
> '10.6 If there is to be a charge for a service the care worker/social worker should ensure that the patient and where appropriate his/her family or carers are made aware of all charges and agree to the arrangements.'

Criteria for NHS funded continuing care beds

6. The provision of health services in England and Wales is governed by the National Health Service Act 1977, which states in section 3(1) that:

> 'It is the Secretary of State's duty to provide .... , to such extent as he considers necessary to meet all reasonable requirements—
>
> (a) hospital accommodation;
>
> ....
>
> (e) such facilities for .... the after-care of persons who have suffered illness as he considers are appropriate as part of the health service'.

7. The chief executive of the NHS Management Executive wrote to me in 1990, when I sought his view in the context of another investigation, about the provision of care by health authorities:

> '.... If in a doctor's professional judgment a patient needs NHS care, then there is a duty upon the Health Service to provide it without charge .... this can be done by providing community care to the patient's own home, by providing in-patient care or by a contractual arrangement with an independent sector home (i.e. paid for in full by the health authority). The level of service provided overall is a matter for individual health authorities in the light of local circumstances and priorities.'

and:

> 'a. there is no general duty on a health authority to provide in-patient medical or nursing care to every person who needs it. Legal precedents have established that the Secretary of State's duty under Section 3 of the Act is qualified by an understanding that he should do so 'within the resources available' .... Thus
>
> b. in any particular case the provision of such care may be deferred so that cases may be dealt with, in order of clinical priority, within the resources available; and
>
> c. consideration of clinical priority may mean that a particular patient may never be provided with in-patient nursing care.'

8. The Authority and the local authority's social services department had agreed local criteria for eligibility to NHS funded continuing care. These included as factors to be taken into account:

> 'Continuous medical or technical nursing intervention .... eg intensive support over and above normal nursing home care.
>
> 'A multiplicity of needs requiring very specialist care, equipment or monitoring.'

Evidence of witnesses

9. The complainant said that on several occasions different nurses told her she should be thinking about arranging for her mother to be moved to a nursing home. She told a staff nurse that she was worried about whether a nursing home could cope, and that she was concerned about costs. The nurse left her with the impression that there was no other option, and told her that financial help might be available from the social services department. The complainant already knew that such help was limited to people with less than £8,000 in capital. Another nurse pointed out on several occasions that the complainant's mother was in a rehabilitation unit and patients could not stay long term. The complainant could not identify the particular nurses involved to my officer.

10. In November a sister told her that an assessment report had been requested, which meant the complainant's mother's discharge was imminent. The complainant asked if it was appropriate for the NHS to discharge her mother, whether there was a NHS nursing home, and whether a nursing home was the best option. The sister suggested she spoke to a care manager, who could give her a list of nursing homes, but the fees would have to be paid privately or with social services' help. The care manager would not be able to suggest anything else. The sister also said that the consultant might allow her mother to stay a little longer in hospital.

11. Towards the end of November she received what she described as a 'summons' to see the consultant. A nurse telephoned and asked her to contact the consultant's secretary to arrange an appointment. The secretary told her that the consultant wanted to see her at midday on 1 December. The complainant found the setting for the meeting intimidating. She had assumed that only the consultant would be there, but the meeting was also attended by two nurses and an 'administrator'. They were sitting round a table and everyone seemed to have papers. She was taken aback. There had been no mention of a case conference. The consultant told the complainant that her mother could no longer remain in hospital. He said that the complainant could have her mother at home, but she did not see that as an option since her mother needed two people to help her out of bed. The consultant said that she would need to see the care manager to discuss the arrangements for transfer to a nursing home and the finances for that. The complainant asked for, and was given, confirmation that if her mother had more than £8,000 she would not be eligible for financial assistance from social services.

12. When she was asked to meet the consultant, the complainant had realised that it would be to discuss her mother's discharge. She feared that her mother might be forced to go into any nursing home where there was a vacant bed, and wanted to have a choice of home. Therefore, immediately before the meeting, she had found a suitable home with a bed available, and told Trust staff about that when they met. Later the same day the complainant telephoned the care manager who confirmed that there was no alternative to a nursing home and that her mother would have to pay the fees. She then took up the offer of a placement. Her mother moved two days later.

13. The complainant believes that it was wrong for the NHS not to provide continuing care for her mother, since the care was needed because of her medical problems. She was totally immobile and dependent on staff for all aspects of care. Contrary to what the Trust later said, she could not feed herself and was rarely able to sit in a chair.

14. She did not receive confirmation in writing about financial responsibility for the placement. If she had, it would have alerted her to the fact that she had some choice in the matter. She had been led to believe a move to a nursing home was inevitable. The pressure on her to find a nursing home had been unrelenting. She suggested that her mother's condition and the manner

of her discharge were similar to that of the Leeds man referred to in a special report (HC 197) I issued last year. On that basis she believes she should be reimbursed for the costs of her mother's care.

15. The Authority have said:

> '.... at the time of [the complainant's mother's] admission there was no system whereby patients or relatives were written to concerning who would be paying for nursing home care. This system was subsequently set up ....'

and:

> '.... if a relative or carer advised a member of the nursing staff that they had funds in excess of £8,000 and knew that they would not be entitled to financial assistance in respect of residential care in a nursing home—they would certainly have been advised to talk to the social services care manager.'

16. The ward manager (sister) noted on 20 September 1993 that discharge planning was going to start for the complainant's mother and that all plans were to be discussed with her and her daughter. Part of the planning was a joint assessment of her needs by health and social services staff. She was responsible for overseeing the completion of the joint assessment form near the discharge date. On 27 September she noted that the complainant's mother's condition had deteriorated. The assessment was then halted as the complainant's mother was too unwell to be discharged. On 10 November she noted 'Seen by [consultant]—to carry on completing joint assessment' and on 17 November, 'Seen by [consultant]—to complete joint assessment'. On 24 November she noted that the complainant was to be asked to come to an interview to discuss her mother's nursing home placement. These notes would have been made following the consultant's weekly ward round and subsequent multi-disciplinary case conference, which was usually attended by the care manager. Options for discharge were discussed there and a note was kept of any action to be taken. The complainant was kept informed by regular contact with the nursing staff and would have received weekly feedback from the case conferences.

17. The ward manager thought it was highly unlikely that a nurse would have told the complainant to find a nursing home for her mother. Her recollection was that the complainant asked what was going to happen, which probably prompted the reply that a nursing home was the likely outcome. Nurses would not have been pushing the complainant to find a nursing home placement, as they would not have known when her mother was to be discharged. The consultant decided on that. It was the responsibility of the care manager to deal with financial aspects of placements. A nurse would not get involved. She did know about the effects of personal savings and would, if asked, probably have told the complainant, but would still have advised her to speak to the care manager.

18. Relatives were always given the opportunity to discuss things with the consultant. She would tell them that they should telephone the consultant's secretary to make an appointment. She thought she would have told the complainant that the case conference was to discuss her mother's future care. She would have told her what would happen at the conference, and checked that the complainant understood.

19. She filled in two different discharge checklists about two days before the complainant's mother's discharge. She wrote 'Yes' against 'Care manager informed'. She said she had probably telephoned the care manager or seen her on a ward round. She put a tick against 'Joint Assessment completed and signed by patient' but could not say what she had meant by this. (Note

from the Commissioner: neither the complainant nor her mother signed the joint assessment form.) She also ticked the question, 'Has adequate information been given to the patient/carer prior to discharge?'. On the second checklist against 'Has the patient/relative signed and received the joint assessment and discharge plan?' she entered 'unable to sign'. She said there was no explicit discharge plan—the complainant's mother's transfer to a nursing home happened quickly and as she was going to pay her own fees there was no need for a signature on the form.

20. The consultant has said that the complainant's mother:

> 'required washing and dressing, positioning, care of the bowel and bladder. She could feed herself but the nurses supervised her adequate food and fluid intake. She was helped to sit out on a chair and listened to music. She had no special nursing requirements in the ward. She had no sores. She had no special drug requirements and no special food requirements. Thus she fulfilled the criteria of placement into a .... nursing home.'

The consultant has confirmed that he was referring here to the Authority's local criteria for NHS continuing care.

21. In internal correspondence he wrote, 'At every weekly case conference, the Home Care Manager .... fully participated and provided advice to the family members and updating the information with the ward staff, nursing and medical .... '. He said that a staff nurse or sister would normally start the assessment, before input from the community liaison nurse and a care manager. Once it had gone through all its stages the assessment form would be shown to the relative and there was a space for his or her signature. He assumed that the reason why the complainant's mother's joint assessment was signed only by the nurses was that she would be self-funding. He had not discussed finances with her as that was an area dealt with by the care manager. At the time of this complaint the care manager would not become involved in referrals to nursing homes of patients who would have to pay their own fees.

22. He had probably waited until the joint assessment was finished before seeing the complainant. He thought that the decision to meet her had been made at the multi-disciplinary meeting. The ward manager usually suggested which relatives he should see and he thought she had invited the complainant to the meeting on 1 December. He wanted to tell the complainant that there was no more medical treatment or rehabilitation he could offer her mother. His recollection was that the meeting was cordial, and lasted about half an hour. The complainant was quite cool and calm. In his contribution to the Trust's investigation into this complaint, he suggested that, in future, appointments for relatives to attend case conferences involving several team members could be confirmed in a letter giving details of those to be present.

23. A staff nurse, who was the woman's named nurse, completed much of the joint assessment form on 23 November. The form was usually completed if a patient might not be able to return home. She thought that the form would not have been discussed with the complainant immediately after 23 November as no decisions had been made. The sections on the form about legal or financial status would be completed by the care manager (these have *not* been completed on the complainant's mother's form). Another nurse signed the form to show her agreement with what had been written. There was room for other members of the multi-disciplinary team to become involved in the joint assessment and indicate their agreement by signing the form.

24. Her understanding was that joint assessments were completed for all patients, whether or not they were able to pay their own nursing home fees.

She did not know why the complainant's mother's form did not go to anyone else in the multi-disciplinary team, but suggested that it might have been retained until after the case conference.

25. She had no recollection of any conversation with the complainant about a nursing home. If it was decided that a nursing home placement was the only option, one of the other nurses on the team would have liaised with the complainant. If a relative had asked her about nursing homes, she would have said that they provided a better and more homely environment and that the care manager could supply a list and advise about fees.

26. An enrolled nurse said that she countersigned the form to endorse the assessment. She had not discussed anything with the complainant or her mother as that was the responsibility of a more senior nurse.

27. A second staff nurse said that she did not tell the complainant that she should arrange for her mother to move to a nursing home. She could not recall any specific conversation with her. She was training at the time and would not have known about the impact of savings on fees, except that they would be taken into account. She would have passed an enquiry to the care manager, who often came to the ward and could be seen by relatives when they visited.

28. She wrote in the ward diary on 2 December, 'Ring [care manager] re [the complainant's mother's] funding', but could not remember the circumstances. Another nurse (the third staff nurse) had recorded in the nursing notes on 1 December that the complainant was going to contact the care manager. It may have been that the complainant had been unsuccessful, and that she had been asked to put it in the diary to remind someone to get in touch with the care manager for her.

29. The third staff nurse said she could not recall the complainant's mother or any conversation with the complainant before 1 December, when she attended the case conference. She had recorded that day that the consultant had seen the complainant, who was going to get in touch with the care manager about funding. She had attended few case conferences when a relative was present, and thought she would have recalled if anything unusual had happened. As far as she could remember there was nothing unusual about the meeting with the complainant. Case conferences were held in the day room of the ward, and the relatives were introduced and offered tea or coffee. The conference was usually conducted informally, with relatives encouraged to feel at ease.

30. She remembered that the complainant had found a nursing home for her mother, and that after the case conference she suggested to her that she got in touch with the care manager.

31. The community liaison nurse said she was normally involved with planning and liaising with other agencies about discharge. Anyone who had financial concerns was usually referred to the care manager. As the complainant's mother was going to pay her own nursing home fees, she was not involved except for attending the case conference (attended by the complainant) on 1 December. She did not recall what took place.

32. The care manager, employed by social services, said that although she usually attended the weekly case conferences there had been no request for her to become involved with the complainant's mother. Her informal notes of such meetings showed that unusually she had not been present at three of the four case conferences in November or the one attended by the complainant on 1 December. Nurses had attended joint training when care in the community was implemented and had been told how savings affected payment of fees.

They were advised then to refer anyone to her even if fees might be involved. Patients were entitled to an assessment but at the time of this complaint that was *not* always done. Because of the volume of work, people such as the complainant's mother who were going to pay their own nursing home fees were not referred to a care manager.

33. Joint assessments were normally started when it was not known if a patient would be liable for his or her own nursing home fees. If an assessment form was passed to her she would complete details about the carer's situation and the main social care needs and recommend the level of social services intervention. Referrals to her were usually made by ward managers and she would then formally set up a file on her case load. She had no case file for the complainant's mother and no note or recollection of a telephone call after the 1 December case conference. Since the complainant's mother was not her client she would not have provided a written confirmation of who would be paying for her care. In her opinion the only option open for the complainant's mother was the one she took—to go into a nursing home. Her problems were probably too great for 24 hour home care to have been provided: but from looking at the nursing notes she thought that the complainant's mother did not appear to fulfil the local criteria for NHS continuing care.

34. She said that joint assessments were now fully completed for all patients who were to be discharged into residential or nursing homes and those with complex needs.

35. After discussions with the Authority and the local authority social services, which followed the Trust's own investigations into this complaint, in November 1994 the Trust instructed all senior nurses that:

> 'All complex cases would have a joint assessment, which would involve a written referral to the social worker .... '

For people to be discharged to nursing homes:

> 'All cases .... who would not be funded by the [Authority] would receive a letter from Social Services after the financial assessment indicating whether and to what extent Social Services would pay for their future care.
>
> 'The letter .... would indicate that the patients should make their own financial arrangements if the placement was not being funded by Social Services.
>
> 'A copy of the letter would be sent to the Ward Manager .... '

Findings *(a)* 36. The complainant was not told in writing of the financial consequences of her mother's move to a private nursing home. That is contrary to Department of Health guidance. The Authority's system operated on the assumption that social services would inform patients and carers about financial matters, but it is clear that the complainant's mother was never formally referred to the social services' care manager. Staff had adopted an unacceptable procedure of neglecting to refer patients who might need nursing home care, if it was thought that they were ineligible for financial help. I note that, in the light of this complaint, all such patients are now referred to social services. Another opportunity for the complainant to be given written information about plans for her mother's care was missed, when the joint assessment form was not fully completed. The assessment seems to have been far from 'joint': not only were social services and the community liaison nurse not involved, but the complainant was not either. As a result she was also denied the opportunity to explore fully any other options for her mother's care. The Authority's failures to follow guidance amount to maladministration. I uphold the complaint.

Findings *(b)* 37. I do not criticise the nurses for discussing regularly with the complainant her mother's future needs for care. Involving relatives is good practice, and I have already criticised the Authority for not involving the complainant sufficiently. If the correct procedure had been followed, she could have been involved in discussing the joint assessment and the reasoning behind any recommended action. She would have been more aware of what other options, if any, existed. I can understand why the complainant felt intimidated by the way the case conference was arranged, and note that the consultant now plans to make greater efforts to prepare relatives. I have no doubt that the complainant felt under pressure. Although some of that was an unavoidable consequence of her mother's serious disability, it was increased by the failings of the Authority. I also uphold this aspect of the complaint.

38. I now turn to the question of what injustice or hardship, if any, the complainant suffered as a result of the Authority's maladministration. The guidance that, if they are liable to pay, patients should not be placed in nursing homes against their will, does not mean that they are entitled to insist on remaining in hospital or that a health authority must pay for nursing home care, whatever their assessed needs. The consultant has said that, despite the complainant's mother's severe disabilities, she did not fulfil the Authority's criteria for NHS funded continuing care; and the care manager has supported that view. Indeed, according to the complainant, the consultant raised with her the possibility of her mother going home—a suggestion which, given what I have been told about the woman's disabilities, strikes me as surprising. Despite the failures described earlier, the complainant was aware that she would have to pay for nursing home care: but thought there was no alternative. Even if there had been none of the procedural lapses brought to light by my investigation, it is quite possible that the outcome—discharge to a nursing home with the costs borne by the complainant's mother—would have been the same. The fact remains, however, that there is considerable doubt about whether the care manager was involved at all in the woman's proposed discharge, a joint assessment did not in any real sense take place and the documentation was poor. Serious maladministration resulted in the injustice for the complainant of being denied the opportunity for proper discussion and for receiving considered advice. In the light of the local investigation the Trust have taken steps to ensure that such lapses do not reoccur. That is commendable, but I consider that the Authority, as the body responsible for the hospital at the material time, should make an *ex gratia* payment to the complainant in recognition of the injustice and distress caused by the mishandling of her mother's discharge from hospital. I so recommend.

Conclusion 39. I have set out my findings in paragraphs 36 to 38. East Kent Health Authority have asked me to convey—as I do—their apologies to the complainant for the shortcomings which I have found and have agreed to implement my recommendation in paragraph 38. The Authority have offered to make the complainant an *ex gratia* payment, and I regard that as an appropriate remedy for a justified complaint.

Case No. E.672/94–95

1. The background provided by the complainant was that on 12 October 1992 her husband, then aged 74, was admitted to Halton Hospital (the hospital) after treatment in two other hospitals following a stroke. At the time the hospital was managed by Halton Health Authority, now North Cheshire Health Authority (the Authority), but on 1 April 1993 it became the responsibility of the Halton General Hospital NHS Trust (the Trust). While her husband was a patient at the hospital, the complainant was told that his condition was stable, that the hospital could not do anything more for him and that he would need 24 hour nursing care. On about 10 November the complainant was told that she must arrange for his transfer to a nursing home because

his bed was needed for someone else. She did so and he was moved to a nursing home on 17 November 1992. On 1 March 1994, the complainant took the matter up with the Authority. They declined to accept liability for the cost of her husband's long term care and she remained dissatisfied with their response. The complainant's husband died on 8 July 1995.

2. The complaints which I investigated were that:

(a) the complainant was made to accept her husband's transfer to a private nursing home without adequate advice about their rights in respect of the cost; and

(b) the cost of the complainant's husband's long term nursing care should have been borne by the Authority.

Investigation

3. I told the complainant that her complaint might in part concern actions taken solely in the exercise of clinical judgment which, at the time, were statutorily outside my jurisdiction. I obtained the Authority's comments and examined the man's medical records. My officer took evidence from the complainant, and staff of the Authority, the Trust and a charitable body which managed and arranged placements in residential and nursing homes.

Statutory and policy background: provision of long term care

4. The provision of health services in England and Wales is governed by the National Health Service Act 1977 (the Act), which states in section 3(1) that:

> 'It is the Secretary of State's duty to provide .... , to such extent as he considers necessary to meet all reasonable requirements—
>
> (a) hospital accommodation;
>
> (b) other accommodation for the purpose of any service provided under this Act;
>
> ....
>
> (e) such facilities for .... the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service'.

5. The chief executive of the NHS Management Executive wrote to me in 1990/91—when I sought his view in the context of another investigation—about the provision of care by health authorities:

> '.... If in a doctor's professional judgment a patient needs NHS care, then there is a duty upon the Health Service to provide it without charge .... this can be done by providing community nursing care to the patient's own home, by providing in-patient care or by a contractual arrangement with an independent sector home (i.e. paid for in full by the health authority). The level of service provided overall is a matter for individual health authorities in the light of local circumstances and priorities.'

and:

> 'a. there is no general duty on a health authority to provide in-patient medical or nursing care to every person who needs it. Legal precedents have established that the Secretary of State's duty under Section 3 of the Act is qualified by an understanding that he should do so 'within the resources available'.... Thus
>
> b. in any particular case the provision of such care may be deferred so that cases may be dealt with, in order of clinical priority, within the resources available; and
>
> c. consideration of clinical priority may mean that a particular patient may never be provided with in-patient nursing care.

Further

> d. where a person is receiving private care, in a nursing or residential home, the Health Authority has no power to make 'top up payments' to cover any shortfall between the charges of the home and any income support .... health authorities have, financially, an 'all or nothing' responsibility for patients'.

6. In February 1994—after the man's discharge from hospital—I issued, as a special report (HC 197), the results of my investigation of a complaint that Leeds Health Authority had failed to provide long term NHS care for a brain-damaged patient aged 55. I found that the authority made no provision for the continuing care of such patients. I criticised that as a failure in service and I recommended that the authority meet the costs which the complainant had incurred and review their provision of services. They agreed to do so.

Statutory and policy background: discharge procedures

7. The Department of Health issued guidance (circular HC(89)5) in February 1989 about the discharge of patients from hospital. It states that:

> '.... Where a person moves from hospital to a private nursing home, it should be made quite clear to him/her in writing before the transfer whether or not the health authority will pay the fees, under a contractual arrangement. No NHS patient should be placed in a private nursing or residential care home against his/her wishes if it means that he/she or a relative will be personally responsible for the home's charges'.

8. At the time the complainant's husband was in hospital the Authority's discharge procedures were under review in preparation for implementation of the NHS and Community Care Act in April 1993. Several slightly different versions of the procedures were in circulation. The version which I have been told applied when the complainant's husband was discharged said that where the consultant and multi-disciplinary team considered that a nursing home placement was appropriate:

(i) either the consultant or the ward sister should discuss long term care with the patient or an advocate (not a lawyer but a person acting on the patient's behalf), and give the next of kin an information pack. (The Authority said that it was difficult now to determine exactly what information would have been included in the pack.);

(ii) the ward sister should complete a referral form and pass it to the charitable body's placement officer (the placement officer);

(iii) the placement officer should arrange a meeting with the patient or an advocate to give information about the charitable body and complete a financial assessment. The placement officer was responsible for agreeing a suitable placement with the next of kin.

Another version is similar but says that the ward sister should pass the referral form to the Authority's 'co-ordinating officer' who would 'assess and make appropriate referrals to [the charitable body], i.e. patients eligible for income support.'

9. An (undated) briefing note on the Authority's arrangements with the charitable body includes the following:

> 'Provision for those requiring nursing care on a continuing basis .... is provided in partnership with .... [the charitable body].'
>
> 'The individual is discharged to the care of [the charitable body] .... who effect placement in .... nursing home accommodation.'
>
> 'Individuals requiring Nursing Home care, who are eligible for Income Support, should be referred to [the charitable body] .... '

> 'Individuals .... not eligible for income support .... would be expected to pursue a private arrangement with a nursing home of their choice.'

The Authority have not been able to provide any further documentation on the procedures which were to be followed when discharge to a nursing home was proposed for a patient *not* eligible for income support.

10. After the complainant complained to them in 1994 the Authority arranged for her husband's care needs to be assessed, in conjunction with the local authority social services department, under the arrangements then in force. Under those arrangements the Authority met all the continuing health care costs of patients requiring 'maximum nursing care and medical supervision'. Assessment was made of the patient's level of dependency (usually on a three point scale) in each of seven areas. Only patients with maximum dependency in all seven areas were judged to require care funded by the Authority. Patients with a slightly lower level of dependency were assessed as requiring nursing home care to be arranged by the local authority social services department and, depending on their means, they could be liable for financial contributions towards the cost.

Other evidence

11. The complainant said that a nurse told her that her husband would need 24 hour nursing care and that, as she would not be able to look after him at home, she would have to arrange a nursing home place for him. Every time she visited her husband the nurse asked her persistently whether she had found a place, as they needed the bed for somebody else. The complainant said she was almost frightened to visit her husband because of the pressure she was put under and, eventually, was accompanied by a friend when she visited. She told the nurses that if she could not look after her husband at home she would prefer him to remain in hospital but they said that was not possible. An appointment was made for her to see the consultant, but she happened to meet him in the ward the day before the appointment. He told her that her husband's condition was stable and that they could do nothing more for him. The appointment was then cancelled. She did not speak to any other doctors.

12. The complainant said that she was approached about arrangements for her husband by someone she took to be a social worker (since identified as the placement officer), who asked her if her husband had more than £8,000. When the complainant said he had, the placement officer gave her some nursing home brochures and said that she could not do anything more, but that the complainant could contact her if she needed any further assistance. The complainant was not given any other advice or any other written information about her husband's discharge or the funding of his placement.

13. The clinical records show that the complainant's husband's care was discussed at each of four weekly case conferences, between 23 October and 13 November. The record of the evaluation of the man's care plan includes:

13 October

'Wife would like to take [husband] home.'

17 October

'[complainant] to see [the consultant] re husband's future.'

30 October

'[Seen by the consultant]. [The complainant's husband] is to be [for long term care]. Wife needs to be informed.'

4 November

'Wife [seen by placement officer]. Private arrangement. [Placement officer] advising.'

14. The consultant responsible for the man's care said that decisions about the future care of patients were made at multi-disciplinary case conferences. The nursing staff, usually the sister or the primary nurse, would make the initial contact with relatives; then the consultant would speak to them, if necessary. Patients remained in hospital if there was the potential for improvement, but there were no long term care beds.

15. The consultant said that the complainant's husband had had a severe stroke and was paralysed on his left side. He was totally dependent for all activities. After a period of attempted rehabilitation it became clear that he needed long term 24 hour care, possibly permanently, and that a nursing home was the best option for him. At that time the level of nursing care the complainant's husband needed would not have been available at home.

16. The consultant considered that the complainant should have been told the decision at the earliest opportunity and given the chance to talk to him if she had any reservations. He held regular clinics where relatives could discuss their concerns. He could not remember, and had no record of, whether he had spoken to the complainant either at a clinic or in the ward. Since he could not remember her, he assumed that she had no objections to her husband's transfer to a nursing home. If a relative had refused to pay for nursing home care he would not have discharged the patient, but would have referred the relative to the hospital administration.

17. The consultant said he was aware of the Department of Health circular on discharge arrangements and of the hospital guidelines. The policy was for the nurses to give relatives an information pack and he thought that would have happened in this case.

18. The senior clinical nurse in the department of medicine for the elderly said that patients would not be discharged without their or their relatives' consent. The primary nurse (or the ward sister) would normally tell the family about the decision of a case conference, give them an information pack and complete a form referring them to the charitable body. A copy of the form would go to the assistant manager in the department of medicine for the elderly (the assistant manager). The charitable body would then arrange to meet a relative and assess the family's financial circumstances. These assessments were now carried out by social services. At the time of the complaint there was some pressure on beds but that would not have led nurses to pressurise patients or their relatives.

19. She remembered the complainant and her husband. The complainant's husband was totally dependent, needing constant nursing, but not medical, care. She knew that the complainant wanted him to remain in the hospital rather than go to a nursing home, but that was impossible as he no longer needed medical care and there were no long term beds available.

20. The ward sister said there was no written policy about who should tell the family about the assessment of the patient's needs. That would be decided at the case conference. She could not remember who told the complainant. Financial aspects would then have been discussed with relatives by the charitable body but not by nurses.

21. The staff nurse, who was the man's primary nurse, said she preferred to be the first contact with relatives about discharge plans because of the rapport she would have built up with them. If the case conference concluded that a nursing home was appropriate, a nurse would refer the family to the placement

officer. Nurses did not give any written information to families and were not involved in financial aspects of a placement. If relatives did not want a nursing home place she would refer them to the sister, but that had never happened. She had no recollection of the complainant and her husband.

22. The manager in the department of care of the elderly (the manager) and her assistant (the assistant manager) said that the information pack at that time contained the following leaflets:

(a) Introductory note;

(b) 'Care of the Elderly .... a plan for Halton';

(c) Halton Community Health Council's 'Choosing a nursing home';

(d) Information on claiming income support;

(e) A list of nursing homes;

together with background information on the role of the charitable body. It should have been given to the complainant by either the primary nurse or other ward staff, and the placement officer should have checked that she had received it. Copies would also be available in the ward. If patients were not eligible for income support, neither they nor their relatives were given any other information about their liability for costs of nursing home care. There were no long stay NHS beds in Halton for elderly people and no contracts with nursing homes except through the charitable body. If a patient or relative refused to accept a nursing home placement, the assistant manager or the manager would explain that the hospital could not provide the care they needed.

23. The manager said that the decision about who would discuss discharge plans with relatives depended on the timing of the case conference. If a decision was taken at a conference shortly before his clinic for relatives, the consultant would tell relatives then. Otherwise the primary nurse would tell them. In either case the relatives' wishes should already have been considered. Nursing staff would reinforce what the consultant had said. Relatives should have been able to discuss the financial situation and local facilities with the charitable body. It should have been explained to the complainant that, if the family had more than a certain amount of money, they would have to pay the full cost of her husband's care. In that case the complainant would be responsible for arranging to visit and choose a home. There was no one available at the hospital to help relatives if they did not come under the charitable body's arrangements. At the time the Authority had paid the charitable body a grant for their work in making placements in nursing homes.

24. The assistant manager described the same arrangements with the charitable body as the manager—but said that she would have expected the charitable body to provide information irrespective of financial entitlement.

25. The placement officer said that the Authority had referred patients to them by telephone or by direct contact in the ward. Normally, before referral to the charitable body, patients would be screened by the assistant manager who would check whether they were eligible for income support. If so, a referral form would be sent to the charitable body and a copy would be kept by the assistant manager and the charitable body would then help arrange a placement. If not, they would be referred back to the ward. She understood that an information pack was provided to relatives either by nursing staff or the assistant manager.

26. The placement officer had a form referring the complainant's husband to her, signed by the ward sister on 30 October 1992. She could not remember the complainant but assumed she must have interviewed her in the ward after being approached by nursing staff. On the form she had written 'private arrangement' indicating that the complainant had sufficient funds and would

not qualify for the charitable body's help. She would have referred the complainant back to the ward without detailed advice. The Authority paid a grant to the charitable body for placements in nursing homes only in respect of patients eligible for income support.

27. Contracts and invoices supplied by the charitable body show that the Authority was paying a grant to it which made up the difference between the nursing home fees and the income support received by patients placed in nursing homes by the charitable body.

28. In comments to me the Authority said that they were satisfied that proper procedures were followed for the complainant's husband's discharge. The assessment of his needs in 1994 was that he required 'maximum nursing care'. He was assessed as being at lower than the highest level of dependency on three of the seven factors—feeding, communication and the need for maximum nursing involvement, and therefore was the responsibility of the local authority rather than the health authority (paragraph 10). During the assessment the complainant is recorded as having commented on the improvement in her husband's condition since his admission to the nursing home.

Findings *(a)*

29. The evidence I have seen supports the complainant's account that she was given no written information about plans for her husband's discharge other than some brochures for nursing homes in the area, and that she had little or no discussion with Authority staff about options (however limited) for her husband's care, except for reminders from nurses that she had to find a nursing home for him. The approach was to tell her the decision of the case conference rather than to discuss options. The guidance that she should be notified in writing by the Authority whether they would pay the fees was not followed and she does not appear to have been given the general information pack on nursing homes. Most staff assumed that responsibility for discussing financial matters with relatives lay with the charitable body and referred the complainant to them. In fact the charitable body provided advice only to those eligible for income support. The result was that the complainant went without any proper advice or information about alternatives to—and the cost of—nursing home care. I note that all such patients are now referred to the local authority social services department for advice. I uphold this aspect of the complaint.

Findings *(b)*

30. The Authority had no long term care beds for elderly people, but did make some financial contribution to the long term care of certain patients—in that by giving grants to the charitable body they paid some of the cost of nursing home care for some of those eligible for income support. I cannot say whether that practice was reasonable in the light of the legal prohibition on 'top up' payments (paragraph 5) but the practice was not in itself a source of injustice to the complainant. It was, however, no substitute for a proper mechanism for determining eligibility for NHS funding for continuing health care, regardless of the financial means of the patient.

31. While it was helpful for the Authority to reassess the complainant's husband's needs in 1994 against the criteria then in use (paragraph 10) there might have been a different outcome in 1992 if the complainant had not suffered the maladministration described in paragraph 29 or if the Authority had properly considered then whether the NHS should fund her husband's care. Because of the time which has now elapsed I cannot judge whether the costs of the complainant's husband's care should have been borne by the Authority in 1992, but I recommend that the Authority should consider making the complainant an *ex gratia* payment in recognition of the distress she was caused by their maladministration.

Conclusion 32. I have set out my findings in paragraphs 29 and 30–31. The Authority have asked me to convey through this report—as I do—their apologies for the shortcomings which I have found and have agreed to implement the recommendation in paragraph 31.

Case No. E.787/94–95

Background and complaint 1. The complainant asked her Member of Parliament (the Member) to put her complaint to me in September 1994. The background which she provided was that her husband suffered from various medical conditions including Alzheimer's Disease. Since May 1993 she had been seeking residential nursing care for him, to be funded by the NHS in view of his health needs. In October 1993 her general practitioner (GP) put the request to Oxfordshire Health Authority (OHA). In January 1994 her husband was admitted to Littlemore Hospital and in June he was transferred to Witney Community Hospital (Witney Hospital) where he died in December 1994. Up to 31 March 1994 Littlemore Hospital was administered by OHA; since then it has been administered by Oxfordshire Mental Health care NHS Trust (the Mental Health Trust). Up to 31 March 1994 Witney Community Hospital was administered by OHA; since then it has been administered by Oxfordshire Community Health NHS Trust (the Community Health Trust). A number of assessments were made of the complainant's husband's long term health and social care needs but, despite many exchanges with OHA, the arrangements and funding for his health care remained undecided and the complainant had been left in a state of continuing uncertainty.

2. The complaint subject to investigation was that OHA were taking an unreasonably long time to decide on the provision and funding of long term health care for the complainant's husband.

Investigation 3. I obtained OHA's comments and examined relevant documents. A member of my staff took evidence from the complainant and from the NHS staff involved.

Statutory framework 4. The provision of health services in England and Wales is governed by the National Health Service Act 1977 which states in Section 3(1) that it is the Secretary of State's duty to provide to such extent as he considers necessary to meet all reasonable requirements:

> '(a) hospital accommodation;
>
> '....
>
> '(d) such facilities for .... the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service ....'

In 1990 the chief executive of the NHS Executive advised me in the context of another investigation that legal precedents had established that the Secretary of State's duty under Section 3 of the 1977 Act to provide NHS services was qualified by an understanding that he should do so 'within the resources available'. It was for individual health authorities to decide in the light of local circumstances and priorities what level of services they should provide.

5. Section 47 of the National Health Service and Community Care Act 1990 (the Act) provides that:

> '(1) .... where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority:—
>
> (a) shall carry out an assessment of his needs for those services; and

(b) having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services....

....

(3) If .... during the assessment .... it appears to a local authority;

(a) that there may be a need for the provision .... by such District Health Authority as may be determined in accordance with regulations of any services under the National Health Service Act 1977 ....

the local authority shall notify the District Health Authority .... and invite them to assist .... in the making of the assessment; and in making their decision as to the provision of services needed for the person in question, the local authority shall take into account any services which are likely to be made available to him ....'

Section 44 of the Act provides that where a local authority arranges the provision of accommodation for a person it '.... shall recover from him the amount of payment which he is liable to make'.

6. I first set out a summary of the main events and correspondence. In **February 1993**, the complainant's husband's general practitioner (the GP) suggested a nursing home placement for him. He was assessed by the Department of Psychiatry of Old Age (DPOA) within the Oxfordshire Mental Health Unit, the precursor of the Mental Health Trust. As a result he was given additional daily care. On **12 July 1993**, the then Secretary of State for Health wrote to the Member in reply to an enquiry by him about the complainant's husband's care. The Secretary of State's letter included:

'If a person has continuing health needs, the Health Authority is responsible for arranging and funding appropriate care, ... They can do this by providing hospital in-patient care, or by purchasing a placement in a nursing home.'

7. On **23 July**, the GP wrote to the DPOA, asking for his patient to be placed in a nursing home. On **23 September**, the DPOA's clinical director advised the GP to approach OHA, as the purchasing authority, which he did on **4 October**. The purchasing manager of OHA replied on **5 November**, recommending a clinical assessment, which was carried out by the DPOA, who recommended nursing home care. On **21 December**, the Member wrote to the OHA chief executive, asking for the funding of the patient's care to be resolved. He hoped there would be no further examinations as 'there seems little doubt about his condition and the question seems to be not what he is suffering from but whether he can be helped.'

8. In **January 1994**, after an incident of aggression by the complainant's husband, the social services department (the SSD) of Oxfordshire County Council withdrew the service they had been providing in his home. A consultant psychiatrist in DPOA (the consultant) then arranged the complainant's husband's admission to Littlemore Hospital, Oxford. On **4 February** the consultant advised the clinical director of DPOA that the assessment of his future clinical needs was progressing well and said that in planning his management it would be helpful to be given guidance on how to respond to his wife's request that future care should be NHS-funded. The consultant suggested a meeting with the complainant. The clinical director and the consultant met the complainant on **25 February** and agreed with her that her husband was ready to be discharged from hospital and that placement in a nursing home would meet his identified needs. On **28 February** the clinical director wrote to the purchasing manager that it could be argued that the complainant's husband's nursing home care should be purchased by the NHS and asked for advice on how to proceed.

9. On **11 March** the complainant telephoned the purchasing manager who made a note that he told her that OHA would want her husband to be assessed by a care manager to clarify his health and social care needs; and that if health care was needed which the SSD were unable to fund, OHA would agree to fund it. The complainant had been unhappy about that, knowing that if there was SSD funding it was likely that she would have to contribute. The purchasing manager explained that a care manager's assessment was needed to establish who was responsible for funding. On **16 March** the GP wrote to the chief executive of OHA 'in desperation', suggesting that as his patient had been assessed as requiring medical care he 'should be cared for from the NHS funds'. The GP copied his letter to the clinical director. The clinical director wrote to the GP on **21 March**, with a copy to the complainant, explaining that under the Act a person with complex needs was entitled to a full assessment by a care manager from social services. Expert nursing and medical assessments were an important part of the care manager's total assessment but it was the care manager's responsibility to take account of all the patient's needs. The clinical director hoped that the complainant would now agree to such an assessment taking place.

10. The care management assessment was carried out in April and identified that the complainant's husband's needs were predominantly related to mental and physical health; that his current environment was not conducive to his well-being; and although placement in a nursing home was best to meet his needs the assessor had some reservations that it would be successful. On **22 April** the purchasing manager wrote to the clinical director noting that the SSD's operational policies allowed them to fund nursing home care, subject to a financial assessment but that the complainant had 'indicated as part of the care manager's assessment that she is unwilling for this financial assessment to take place and will, on principle, not pay for a share of [the patient's] care'. He suggested that given that refusal the best option was to offer the complainant's husband continuing care in a community hospital and arranged to meet the clinical director to discuss the matter on 24 April. On **27 April** the SSD sent the care assessment of the complainant's husband to the purchasing manager and said that they were not prepared to place him in a private nursing home if his wife refused to make an appropriate financial contribution. On **28 April** the chief executive wrote to the Member that a fully funded nursing home placement by OHA for the complainant's husband was not an option as there were some 200 persons in the county in a similar position and doing the same for them would place an intolerable burden on OHA. He said that OHA proposed to transfer him to a community hospital. The chief executive apologised for the length of time it was taking to resolve the issue.

11. On **3 May** the complainant attended a meeting with the clinical director and the purchasing manager. The latter confirmed that OHA would fund care to meet the complainant's husband's health needs. The complainant considered that the NHS should meet all the costs of nursing home care but of the options offered preferred placement in a community hospital. On **17 May** the purchasing manager wrote to the complainant that the manager of Burford Community Hospital (Burford Hospital) would visit her husband at Littlemore Hospital to assess how his needs could be met at Burford. On **26 May** the chief executive of the Community Health Trust, which is responsible for Burford Hospital, sent the hospital manager's report to OHA. The conclusions were that her husband's needs would be 'best met in a home environment and with nurses with skills in mental health nursing'. Burford Hospital was not a suitable environment for the complainant's husband and did not have staff trained to meet his needs.

12. On **9 June** the Community Health Trust's chief executive and the purchasing manager met to discuss arrangements for the complainant's husband's future care and on **10 June** the chief executive said that as Burford Hospital was not suitable for him he would be transferred to Witney Hospital for his

future care to be agreed and developed. On **20 June** the purchasing manager confirmed to the complainant the proposal to transfer her husband to Witney Hospital by the end of June after which a multi-professional assessment would take place. The assessment was carried out on **19 July** and concluded that, although Witney Hospital was meeting the patient's needs, the level of nursing care which he required could be provided by a carefully chosen nursing home. The hospital had patients who were much more difficult to care for. Those involved in the assessment, including the complainant, agreed that a nursing home was the first choice for her husband's long term care. On **10 August** the purchasing manager sought solicitors' advice on how OHA could share in the costs of the complainant's husband's continuing care in a way that was legal and could not be seen as a precedent to full funding of nursing home care which would raise expectations OHA could not meet. On **11 August** the purchasing manager wrote to the complainant that he was 'taking final advice on an appropriate method of funding the health care needed to meet your husband's needs. I would then hope to meet you and social services to agree a way forward. I hope that this can happen in early September. In the meantime, your husband's care at Witney Hospital will continue to be funded by [OHA] and you need have no anxiety on that score'. On **15 August**, following a meeting with the solicitors, the purchasing manager asked the consultant for the percentage of care time to meet the complainant's husband's daily *health* needs with the possibility of OHA funding the provision of those and the SSD funding the couple's remaining costs, subject to rules on payment and financial assessment. On **30 August** the solicitors confirmed their advice that the preferred option was for OHA to purchase the complainant's husband's health care in a private sector home, but that ordinary day to day care and accommodation had to be dealt with by the SSD following the appropriate means test.

13. On **5 September** the complainant asked the Member to put to the Health Service Commissioner her complaint that OHA were 'taking an unreasonably long time to make the decision to provide long-term care for [her husband]'. On **20 September**, at a case conference attended by the complainant, representatives of OHA and the SSD made a joint proposal that OHA fund the complainant's husband's health care needs by making a grant to the SSD who would carry out a financial assessment on the remaining cost of the nursing home placement. OHA's notes of the meeting recorded that the complainant would not accept that because in her view the NHS were responsible for funding both health and social care for those with health needs. On **20 September** the OHA chief executive and the SSD director wrote jointly to the NHS Executive asking how they should proceed, noting that recent draft guidance did not offer a way to do so within the resources available to both organisations. Full funding of the nursing home placement would be an unaffordable precedent for OHA; equally waiving the charge would be unacceptable for the SSD, and the complainant would not accept any financial assessment. On **5 December** the NHS Executive and the Social Services Inspectorate of the Department of Health replied jointly that:

> '.... health authorities should purchase a range of services to meet long term health needs .... for people who because of the complexity or nature of their health care needs require full time care from the NHS in hospital or fully funded by the NHS in a nursing home. Obviously the NHS is not responsible for all needs for long term support and it is a matter for local health authorities, in close consultation with their partners in social services, to determine the precise level and range of services which they secure.'

Where a patient exercised his right not to be discharged to a nursing/residential home where there was a charge, provided the clinical assessment was that continuing NHS care was not required, there was a responsibility on the health and local authorities and on the patient and his family to find a satisfactory alternative option such as a package of support to allow the patient to return home. On **21 December** the OHA chief executive replied to the NHS Executive that they had not helped to resolve what he and the SSD director saw as a test case. OHA had made significant progress with SSD on funding the placement of those with a combination of health and social care needs; but even under this agreement hospital discharge ground to a halt when a family was not prepared to contribute to care in a nursing home. They had reached an impasse because of the unwillingness of the family to be financially assessed by the SSD. He hoped that the forthcoming guidance would offer a way of meeting needs within available resources while resolving situations such as that which had prompted the correspondence.

14. The complainant's husband died in Witney Hospital in December 1994.

The complainant's evidence

15. The complainant said that the GP arranged an assessment in February 1993 with a view to her husband moving to a nursing home but the outcome was an increase in day and respite care and not a nursing home placement. In October 1993, on the basis of advice which the Member obtained from the Secretary of State for Health that, 'If a person has continuing health needs, the Health Authority is responsible for arranging and funding appropriate care,' the GP asked OHA to fund the complainant's husband's care in a nursing home. The complainant repeated that request in the early months of 1994 after her husband was admitted to Littlemore Hospital. At the meeting in May (paragraph 11) she was told that discharge to a nursing home was not an option as she had refused to have a financial assessment. The complainant told my staff that that was not so and that if OHA had refused to take responsibility for her husband she would have given his financial statements to the SSD. At the case conference in September 1994 (paragraph 13) about funding she was offered a financial assessment on a 'no-commitment basis' to which she had agreed. However the forms included questions about a wife's assets which she had been told would not be taken into account, so she had refused to complete the assessment. She told the SSD that she would provide the details if she wished them to fund her husband's stay in a nursing home.

Staff evidence

16. The consultant said that it was agreed in February 1994 that for clinical reasons the complainant's husband could not be discharged home from Littlemore Hospital. The complainant's view was that her husband needed health care and that the SSD played no part in that; the rights of older people were very important to her and she saw her husband's situation as a test case. The consultant said that she had not participated in the care manager's assessment, except to provide a medical report, and had not been present at the meeting on 3 May 1994. The decision to move the complainant's husband to a community hospital had not been ideal as the clinical team had been looking for a permanent home for him but a nursing home had not been an option because, as she understood, the complainant was unwilling to be means-tested. At the request of Witney Hospital she had organised the multi-agency review in July 1994 when it was agreed that the complainant's husband should be placed in a nursing home where he could have his own room and music. The complainant had identified a nursing home for her husband and the consultant asked the SSD to arrange a placement. During that time discussions on funding had continued and the consultant was asked by the purchasing manager to estimate the amount of care time attributable to the complainant's husband's health needs. She had done so and later attended a meeting to discuss that.

17. The clinical director said that in February 1994, after the complainant's husband's admission to Littlemore Hospital, the consultant had asked her advice about his future care and together they met the complainant. They agreed that a nursing home placement was required and she wrote to the purchasing manager about funding. The next step should have been for the complainant to visit nursing homes but she had been unwilling to do so until it was clear who would provide the funding. As funding was an issue the purchasing manager said that a care manager's assessment was necessary under

the Act. The clinical director wrote to explain that to the GP and spoke to the complainant. The latter could not understand the situation saying that her husband's needs were beyond social care. The community hospital to which the complainant's husband was transferred was in many ways satisfactory but it was not suitable for his long term care; the hospital dealt with a broad range of patients and there were no nurses at Witney with psychiatric training which the complainant's husband needed to help him with everyday tasks. In the clinical director's view the provision of that type of specialised care was a NHS responsibility. Since October 1994 OHA and SSD had jointly funded the long term care of certain categories of patient suffering from severe illness. In the complainant's husband's case there had been delays but his clinical care had not been compromised in any way. It was necessary to remember that there were other patients with comparable needs—the complainant had not asked for her husband to be made an exception but was fighting for a general principle.

18. The purchasing manager said that it was unusual for OHA to be involved in discharge arrangements as these were normally resolved between the hospital and SSD; it was routine for a patient about to be discharged and requiring long term care to have a care manager's assessment. In the complainant's husband's case a decision had been made in April 1994 about his long-term care but the complainant had not been prepared to be means-tested. At meetings in May and September she had been told that OHA would fund the elements of her husband's care which were health-related but that they could not fund his social care or accommodation. The proposals had been confirmed in letters to her. OHA had followed the requirements of the Act, they had not acted unreasonably and had moved as quickly as was reasonable in the knowledge that the decision had implications for other families. An OHA/SSD joint funding agreement was introduced in October 1994 for the care of patients whose health needs were assessed as just below the level justifying total NHS care (usually in a hospital). Patients to whom the 'joint funding' arrangement applied still, however, required to be means-tested; so, if they or a relative refused such a test, the problem illustrated in this case remained.

19. In his official response to me about the complaint, written on 25 October 1994, the OHA chief executive stated that since January of that year the complainant's husband had been receiving hospital care which had been funded by OHA, and no threat had been made to withdraw it. After the husband's admission to hospital in January, his care manager produced an assessment and statement of needs, but no financial assessment was carried out and the SSD had not been prepared to place the husband in a private nursing home if his wife refused to make the appropriate financial contribution. Recognising that it had 'a considerable responsibility in ensuring that the patient continues to receive the correct and appropriate level of health care', but that if it were to meet the full costs of a nursing home placement for him it would have to do likewise for others with similar needs, OHA had suggested that a move to a community hospital could offer more appropriate local care. Clinical assessments showed that he needed limited nursing care, but not enough to require long term care in a hospital setting. A nursing home had been agreed by all concerned with his care (including his wife) to be the best environment for him. The complainant had stated repeatedly that she saw this as a test case to challenge nursing home care being subject to financial assessment by SSDs rather than being fully funded by the NHS. OHA had offered to fund the health element of the cost of care for the complainant's husband in a nursing home, having taken legal advice which stated that 'the NHS will not and ought not to be responsible for [the patient's] ordinary day to day care and accommodation'. That offer left the remaining costs of the nursing home placement subject to a financial assessment under the SSD's rules. OHA would continue to fund the complainant's husband's care at Witney Hospital until national advice offered a way to proceed with his discharge to a nursing home

which could be followed for others with similar needs. OHA deeply regretted the delay to his discharge and considered that until it could be achieved, he was receiving high quality care.

20. The chief executive said that clinical assessments from February 1994 were that a nursing home was the appropriate environment for the complainant's husband; OHA had been prepared to fund the 20% attributable to health care, the remainder being the responsibility of the SSD. The stumbling block had been that the complainant, as a matter of principle, refused to be means-tested on the SSD element. This case had been a contributory factor in the introduction of the category of joint funding and panels had been established to decide on appropriate cases and consider appeals. OHA and the SSD had co-operated well throughout this case leading to their joint letter seeking guidance from the Department of Health. The response in December had not answered the problem of what action to take if a patient's next of kin refused to be means-tested.

Findings and conclusion

21. The complaint was that it took an unreasonably long time to decide on the provision of long term health care for the complainant's husband. When he died in December 1994—some thirteen months after he had first been assessed as requiring nursing home care (paragraph 7)—the matter had still not been resolved. That was unsatisfactory. During most of that period, however, the complainant's husband received in-patient care in a NHS community hospital, which was the second option in his assessment, and no-one disputes that the care he received was satisfactory, although all involved with his care agreed that a nursing home would have been more suitable. There was therefore no maladministration leading to injustice. There was no failure to provide a service which it was a duty of the NHS to provide; but the husband's death left matters unresolved.

22. There were two closely linked reasons for the delay in arranging nursing home care for the complainant's husband. First, there was a dispute about whether he qualified for nursing home care fully funded by the NHS. Encouraged (not unreasonably) by the wording of the Secretary of State's letter to the Member (paragraph 6), the complainant believed that the NHS ought to meet all the costs of her husband's nursing home care. I have not found evidence that OHA failed to develop and apply criteria which met the national requirement to provide NHS funding to meet all the costs of the continuing health care of the most highly dependent patients, whether in hospital or in a nursing home. OHA considered, however, that the complainant's husband's needs were below the threshold which would qualify him for all the costs of his care to be met by the NHS.

23. OHA acknowledged that they had a duty to fund the health care support which the complainant's husband would need, over and above his routine daily care, and their discussions with the SSD concluded that the SSD should meet the other costs of his care. It is not for me to determine whether the arrangement proposed fell within the legal requirements on joint financing arrangements between health authorities and local authorities, or whether the method used by OHA to identify health costs fell within the national requirements for the funding of continuing care. Those are matters for the Department of Health.

24. The second reason for the delay was that the complainant, who believed that the NHS had a duty to finance her husband's care, refused to agree to be financially assessed by the SSD, which was a necessary part of the assessment of his means. Bearing in mind the requirement to recover from the husband the costs for which he was liable (paragraph 5) the SSD could not proceed to arrange care without a financial assessment. OHA had legal powers to finance all the husband's nursing home care, but they argued that it would be inequitable to do so without doing the same for other patients in comparable circumstances. OHA accepted that they could not force the complainant's

husband to enter a nursing home against his will, and clinical advice prevented his discharge home. Care in a community hospital was the solution and OHA funded it. Despite the conundrum which is not for me to resolve I find that OHA did not act unreasonably nor did they fail to provide a service which it was their duty to provide. It follows that I do not uphold the complaint.

Case No. E.615/94–95

Background and complaint

1. The background provided by the complainant was that his mother, who suffered from multiple sclerosis and was totally dependent, was admitted to Bristol General Hospital (the hospital) shortly after her husband's death in March 1993. Six weeks later she was discharged from hospital and admitted to a nursing home. On 22 November the complainant wrote to the United Bristol Healthcare NHS Trust (the Trust), which manage the hospital, seeking clarification of the Trust's responsibility for the continuing nursing care of his mother. Replies from the general manager for community services suggested that the issues raised were best answered by Bristol and District Health Authority (the Authority). The complainant wrote to the Authority on 8 February 1994. Their chief executive (the CE) replied on 30 March. The complainant wrote again to the CE on 14 April. After a delay of three months, the CE replied that the Authority were unable to accept financial responsibility for his mother's care in the nursing home. The complainant's mother died on 11 November 1994. In April 1996 the Authority was succeeded by Avon Health Authority.

2. The complaints which I investigated were that:

(a) the Trust had failed to follow the correct procedure when discharging the complainant's mother to the nursing home; and

(b) the Authority had failed in their duty to provide for the complainant's mother's care.

Investigation

3. I obtained the comments of the Trust and the Authority, and examined their correspondence and other relevant documents. My officer took evidence from the complainant and relevant members of staff at the Trust and the Authority. Although local authorities are not within my jurisdiction, my officer also took evidence from a social work team manager (the team manager) who worked in the Social Services Department of Avon County Council (the Social Services Department).

Complaint *(a) The Trust's discharge procedure*

4. Circular HC(89)5, issued in February 1989 by the Department of Health (DH), gives guidance on the discharge of patients from hospital. A booklet entitled 'Discharge of Patients from Hospital', which accompanied it reads:

> '.... Where a person moves from hospital to a private nursing home, it should be made quite clear to him/her in writing before the transfer whether or not the health authority will pay the fees, under a contractual arrangement ....
>
> '.... patients and .... relatives or carers [should] be consulted and informed at every stage ....'

5. In February 1995—after the events which are the subject of the complaint—the DH issued guidance in HSG(95)8, entitled 'NHS responsibilities for meeting continuing health care needs', which replaces the guidance in Circular HC(89)5. HSG(95)8 reads:

> '.... hospital and social services staff should ensure that patients receive written details of any continuing care which is arranged for them. This should include a statement of which aspects of care will be arranged and funded by the NHS.'

6. The Authority's quality specification for NHS bodies, such as the Trust, which provide services for their residents reads:

> 'All patients will be discharged in accordance with good practice laid down in Circular HC(89)5 and the Provider's discharge arrangements. Patients and their carers will be consulted and informed at all stages in the process.
>
> 'These arrangements will include the process agreed with Avon Social Services Department for assessment prior to discharge ....
>
> 'Providers will be expected to ensure that staff have appropriate training to understand and adhere to this agreed process.'

7. The Trust's discharge policy is silent on the financial consequences of discharge to a nursing home.

8. The 'Notes of guidance' for completion of the health needs assessment form, prepared by the Social Services Department, read in part:

> 'It has been agreed with [the Authority] and [the Trust] that the following arrangements will be appropriate ....
>
> 'Whenever consideration is being given to .... nursing home care provision, then a health needs assessment must be obtained.
>
> '.... the responsibility for undertaking assessment and detailing service provision from the Health Service is lodged with the health care professionals employed by .... Trusts.'

9. The complainant told my officer that neither he nor his mother had been given any information by the Trust or the Authority about the financial consequences of her discharge from hospital; but that he had been informed of the financial position by the team manager. The health needs assessment form had not been completed fully: the last section had been left blank. (I have seen the form, and the complainant is correct.) He had raised the question of the apparently incomplete health needs assessment form in a letter to the CE dated 14 April 1994, but the reply had made no mention of it.

Evidence of the Trust

10. The consultant geriatrician who had treated the complainant's mother (the consultant) told my officer that he did not involve himself in the financial aspects of community care because he considered that that was a matter for social services. He was not aware of the DH guidance (see paragraph 4), and said that he did not take any action to inform patients or their relatives of the financial consequences of discharge to a nursing home—nor, to the best of his knowledge, did any of his colleagues. It was not the role of medical staff to write letters about financial matters.

11. An associate consultant geriatrician, who worked with the consultant, told my officer that social workers had explained the financial consequences of the proposed course of action to the complainant—whom she had not met. If asked, she would advise people to speak to the social workers about such matters; she was not aware that the Trust had any responsibility to convey financial information to patients or their relatives. She, or a senior house officer, should have completed one part of the health needs assessment form, but she had not been asked to do so. The nurse who had completed most of the form (the staff nurse) should have completed another part which had been left blank.

12. The staff nurse told my officer that she was not aware of any obligation on the Trust staff to discuss financial arrangements with patients who were being discharged to nursing homes. She had filled in the health needs assessment form on 3 April 1993—it had probably been the first such form which she had done, because the relevant community care legislation had only just come into force. One part which she had filled in should have been done by a

doctor, and she should have filled in the part which had been left blank. The ward sister who had been responsible for the ward in which the complainant's mother had stayed told my officer that there had been some debate about who should fill in which parts of the form. The form had since been redesigned. (I have seen the redesigned form: it has more detailed notes of guidance than its predecessor.) The social workers usually contacted patients' relatives about community care issues, and she believed that they had done so in this case.

13. The Trust's director of operations (the director) told my officer that staff of the Social Services Department should ensure that patients or their relatives were informed of the financial consequences of a discharge to a nursing home. Trust staff were not experts in such matters, and would not necessarily be able to explain the financial details. It was not the role of nursing staff to write letters about financial matters. She would expect Trust staff to refer patients to the on-site social work team, who would provide them with the necessary financial information. The complainant had already been in contact with the Social Services Department before his mother's admission to hospital. The director's assistant told my officer that she had spoken recently to the members of the multi-disciplinary team involved in discharging patients and had satisfied herself that patients or their representatives were receiving all the appropriate information—albeit from social workers rather than from Trust staff. She considered that the document which the complainant had signed, on behalf of his mother, agreeing to pay a contribution to the cost of her care, constituted written communication of the fact that fees would be payable. That document, which is entitled, 'Arrangement for purchase of service', reads in part:

> 'Does the Service User [i.e. the complainant's mother] agree to pay the Service User's Contribution direct to the Provider?
>
> YES'

It has been signed by the team manager, by a representative of the nursing home and by the complainant.

Evidence from the Authority

14. In a letter to the complainant, dated 30 March 1994, the CE wrote:

> 'Our service specification requires Trusts to follow the guidelines set down in the Department of Health's circular HC(89)5 when discharging someone from hospital.'

He went on to quote from that circular (see paragraph 4) and continued:

> 'Through our discussions with the various Trusts providing hospital services and through our monitoring of their practice, we seek to ensure that they do follow these guidelines. Certainly [the Trust] are well aware of these guidelines ....'

The CE told my officer that Trust staff should have explained the financial consequences of the complainant's mother's discharge to her or her family, in writing, in line with the DH guidance. The health needs assessment form should have been completed fully, as the complainant had suggested in his letter. He had not replied to that point in his answer to the complainant because he had not considered it important—his reply had concentrated on the question of whether the Authority had had an obligation to pay for the complainant's mother's nursing home care. The Authority's director of public health told my officer that he agreed with the CE about the duty of the Trust staff to complete the form and to inform the complainant or his mother of the financial consequences of her discharge. The Authority's new chief executive (the second CE), who succeeded the CE in October 1994, told my officer that while it was the responsibility of Trusts to ensure that patients or their relatives received correct information about the financial consequences of discharge to a nursing home, there was no reason why that information should not be given by social workers rather than Trust staff. The responsibility of Trusts would be clarified in the contracts with Trusts for 1995–96. (I have seen the relevant part of this new contract, and it is the same as that for 1993–94, from which I quoted in paragraph 6.) The Authority's deputy director of contract management told my officer that the quality specification in the contract would be changed when the Authority reviewed their arrangements for the provision of continuing care, in line with DH guidance HSG(95)8 (see paragraph 5).

15. During the course of my investigation, there was correspondence between the Authority and the Trust as follows:

14 December 1994

The Authority's contracts manager wrote to the director's assistant that the Authority required Trusts to follow the guidance in DH Circular HC(89)5, quoted from that circular, and requested confirmation that Trust staff were aware of the guidance and carried out its provisions.

25 January 1995

The facilitator (see paragraph 16) wrote to the director's assistant that 'Nurses are not aware and have never produced written documentation to patients about payment of fees for nursing homes .... it is the Social Worker's responsibility to discuss funding arrangements with patients ....'

27 January

The director's assistant wrote to the contracts manager enclosing the facilitator's letter of 25 January, and requesting comments on it.

2 March

The contracts manager replied to the director's assistant reiterating that NHS staff had a '.... duty to ensure patients and carers are notified in writing of all important discharge issues, of which funding is one.'

16. The community care management facilitator (the facilitator) told my officer that she had been appointed in May 1993 to a post which was funded jointly by the Authority and the Social Services Department. Her role was to liaise on all matters concerning community care for patients of the Trust. She said that Social Services Department staff had to do a financial assessment when a patient was discharged to a nursing home, but that it was not clear who should inform the patient or family. In the complainant's mother's case the team manager had done so. The Trust's staff worked very closely with the social workers and it was therefore not important who informed the patient or relatives. Trust staff had an expectation that social workers would do so—which they did. One of her early tasks had been to train staff in the procedure for completion of the health needs assessment form. The complainant's mother's form had been completed on 3 April 1993, immediately after the coming into force, on 1 April, of the National Health Service and Community Care Act 1990.

Evidence from staff of the Social Services Department

17. The team manager confirmed that he had talked to the complainant about the nursing home fees, and they had both signed the appropriate forms. The completion of such documents, and liaison with patients and their relatives was part of the social worker's role; that procedure was followed in all such cases. He considered that his and his colleagues' contact with the complainant—including the signing of the relevant documents—had constituted adherence to the DH guidance. He believed that the non-completion of the health needs assessment form had been an oversight which had made no material difference.

Findings *(a)*

18. There was maladministration in the way in which the complainant's mother's health needs assessment form was completed—one section was left blank, and one which should have been completed by a doctor was filled in

by the staff nurse. These errors were not noticed until the complainant referred to them in his letter of 14 April 1994 to the CE—12 months after completion of the form. The facilitator, who had not started in her post at the relevant time, has since trained staff in the correct procedure. The forms have been redesigned, and now have fuller instructions for completion. I appreciate that the complainant's mother's was probably the first such form that the staff nurse had completed, and I am not minded to criticise her for minor omissions; but I **recommend** that the Trust and the Authority ensure that all such forms are completed fully in future. While the errors in this case made no material difference to the complainant's mother's treatment and no injustice or hardship were sustained, I nevertheless uphold that aspect of the complaint as a fact.

19. Although the complainant was not given any information by the Trust or the Authority about the financial consequences of his mother's discharge, he did receive such information from the team manager, and the documents which the complainant signed provided written confirmation of his liability. I do not consider that the complainant sustained any injustice or hardship as a result of receiving the information in that way. I do not uphold that aspect of the complaint.

20. However, I do not condone the confusion between the Authority and the Trust. The DH guidance on the discharge of patients, which was in force at the time, makes clear that it is the responsibility of the NHS to ensure that patients or their relatives are informed in writing about whether the NHS will pay when a patient is discharged to a private nursing home. The Authority expected the Trust to adhere to the guidance; but none of the relevant Trust staff was aware of the guidance, and the Trust's discharge policy does not refer to it. The Authority told my officer that they would clarify the responsibility of providers in this area in their contracts for 1995–96. They have not done so; and I criticise the Authority for that failure. I recommend that the Authority should agree explicitly with local providers and the Social Services Department who will be responsible for informing patients or their relatives about the financial consequences of discharges.

Complaint *(b) The Authority's duty to provide care*

21. The complainant told my officer that, at the time of his mother's discharge, he had thought that the NHS had no responsibility to provide continuing care for her. Subsequently he had heard about my finding (in case E.62/93–94 which was published in February 1994 and which concerned the discharge of a patient in 1991) that a health authority's policy of making no provision for continuing care at NHS expense constituted a failure in service; and he had written to the Trust, and subsequently the Authority, to see if they would pay the nursing home fees. They would not.

22. Section 3(1) of the National Health Service Act 1977 says that:

> 'It is the Secretary of State's duty to provide throughout England and Wales, to such extent as he considers necessary, to meet all reasonable requirements—
>
> '....
>
> 'such facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as he considers are appropriate as part of the health service.'

23. The Government's 1989 White Paper, 'Caring for People', reads in part:

> 'Where .... people require continuous care for reasons of ill-health, it will remain the responsibility of health authorities to provide for this ....
>
> 'Health authorities will need to ensure that their plans allow for the provision of continuous residential health care for those highly dependent people who need it.'

24. DH guidance in HSG(95)8, issued in February 1995, includes:

> 'Health Authorities must develop by 29 September 1995 draft local policies and eligibility criteria for continuing health care. These should be made publicly available for consultation and finalised by 1 April 1996.
>
> 'Health Authorities .... must review by 29 September 1995 their current arrangements for arranging and funding continuing health care. Where they are currently not purchasing a full range of services they must make the necessary investment in their 1996/7 contracts to address this.
>
> '.... Where major gaps in provision exist health authorities .... must consider taking action in 1995/6 to address this, anticipating the outcome of work on local policies and eligibility criteria.'

25. In 1992, the Authority prepared a continuing care inventory which set out their commitment to continuing care for adults. It reads in part:

> 'The [Authority] does not purchase any continuing care beds for elderly people.'

A paper which the CE put to the Authority on 27 April 1994 reads in part:

> '.... we do not purchase continuing care for elderly people in hospitals.
>
> '.... [the Authority] do not purchase continuing care for elderly people in nursing homes.
>
> '.... If the combined social and nursing needs of the individual are more than can be met at home, our policy is that a nursing home is the appropriate provision. The Government's policy is that Social Services Departments should arrange placement in nursing homes, and that funding of such placements should depend on a means test.'

The minutes of the meeting at which that paper was considered read in part:

> 'It was agreed that the Authority should reaffirm to Providers its current policy ....'

The CE's letter of 14 July 1994 to the complainant states:

> '.... [The Authority] has a policy of not purchasing continuing care for people in nursing homes ....
>
> 'I regret that we are unable to accede to your request to accept financial responsibility for your mother's placement [in a nursing home] ....'

In their reply to me dated 14 December 1994 the Authority said:

> '.... The issue of the extent of the Health Authority's responsibility for continuing care was recognised as a difficult area, and this was reflected by the reconsideration of the policy on the discharge of elderly in-patients to continuing care at the Health Authority meeting in April 1994. The policy, which includes the decision that [the] Authority does not purchase continuing care for elderly people in nursing homes, was reaffirmed ...., and the response to the complainant sent on 14 July was written in this light.'

26. The CE told my officer that the Authority had received legal advice that their policy was in line with their statutory obligations. It had been formulated having taken account of local needs, competing priorities and the finite nature of their budget. The Authority's director of public health agreed with that view and said that the only elderly people who received continuing care at the Authority's expense were those who were in hospital awaiting placement in a nursing home—as the complainant's mother had been for a few weeks. He did not believe the Authority to be under any obligation to purchase continuing care.

27. In January 1995, the second CE told my officer that the Authority had no plans to amend their policy unless they received central guidance that they should. In March she said that she welcomed the new DH guidance (in HSG(95)8) and that the Authority had not yet decided how to implement its provisions because of the impending abolition of the County of Avon as a result of local government reorganisation. She hoped that the Authority would be able to agree common criteria with the four new unitary local authorities in order to identify those patients who would qualify for health authority funding of their continuing care.

28. In a letter dated 14 September 1995 to one of my staff the second CE wrote:

> ' ... [the Authority] currently commit some £54 million to a range of continuing (health) care, mainly for elderly people ... It is correct that this does not include the purchase of beds in nursing homes: our policy is that if the needs of people can be met in a general nursing home setting, they are not those which are the responsibility of the NHS ...
>
> '[.... we] are well advanced with our work to implement the guidance embodied in HSG(95)8. A draft policy incorporating eligibility criteria ... affirms our commitment to providing continuing health care ... It does not, however, commit [the Authority] to purchasing general nursing home places for the .... reasons which I have set out.'

In a letter dated 20 September 1995 to one of my staff she wrote:

> ' .... on 31 March 1995 .... some 35 [hospital] beds were being used for people with continuing health care needs ....
>
> 'It is accepted that there will be individuals who have longer term needs [who] require specialist hospital care and that need is represented by the 35 beds to which I have referred ....'

29. The Authority's corporate services manager told one of my officers that the number of hospital beds occupied by patients with continuing health care needs depended on the clinical assessment of the individual patients' need for hospital care. It was not—and had not been in 1993 and 1994—the Authority's policy to contract for continuing care beds, although patients judged to be in clinical need of such hospital care did in fact receive it.

30. The team manager told my officer that he had been recruited to assist the Social Services Department with implementation of the provisions of the National Health Service and Community Care Act 1990. He believed that since the relevant parts of that legislation came into force in April 1993, responsibility for providing continuing nursing home care had rested with local authorities, rather than health authorities.

Findings *(b)*

31. At the time of the complainant's mother's discharge from the hospital, all parties were content that she should move to a nursing home. At that time, the complainant thought that the NHS had no responsibility to provide continuing care; but he heard later about my ruling in another case that a health authority's policy not to purchase any such care constituted a failure in service, and questioned whether the Authority should, therefore, have paid his mother's nursing home fees. He corresponded with the Authority, who told him that they did not purchase any continuing care in nursing homes. In my view the Authority's policy at that time of not purchasing any continuing care beds in hospital or in nursing homes (paragraph 25) was unreasonable. I have been told that the practice differed from the policy, in that there were patients who received continuing health care in hospital; but as a result of that policy, patients such as the complainant's mother, who was highly dependent and required continuing institutional care, were not given the chance to be considered for NHS-funded continuing health care. It is impossible for me to say whether the complainant's mother would have satisfied the eligibility criteria

for access to NHS-funded continuing health care if the Authority had had such criteria. I am therefore unable to make a finding on the complaint as put to me; but the effect of the Authority's policy in excluding the complainant's mother from consideration was unfair, and I invite the Authority to consider redressing that unfairness by making an *ex gratia* payment to the complainant.

32. While I was conducting my investigation, the Department of Health issued new guidance instructing health authorities to review their arrangements for funding continuing health care, to develop eligibility criteria for such care, and to take action to address any major gaps in provision. If the Authority are in any doubt about their obligations under that guidance, they should consult the Department of Health. In developing criteria as required by that guidance, it may be prudent for the Authority to have in mind particularly the needs of highly dependent patients requiring intensive nursing care.

Conclusion

33. I have set out my findings in paragraphs 18–20 and 31–32. The Bristol and District Health Authority have agreed to act on my recommendations in paragraphs 18 and 20. The United Bristol Healthcare NHS Trust have agreed to act on my recommendation in paragraph 18. Both bodies have asked me to convey through my report—as I do—their apologies to the complainant for the shortcomings which I have identified.

Case No. E.118/94–95

Background and complaint

1. The background provided by the complainant was that on 4 November 1992 her brother-in-law, then aged 91, was admitted to Stoke Mandeville Hospital (the hospital) after a fall. The complainant's brother-in-law was registered blind, complained of deafness and had difficulty walking. After treatment his condition improved and he was transferred to a rehabilitation ward. In February 1993 the complainant was told that her brother-in-law would have to leave the hospital as the bed was needed for more urgent cases. He was discharged to a private nursing home where he remained, largely at his own expense, until his death in September 1994. At the time of the man's discharge the hospital was administered by Buckinghamshire Health Authority (the Authority), but on 1 April 1994 it became the responsibility of Stoke Mandeville Hospital NHS Trust (the Trust).

2. The complaint which I investigated was that the complainant's brother-in-law was obliged to pay for continuing nursing care which should have been provided through Buckinghamshire Health Authority free of charge under the National Health Service.

Investigation

3. I told the complainant that her complaint might in part concern actions taken solely in the exercise of clinical judgment which, at the time, were statutorily outside my jurisdiction. I obtained the Authority's comments, and their correspondence and other relevant documents, including the complainant's brother-in-law's hospital records, were examined. My staff took evidence from the complainant and her husband, and staff of the Authority and the Trust. I also obtained evidence from staff of the social services department of Buckinghamshire County Council (the Social Services Department), although their actions are not within my jurisdiction.

Statutory and policy background

4. The provision of health services in England and Wales is governed by the National Health Service Act 1977, which states in section 3(1) that:

> 'It is the Secretary of State's duty to provide ...., to such extent as he considers necessary to meet all reasonable requirements—
>
> (a) hospital accommodation;
>
> ....

(e) such facilities for .... the after-care of persons who have suffered illness as he considers are appropriate as part of the health service'.

5. The chief executive of the NHS Management Executive wrote to me in 1990, when I sought his view in the context of another investigation, about the provision of care by health authorities:

> '.... If in a doctor's professional judgment a patient needs NHS care, then there is a duty upon the Health Service to provide it without charge .... this can be done by providing community care to the patient's own home, by providing in-patient care or by a contractual arrangement with an independent sector home (i.e. paid for in full by the health authority). The level of service provided overall is a matter for individual health authorities in the light of local circumstances and priorities.'

and:

> ' ....
>
> a. there is no general duty on a health authority to provide in-patient medical or nursing care to every person who needs it. Legal precedents have established that the Secretary of State's duty under Section 3 of the Act is qualified by an understanding that he should do so 'within the resources available' .... Thus
>
> b. in any particular case the provision of such care may be deferred so that cases may be dealt with, in order of clinical priority, within the resources available; and
>
> c. consideration of clinical priority may mean that a particular patient may never be provided with in-patient nursing care.'

6. The Department of Health issued guidance (circular HC(89)5) in February 1989 about the discharge of patients from hospital. It stated that:

> '.... Where a person moves from hospital to a private nursing home, it should be made quite clear to him/her in writing before the transfer whether or not the health authority will pay the fees, under a contractual arrangement. No NHS patient should be placed in a private nursing or residential care home against his/her wishes if it means that he/she or a relative will be personally responsible for the home's charges.
>
> '.... patients and .... relatives or carers [should] be consulted and informed at every stage ....'

7. In February 1994—after the man's discharge from hospital—I issued, as a special report (HC 197), the results of my investigation of a complaint that Leeds Health Authority had failed to provide long term NHS care for a brain-damaged patient aged 55. I found that the authority made no provision for the continuing care of such patients. I criticised that as a failure in service and I recommended that the authority meet the costs which the complainant had incurred and review their provision of services.

8. In February 1995 the Department of Health issued guidance in HSG(95)8—which replaced HC(89)5—on NHS responsibilities for meeting continuing health care needs. That described how a consultant, in consultation with a multi-disciplinary team, should decide whether a patient needs continuing in-patient care funded by the NHS. That could be because:

'— either he or she needs ongoing and regular specialist clinical supervision (in the majority of cases this might be weekly or more frequent) on account of:

— the complexity .... of his or her medical, nursing or other clinical needs;

— the need for frequent not easily predictable interventions;

— or because .... he or she is likely to die in the very near future ....'.

9. The local discharge policy at the hospital at the time of the man's discharge stated that 'the patient and relative/carer should be consulted at all stages before any decisions are finalised'. It also required a co-ordinated discharge plan to be prepared for each patient. In disregard of HC(89)5 it did not explain where responsibility lay for telling patients and relatives about the possible need to pay nursing home fees.

The complainant's account

10. The complainant said that she was told at one point by a nurse in the rehabilitation ward that her brother-in-law would eventually be moved to the long stay ward. Arrangements were made at another point for home visits to assess how he would cope at home, but they did not take place. She believed that that plan was abandoned because her brother-in-law was incapable of carrying out the simplest of essential living tasks. She was told by a consultant and a social worker that her brother-in-law would have to leave the hospital as his bed was needed for more urgent cases and that the long stay ward was full. The consultant had decided that her brother-in-law needed long term nursing care and, as the hospital could not provide it, he would have to go into a nursing home. The complainant understood that the long stay ward was to close. There was no discussion of alternatives and the only written information she received was a list of nursing homes. A social worker told her that, until his savings fell below £8,000, her brother-in-law would have to pay the full cost of a nursing home. She agreed to his discharge because she thought that there was no alternative: her brother-in-law did not really understand about the plans being made for his future care. The complainant, who was aware of my decision in the Leeds case (paragraph 7), considered that there was 'sleight of hand' by the authorities in denying NHS care to patients whose fragile state meant that they would require nursing care for the rest of their lives.

Evidence from the Authority

11. In their comments to me the Authority said:

> '.... There were and are still long stay places for those patients needing more continuous medical input, and it was the consultant's clinical judgement that [the complainant's brother-in-law] was not .... appropriate for a place. .... [As he] had apparently completed his acute medical care and was not placed within [the hospital], it was not felt [Note by the Commissioner: the Authority did not make clear by whom it was not felt.] that he would be appropriate for NHS payment of his continuing care....
>
> 'Decisions such as .... in [this] case are difficult to make. We .... have improved such discharge arrangements since 1993. In the event of a case like [this] arising now I believe we would take a similar view and would arrange for any special needs over and above nursing home care.'

12. The Authority have been unable to trace any written local policy on or eligibility criteria for the provision of NHS funding for continuing care which would have applied in February 1993. They said that in the financial year 1992–93 they purchased 67 places for continuing care for elderly patients in the hospital, 30 places in another hospital and 68 places in nursing homes. The Trust have said that, in the 1992–93 financial year, there were 61 admissions to the two long stay wards in the hospital. These included 13 transfers from other wards. The Authority told me that they had reviewed their eligibility criteria, to be implemented from 1 April 1996, and that they were also reviewing discharge procedures to ensure that patients received appropriate information.

Documentary evidence

13. On 24 November 1992 the consultant physician responsible for the complainant's brother-in-law's care wrote in the clinical records:

> 'I think [the complainant's brother-in-law] would benefit from further rehabilitation on ward 19 before a home visit and discharge.'

The consultant next made an (undated) entry—beneath a note (part of which read '[the consultant] will discuss [with] relatives re home') made, after a ward round, on 7 December by the senior house officer (SHO) directly involved in the man's care, and above an entry dated 9 December—which read:

> 'Discussion with sister-in-law and her husband
> — major concerns about his ability to cope
> — explained plans for Home Visit before discharge—agreed
> — agreed that Power of Attorney to be taken out
> — PLEASE NOTIFY ME OF ANY ARRANGEMENTS
> — check heating.'

The complainant told my investigator (and showed her a diary entry) that a meeting with the consultant planned for 7 December did not take place. Her solicitor, who was also due to attend, has confirmed that. The consultant, on the other hand, said that he could not remember the meeting but he was sure that the entry in the records was accurate. The social worker's records have a similar entry for 7 December.

14. On 21 December the SHO wrote, 'Due [home visit] today. ? no heating in home. [Rearrange] visit. Need *heating* arranged'. The social worker recorded that the home visit was cancelled as the complainant's brother-in-law was unwell and the weather was cold. On 29 December the SHO wrote, 'Needs repeat home visit appointment'. On the same day the social worker recorded that the man was not asking to go home and was doing very little for himself.

15. The social services department's records show that on 4 January 1993 a social worker had spoken to the complainant's husband on the telephone and agreed to meet him and his wife in the ward to talk to the complainant's brother-in-law about future care plans and the possibility that he might go to a nursing home. His financial position was also discussed. On 6 January the social worker recorded meeting the complainant, her husband and her brother-in-law who said that he would like to stay where he was but, when told that this was not possible, agreed to move somewhere else where he could be looked after.

16. On 11 January the SHO wrote:

> 'Can [move about] well with a frame. Funds have been found [therefore] waiting for placement.'

On 17 February a social worker noted that she had met the complainant and discussed financial matters. The records contain an undated discharge planning form for the complainant's brother-in-law. Although little of the form was completed, most of the uncompleted sections dealt with matters not relevant to the complainant's brother-in-law's discharge. In a discharge letter, dated 11 March 1993, to the man's general practitioner the SHO said that the complainant's brother-in-law was not on any medication and did not need any routine follow up, but was not very mobile and required two nurses and a frame to walk.

Oral evidence

17. The consultant treating the complainant's brother-in-law said that the purpose of the rehabilitation ward was to facilitate the discharge of elderly patients, to their own homes if possible. Nursing home care would be suggested only when it became clear, after assessment and discussion with the multi-disciplinary team and with the patient and relatives, that discharge home was not feasible. There were still two long stay wards for patients who needed continuing hospital care—as there had been when the complainant's brother-in-law was discharged. No such ward closed at that time, although one had closed in February 1991 and the rehabilitation ward was relocated in May 1993 (with no loss of beds). Patients who transferred to the long

stay wards had the most severe levels of disability: most had no independent mobility and stayed in bed or a chair, a significant number needed special pressure-relieving mattresses and some were fed by tube. The eligibility criteria for the NHS care provided in the long stay wards were known to the consultants but not written down and would not be known to patients or their families. Whether the long stay wards were full was irrelevant, as the complainant's brother-in-law would not have been transferred there.

18. The consultant said that as the man's condition was stable he would not have benefited from staying in the rehabilitation ward, a transfer to a long stay ward was not appropriate as he did not fall into the category of patients for whom that care was provided, and he was not independent enough for care in a residential home. He had no reservations about the man's placement in a nursing home. He acknowledged that, although it was his practice to discuss those issues with relatives, the distinctions between the different types of care might not have been made clear to the complainant.

19. The consultant said that Trust staff might not have given the complainant and her husband or her brother-in-law any information in writing about his discharge or the need to pay nursing home fees. He understood that the social workers gave information about nursing homes and the fees involved. He and his staff were sensitive to the need to avoid putting relatives under pressure and tried to balance the concerns of relatives with the need to plan the patient's discharge.

20. The SHO involved in the man's care said that decisions about discharges from the rehabilitation ward were generally made at the weekly ward meetings. The aim was to return patients to their previous physical state, but if that was not possible and patients needed long stay hospital care they were transferred to the long stay wards. He was sure that criteria existed for such transfers but he did not know what they were. There was pressure on the long stay wards and beds were rarely available. He was not involved in, and did not understand, arrangements for funding nursing home care. He had little recollection of the complainant's brother-in-law and could not remember if he had spoken to the family.

21. A social worker, employed by the social services department but based in the hospital, said that her role had been to provide information to enable patients and their families to make their own choices about care after discharge. Often she and the consultant saw families together. If it was not feasible for a patient to go home she would look at alternatives—residential or nursing home care. The long stay wards were for the very infirm and only one of the patients she had dealt with at that time had been transferred there. The decision on placement depended on the patient's level of fitness and would be made at the multi-disciplinary planning meeting. She remembered the complainant's brother-in-law but could not recall if she had spoken to the complainant about his care. Information provided to the family about alternatives for care would have been mainly oral, though she would have given a written list of nursing homes. She would also have explained the rules about funding.

Findings and conclusion

22. The Authority did not give the family written information about the need to pay for nursing home care (as they should have done). I accept that the family were told about that by the social worker. The complainant felt that they were given no alternatives: but a return home was discussed early in her brother-in-law's stay (though the complainant did not think he was fit enough) and her brother-in-law eventually said that he would like to be looked after. Even if the family had been given the written information they should have had in order to have an informed discussion of alternatives, I cannot tell whether the outcome would have been any different.

23. The complainant believed that her brother-in-law's continuing care—in hospital or a nursing home—should have been funded by the NHS. Contrary

to what the complainant understood, no long stay ward in the hospital was being closed at that time, and some patients were still transferred to such wards for continuing care. While the Authority have not been able to provide details of any eligibility criteria used for NHS funding of continuing care, the consultant has said that in his opinion the complainant's brother-in-law did not come within the category of patients who required long term care in hospital. Such matters of clinical judgment and are not open to question by me.

24. In this case I have not seen evidence of a failure in service as in the Leeds case. Here NHS continuing care was being provided in hospital for patients with the most severe health care needs, and I have seen no evidence which would cause me to question the unwritten eligibility criteria being applied; but I criticise the fact that they were unwritten since that made it difficult to explain decisions to relatives or scrutinise them in retrospect. The Authority have said (paragraph 11) that a decision taken now on a patient such as the complainant's brother-in-law would be no different. Although the guidance in HSG(95)8 did not exist in 1993, the Authority were in effect saying that the man's needs were not so complex or frequent and unpredictable as to place him within the category of patients which that guidance now says should receive continuing in-patient care (in a hospital or nursing home) funded by the NHS. I do not uphold the complaint.

NHS Responsibilities For Meeting Continuing Health Care Needs

Section A—Introduction

1. The arrangement and funding of services to meet continuing physical and mental health care needs are an integral part of the responsibilities of the NHS. This includes, but is not limited to, the responsibility to arrange and fund an appropriate level of care from the NHS under specialist clinical supervision in hospital or in a nursing home. It also includes equally important responsibilities around rehabilitation, palliative health care, respite health care, community health services support and specialist health care support in different settings. All health authorities and GP Fundholders must arrange and fund a full range of these services to meet the needs of their population.

2. Both the NHS and local authorities have responsibilities for arranging and funding services to meet peoples' needs for continuing care. Collaboration is crucial to ensuring the effective and integrated delivery of care. The introduction of the new community care arrangements in April 1993 strengthened further the need for joint working. In particular health authorities, GP Fundholders and local authorities need to work together to ensure:

- clear agreements are in place covering their respective responsibilities for arranging and funding care;
- effective co-operation between services to ensure a co-ordinated response to the needs of individual patients or users;
- good quality and sensitive arrangements for transferring responsibility for a person's care between agencies and between different parts of the NHS.

3. In this context this guidance specifically confirms and clarifies the NHS's responsibilities. It addresses a number of concerns raised in the report made last year by the Health Service Commissioner and:

- gives details of the range of services which all health authorities and GP Fundholders must arrange and fund;
- describes the arrangements which should apply for discharging people from hospital or hospice with continuing health or social care needs;
- highlights key areas in which health authorities, GP Fundholders and local authorities must collaborate and consult in agreeing or changing their respective responsibilities for continuing care;
- sets out the action which health authorities, in conjunction with GP Fundholders and local authorities, must complete to implement this guidance;
- stresses the requirement for health authorities and GP Fundholders failing currently to arrange and fund a full range of services to make the necessary investment in their 1996/7 contracts to address this.

GP Fundholders

4. Health authorities are responsible for purchasing the majority of continuing health care services. Health authorities, in conjunction with local authorities and the other parties involved, have the lead responsibility for implementing this guidance. The guidance also applies, however, to GP Fundholders:

- in respect of the range of community health services they are responsible for purchasing;
- in respect of other aspects of continuing health care for those fundholding practices taking part in total purchasing pilots.

5. The full list of goods and services to be purchased by GP Fundholders from April 1996 will be issued in April 1995.

6. Health authorities are expected to secure the agreement of GP Fundholders to the relevant aspects of local policies and eligibility criteria for continuing care. In their turn GP Fundholders will be expected to take account of local policies in their purchasing intentions and to apply agreed eligibility criteria.

Needs of specific client groups

7. This guidance relates most directly to the needs for continuing health care of:

- older people;
- older people suffering from mental illness;
- people with dementia;
- younger adults requiring continuing health care as a result of illness or accidents;
- children.

8. It is relevant to the general continuing health care needs of other client groups but does not affect the requirements set out in previous guidance for other specific client groups, in particular for children, adolescents and adults with a mental illness or with learning disabilities. Details are covered:

- for **adult mental health services** in the Health of the Nation—Key Area Handbook;
- for **learning disability services** in circulars HSG(92)42 and LAC(92)15;
- for **children** in the Welfare of Children and Young People in Hospital guide issued under cover of HSG(91)1. In addition, Section 17 of the Children Act (Children in Need), and the Code of Practice on the Identification and Assessment of Special Educational Needs issued under Part III of the Education Act 1993 provide a framework for the arrangement of continuing care for **children with chronic illness and disabilities.**

Summary of action

9. In light of this guidance and in consultation with local authorities and other relevant parties:

a) *Health Authorities* must develop **by 29 September 1995** draft local policies and eligibility criteria for continuing health care. These should be made publicly available for consultation and finalised by **1 April 1996.**

b) *Health Authorities and GP Fundholders (as appropriate—see para 4)* must review by **29 September 1995** their current arrangements for arranging and funding continuing health care. Where they are currently not purchasing a full range of services they must make the necessary investment in their **1996/7** contracts to address this.

c) *NHS Trusts and other hospitals and social services departments* must by **29 September 1995** review arrangements to ensure that appropriate information is available to patients, their families and any carers about how procedures for hospital discharge will work and about the local arrangements for continuing health or social care support.

d) *NHS Trusts and other hospitals* to ensure by **1 April 1996** that front line staff are fully conversant with procedures for hospital discharge and arranging continuing care, as outlined in this guidance and including the operation of eligibility criteria;

e) *Health authorities* must have in place as soon as practicable and no later than **1 April 1996** arrangements to handle requests to review decisions on eligibility for NHS continuing care including arrangements for the operation of independent panels.

Section B—NHS responsibilities for securing continuing health care

10. The NHS is responsible for arranging and funding a range of services to meet the needs of people who require continuing physical or mental health care. The range of services which all health authorities and GP Fundholders (as appropriate—see para 4) must arrange and fund to meet the needs of their population includes:

- — specialist medical and nursing assessment;
- — rehabilitation and recovery;
- — palliative health care;
- — continuing inpatient care under specialist supervision in hospital or in a nursing home;
- — respite health care;
- — specialist health care support to people in nursing homes or residential care homes or the community;
- — community health services to people at home or in residential care homes;
- — primary health care;
- — specialist transport services.

11. This guidance requires health authorities to develop local policies and eligibility criteria which set out clearly:

- — the criteria which will be used as the basis, in individual cases, for decisions about need for NHS funded care;
- — the range, type, location and level of services which will be arranged and funded by the NHS to meet continuing health care needs in their area.

12. As for all other areas of NHS care, health authorities and GP Fundholders will need to set priorities for continuing health care within the total resources available to them. While the balance, type and precise level of services may vary between different parts of the country in the light of local circumstances and needs, there are a number of key conditions which all health authorities and GP Fundholders must be able to cover in their local arrangements. These are set out in **Annex A**. These conditions will be the basis on which the NHS Executive will review health authorities' local policies. Health authorities must be prepared to justify the balance and level of services they are proposing to arrange and fund.

13. In drawing up local policies and criteria health authorities must consult and involve fully:

- — local authorities (in particular social services departments but also where relevant housing authorities and in relation to the needs of children, education authorities);
- — all GPs (including GP Fundholders);
- — providers both in the NHS and the independent sector;
- — representatives of users and Carers.

14. Draft policies and criteria must be completed by **29 September** to inform decisions for the 1996/7 contracting round. They should be made available for consultation as part of the community care planning round and be finalised by **1 April 1996**. Details should be included in local community care charters. Health authorities will be expected to have agreed their final policies and eligibility criteria with local authorities and GP Fundholders.

15. Until the policies and eligibility criteria required by this guidance have been finalised, health authorities or GP Fundholders should not proceed with

any plans to reduce continuing health care services or alter hospital discharge criteria unless those plans are clearly covered by existing agreements with local authorities. Where major gaps in provision exist health authorities or GP Fundholders must consider taking action in 1995/6 to address this, anticipating the outcome of work on local policies and eligibility criteria.

Section C—Hospital discharge arrangements for people with continuing health or social care needs

Responsibility for decisions on discharge

16. All consultants, (or in some community hospitals GPs) are responsible for the medical care of their patients. They are responsible, in consultation with other key staff working with them, especially nurses, for deciding when a patient no longer needs acute care. The large majority of people, after a stay in hospital, will be able to return to their own homes.

17. A minority of patients may need intensive support including the possibility of continuing NHS inpatient care, nursing home or residential care or an intensive package of support at home. Decisions about the discharge of these patients from NHS care and on how their continuing care needs might best be met should be taken following an appropriate multi-disciplinary assessment of the patient's needs. In many cases this will involve referral to a consultant with specialist responsibility for continuing care (including geriatricians or psycho-geriatricians or other consultants responsible for continuing inpatient care) along with the other specialist staff, including specialist nursing staff, working with them. Such consultants, working with other specialist staff, will also be normally responsible for assessing patients referred directly from the community who may require NHS continuing inpatient care.

18. In all such cases social services staff should be involved at the earliest appropriate opportunity. Hospitals and social services staff should work together to ensure the most effective integration between social services assessments and care management procedures and hospital discharge arrangements.

19. The multi-disciplinary assessment should be co-ordinated between key professional staff from health and social services. The assessment process should involve consultation with the patient's GP and where appropriate community health services or social services staff who are familiar with the patient's circumstances. Where a patient has no form of accommodation to go to or where their housing is no longer suitable for their needs, staff from housing authorities and housing providers should be fully involved at an early stage The assessment should also take account of the views and wishes of the patient, his or her family and any carer.

20. Taking account of the results of the assessment And local eligibility criteria, the consultant (or GP in some community hospitals) in consultation with the multi-disciplinary team, and in particular with nursing staff, should consider what the most appropriate response to the patient's needs would be.

21. As a result the consultant (or GP in some community hospitals), in consultation with the multi-disciplinary team, will decide whether:

a) The patient needs continuing inpatient care arranged and funded by the NHS because:
   - either he or she needs ongoing and regular specialist clinical supervision (in the majority of cases this might be weekly or more frequent) on account of:
   - the complexity, nature or intensity of his or her medical, nursing or other clinical needs;
   - the need for frequent not easily predictable interventions.

— or because after acute treatment or inpatient palliative care in hospital or hospice his or her prognosis is such that he or she is likely to die in the very near future and discharge from NHS care would be inappropriate;

b) the patient needs a period of rehabilitation or recovery arranged and funded by the NHS to prepare for discharge arrangements breaking down;

c) the patient can be appropriately discharged from NHS inpatient care with:

— either a place in a nursing home or residential home or residential care home arranged and funded by social services or by the patient and his or her family;

— or a package of social and health care support to allow the patient to return to his or her own home or to alternatively arranged accommodation.

22. Where a patient meets the eligibility criteria for continuing NHS inpatient care but a bed is not available within the provision which has been contracted for, the agreement of the health authority should be sought for an extra contractual referral to another hospital or nursing home in the NHS or independent sector.

23. Health and local authorities should have in place clear agreements on how they will resolve disputes about responsibility in individual cases for meeting continuing care needs.

24. Health authorities or local authorities should not place younger people inappropriately in inpatient, nursing or residential care intended for older people.

Information

25. Patients and their families and carers should be kept fully informed about how procedures for hospital discharge and assessment will work and should receive the relevant information (in writing and in other formats appropriate to their needs) they require to make decisions about continuing care. In particular:

— **hospitals** should provide simple written information about how hospital discharge procedures will operate and what will happen if patients need continuing care;

— **hospital and social services staff** should ensure that patients, their families and any carers have the necessary information, where appropriate in writing, to enable them to take key decisions about continuing care.

— **social services staff** should provide written details of the likely cost to the patient of any option which he or she is asked to consider (including where possible and appropriate the availability of social security benefits);

— **hospital and social services staff** should ensure that patients receive written details of any continuing care which is arranged for them. This should include a statement of which aspects of care will be arranged and funded by the NHS.

Direction on choice

26. Where a patient has been assessed as needing care in a nursing home or residential care home arranged by a local authority, he or she has the right, under the Direction on Choice (LAC(92)27 and LAC(93)18) to choose, within limits on cost and assessed needs, which home he or she moves into. Where, however, a place in the particular home chosen by the patient is not currently available and is unlikely to be available in the near future, it may be necessary for the patient to be discharged to another home until a place becomes available.

Rights to refuse discharge to nursing home or residential care

27. Where patients have been assessed as not requiring NHS continuing inpatient care, as now, they do not have the right to occupy indefinitely an NHS bed. In all but a very small number of cases where a patient is being placed under Part II of the Mental Health Act 1983, they do however have the right to refuse to be discharged from NHS care into a nursing home or residential care home.

28. In such cases the social services department should work with hospital and community based staff and with the patient, his or her family and any carer to explore alternative options.

29. If these other options have been rejected it may be necessary for the hospital, in consultation with the health authority, social services department and, where necessary housing authority, to implement discharge to the patient's home or alternative accommodation, with a package of health and social care within the options and resources available. A charge may be payable by the person to the social services department for the social care element of the package.

Arrangements for reviewing decisions

30. As a final check before such a discharge is implemented, a patient and his or her family and any carer have the right to ask the health authority, in which the patient is normally resident, to review the decision which has been made about eligibility for NHS continuing inpatient care. The health authority should deal urgently with such a request and the patient and his or her family and any carer should expect a response in writing from the health authority, with an explanation of the basis of its decision, within 2 weeks of them making their request.

31. In reaching a decision the normal expectation will be that the health authority will seek advice from an independent panel who will consider the case and make a recommendation to the health authority. The health authority, in consultation with the local authority, does have the right to decide, in any individual case, not to convene a panel, for instance in those cases where a patient's needs fall well outside the eligibility for NHS continuing inpatient care. In those cases the health authority will be required to give the patient, his or her family and any carer a written explanation of the basis of its decision.

32. Further detailed practical guidance on the establishment and operation of panels and on other aspects of these arrangements will be issued by the end of June, following further work with key interested parties.

33. The key features of these arrangements would be:

- the role of the panel would be advisory. It would not have any legal status;
- that, while its decision would not be formally binding, the expectation would be that its recommendation would be accepted in all but very exceptional circumstances by the health authority or GP Fundholder concerned;
- the panel would have an independent chairman.
- the panel would also include a representative of the health authority and the local authority;
- the panel's key task would be to assess whether the health authority's eligibility criteria for NHS continuing care had been correctly applied in individual cases;
- the panel would seek appropriate professional advice from hospital staff, social services, the patient's GP and community health services staff. It could call for independent clinical advice where it deemed this to be necessary;

— the panel would wish to consider evidence from the patient or his or her family or any carers;

— the procedure and the criteria above would apply to the patients of GP Fundholders in respect of services they were responsible for purchasing. The expectation would be that the health authority would organise the panel on behalf of the Fundholder;

— patients' rights under the existing NHS complaints procedures, and their existing right to refer their case to the Health Service Commissioner, would remain unchanged by these arrangements.

Review of discharge arrangements

34. Health authorities, in consultation with local authorities, GPs and other agencies, should ensure that hospitals and community health services keep discharge procedures under review and should regularly audit performance. General good practice guidance on hospital discharge procedures—"Hospital Discharge Workbook—a manual on hospital discharge procedures" was issued in 1994 to all health authorities, local authorities, GPs, hospital and community health services. Further copies can be obtained from the same address as this guidance.

Section D—Collaboration with local authorities

35. In implementing the new community care arrangements health and local authorities have been required to make agreements on their respective responsibilities for continuing care and on arrangements for hospital discharge. These agreements should continue to form the basis for local collaboration. In this context, health authorities, acting on behalf of GP Fundholders, and local authorities should confirm jointly on an annual basis:

— their best estimates of the likely numbers of people who will need continuing health or social care during the year;

— their respective commitments in finance and activity on continuing care;

— their agreed contingency arrangements, at the beginning of the year, for managing in year any unexpected variations in the numbers of people likely to require care.

36. Where either health or local authorities are proposing a significant change in the pattern of services which will impact on the resources of the other agencies for providing care, they must seek the agreement of the other agency. This might relate to:

— changes in the number of people who need care at home as a result of the new community care arrangements;

— changes in acute activity and plans to reduce hospital lengths of stay;

— the reprovision of services into the community from long stay hospitals.

37. Discussions should take account of the need for any appropriate and continuing transfer of resources from the health authority to the local authority under Section 28A of the NHS Act 1977. Details of any significant changes in respective responsibilities should be included in published community care plans. Health authorities and GP Fundholders should also take account of the need for any resource shifts to community and primary health care services as a result of any planned changes in the pattern of services.

Section E—Implementation and monitoring

38. The full implementation of this guidance will be a key priority for the NHS. The NHS Executive and Social Services Inspectorate will work closely with authorities and monitor performance to ensure:

— that by **29 September 1995** all health authorities, in consultation with local authorities and GPs and other relevant parties, have developed draft local policies and eligibility criteria which reflect the conditions of this guidance;

— that timed and costed plans are in place for implementation by **1 April 1996** including how any necessary investment is managed;

— that by **1 April 1996** policies and eligibility criteria are finalised and agreed with local authorities and GP Fundholders and that the other requirements of this guidance are effectively implemented, including any required investment in services.

39. Starting from **1 April 1996** health authorities will be required to report to the NHS Executive on an annual basis on their planned and achieved level of spending and activity on continuing health care.

40. This guidance expires on 1 March 2000. It replaces existing guidance on hospital discharge HC(89)5 and LAC(89)7.

41. Further copies of this guidance (quoting the circular numbers ....) can be obtained from:

BAPS
The Health Publications Unit
Storage and Distribution Centre
Heywood Stores
Manchester Road
Heywood
Lancashire
OL10 2PZ

ANNEX A [to HSG(95)8]

Conditions For Local Policies And Eligibility Criteria For Continuing Health Care

Health authorities are required, in collaboration with local authorities and GPs, to produce local policies and eligibility criteria for continuing health care. Policies must address the following issues:

A Assessment of need

Health authorities, in collaboration with GPs, are expected to base purchasing decisions on a full assessment of the needs of their population, fully discussed and, if possible, jointly agreed with local authorities. This should be reflected in policies for continuing health care which should cover trends in demography, morbidity, clinical practice and other factors which are likely to impact on the need for continuing health care.

B Balance of services and priorities

Health authorities must ensure, within the total resources available to them, that they purchase a full range of services to meet the needs of their population for continuing health care. They can however determine, in consultation with local authorities, the balance and type of services they purchase locally, in the light of local circumstances. For instance, the existence of good rehabilitation services and well developed community health services and social care support may lessen, although not eliminate, the need for continuing inpatient care. Local policies should set out the health authority's plans for meeting continuing health care needs, the range, quality and level of services which will be purchased to meet those needs and how they are planned to change over time to meet projected changes in need.

C Rehabilitation and recovery

Health authorities and GP Fundholders (as appropriate—see para 4) must take full account of the need for services to promote the most effective recovery and rehabilitation of patients after acute treatment so as to maximise the chances of the successful implementation of long term care plans. This is particularly important for older people who may need a longer period to reach their full potential for recovery and to regain confidence. Local policies should guard against the risk of premature discharge in terms of poorer experiences for patients and increased levels of readmissions. Health authorities and GP Fundholders should ensure that hospitals have in place mechanisms for routinely monitoring rates and causes of readmission (in particular amongst older people) and the outcomes of hospital discharge. Monitoring should be shared with social services and performance should also be reviewed through clinical audit. Local policies should include explicit protocols and eligibility criteria for rehabilitation. Health authorities should agree with local authorities the need for any additional social or educational support which may be required as part of an agreed package of rehabilitation.

D Palliative health care

Working closely with the voluntary sector the NHS retains responsibility for arranging and funding palliative health care. This includes:

- palliative health care, on an inpatient basis, fully funded by the NHS in hospital, hospice or in a limited number of cases in nursing homes capable of providing this level of care;
- specialist palliative health care to people already in nursing homes;
- palliative health care support to people in their own homes or in residential care.

Local policies should include protocols and eligibility criteria for the provision of palliative health care in different settings.

Detailed guidance on NHS responsibilities for palliative health care is given in EL(93)14 and EL(94)14.

E Continuing inpatient care

All health authorities and GP Fundholders should arrange and fund an adequate level of service to meet the needs of people who because of the nature, complexity or intensity of their health care needs will require continuing inpatient care arranged and funded by the NHS in hospital or in a nursing home. In addition to the other areas already set out in this annex the NHS is responsible for arranging and funding continuing inpatient care, on a short or long term basis, for people:

- where the complexity or intensity of their medical, nursing care or other clinical care or the need for frequent not easily predictable interventions requires the regular (in the majority of cases this might be weekly or more frequent) supervision of a consultant, specialist nurse or other NHS member of the multidisciplinary team;
- who require routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff;
- have a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision.

In addition patients who have finished acute treatment or inpatient palliative care in a hospital or hospice, but whose prognosis is that they are likely to die in the very near future should be able to choose to remain in NHS funded accommodation, or where practicable and after an appropriate and sensitive assessment of their needs, to return home with the appropriate support. Health authorities should jointly monitor activity in this area with local authorities and use clinical audit to address areas where inappropriate discharges from NHS care appear to be taking place.

Local policies should include details of arrangements and eligibility criteria for people who require continuing inpatient care from the NHS. Policies should set out details of how continuing inpatient care will be purchased and how resources can be accessed, including arrangements for onward referrals to contracted beds and ECR placements in other NHS hospitals or in the independent sector.

F Respite health care

For many people local authorities will have the lead responsibility for arranging and funding respite care. The NHS however also has important responsibilities in this area and all health authorities and GP Fundholders (as appropriate—see para 4) must arrange and fund an adequate level of care. In particular however they should address the needs of:

- people who (as described in Section E) have complex or intense health care needs and will require specialist medical or nursing supervision or assessment during a period of respite care;
- people who during a period of respite care require or could benefit from active rehabilitation;
- people who are receiving a package of palliative care in their own homes but where they or their carer need a period of respite carers.

In making arrangements for respite care health authorities and GP Fundholders should pay careful attention to the wishes of patients and their carers.

Local policies should include details of arrangements and eligibility criteria for people who require respite care from the NHS. Health authorities should agree with local authorities their respective responsibilities.

G Access to specialist or intensive medical and nursing support for people placed in nursing homes, residential care homes or in the community

Some people who will be appropriately placed by social services in nursing homes, as their permanent home, may still require some regular access to specialist medical, nursing or other community health services. This will also apply to people who have arranged and are funding their own care. This may include occasional continuing specialist medical advice or treatment, specialist palliative care, specialist nursing care such as continence advice, stoma care or diabetic advice or community health services such as physiotherapy, speech and language therapy and chiropody. It should also include specialist medical or nursing equipment (for instance specialist feeding equipment) not available on prescription and normally only available through hospitals. It would not cover basic equipment such as incontinence supplies which should be included in the basic price charged by the home to the local authority or the person.

Assessment procedures and arrangements for purchasing care should take account of such needs and details should be identified in individual care plans. In such cases the NHS can either provide such services directly or contract with the home to provide the additional services required. Such additional services should be free at the point of delivery.

Health authorities should draw up, in consultation with local authorities, GPs (including GP Fundholders) and the independent sector, protocols and eligibility criteria for the availability of such support.

Access to specialist medical and nursing services should also be available on the same basis for people who are receiving a package of social care and community health services support in residential care homes or their own homes.

H Community health and primary care services for people at home or in residential care homes

Community health services are a crucial part of the provision of continuing care for people at home or in residential care. Health authorities should work closely with local authorities, GPs, hospital and community provider units and the independent sector to agree the likely demand for continuing community health services support, taking account of the impact of:

- changes in the number of people who need care in their own home as a result of the new community care arrangements;

- changes in acute sector practice and provider plans to reduce hospital lengths of stay;
- significant changes in the local pattern of residential or nursing home care (for instance the impact of the development of new homes or extensions of existing facilities in terms of increased demands on local primary care and community health services).

This should be reflected in health authorities' policies on continuing health care, health authority and GP Fundholder purchasing plans and in community care plans. Health authorities and GP Fundholders should take account of the need for any resource shifts to community and primary care services as a result of any planned changes in the pattern of services.

Policies should also indicate how health authorities intend to work with hospital and community providers and GPs to ensure effective integration between specialist and community and primary care services in meeting needs for continuing health care.

I Specialist transport

Health authorities and GP Fundholders should include as part of their local policies for continuing health care arrangements for ambulances and other specialist NHS transport. This should include, on the basis of patients' needs:

- transport to and from hospital or hospice;
- transport where an emergency admission is being made to a residential care or nursing homes;
- non-emergency transport for people in residential care and nursing homes or in their own home to and from health care facilities.

ANNEX B
EL(96)8
CI(96)5

26 February 1996

NHS Responsibilities For Meeting Continuing Health Care Needs—Current Progress And Future Priorities

The attachment to this letter reports on the emerging issues from monitoring work undertaken by the NHS Executive and the Social Services Inspectorate on preparations for the implementation of the guidance on NHS responsibilities for meeting continuing health care needs. While recognising that work is still ongoing it identifies the current state of progress and priorities for future work by health and local authorities.

Many health authorities, working closely with local authorities, have given a high priority to the implementation of the guidance and have made considerable progress against a challenging agenda. This needs to be maintained in order to ensure the smooth introduction of the new arrangements and to achieve the longer term objectives of the guidance. In some places significant further progress on some issues will be required both before and after April. NHS Executive Regional Offices and SSI will continue to work with authorities to ensure that necessary progress is made.

We would want to highlight three issues in particular which health and local authorities should address:

Health authority/local authority joint working

Monitoring has confirmed the importance of joint working between health and local authorities in this area. This is crucial to the practical delivery of care and the interests of users and carers. Health authorities and local authorities should work to reach an acceptable agreed position. Some principles around which this might be based are set out in **paragraph** 7. This should include agreed arrangements for monitoring and reviewing the impact of eligibility criteria and an agreed commitment to a longer term work programme.

Application of eligibility criteria

Monitoring work has identified a number of areas where the proposed application of eligibility criteria in some authorities could operate over restrictively. These are detailed at **paragraph 16**. Health authorities must ensure in introducing and operating their eligibility criteria that they have taken account of these points.

Future priorities

While April 1996 will be an important milestone there is a significant further programme of work for health and local authorities jointly to address in working out the longer term implications of the guidance, in securing greater consistency in arrangements and access to continuing care and in developing more effective and better focused models of provision. **Appendix A** sets out some suggestions of priorities for 1996/7 and beyond.

Ministers are committed to ensuring the successful implementation of the guidance. NHS Executive Regional Offices and SSI will continue to monitor implementation and will issue further reports on progress in due course.

ALASDAIR LIDDELL	HERBERT LAMING
DIRECTOR OF PLANNING	CHIEF INSPECTOR
NHS Executive	Social Services Inspectorate

NHS responsibilities for meeting continuing health care needs—current progress and future priorities

Section A—Overall progress

1. In February 1995 the Department of Health issued guidance to health and local authorities on NHS responsibilities for meeting continuing health care needs. The NHS Executive and Social Services Inspectorate have been monitoring its implementation. EL(95)88 issued in August 1995 set out the basis on which monitoring would be carried out.

2. In general work on the guidance has been given a high priority by health authorities. Across the country significant progress has been made against a challenging agenda. Where good progress has been made this has been characterised by:

- senior manager commitment in health and local authorities to this issue and tight project planning;
- integration of continuing care with other priority initiatives;
- an open relationship between health, local authorities GPs and other partners and a joint approach to the development of local policies and eligibility criteria;
- draft eligibility criteria which are clearly drafted and reflect the intentions of the national guidance;
- locally agreed definitions of the activities under discussion;
- strong clinical involvement in the development and testing of eligibility criteria;
- open and well managed public consultation on draft policies and eligibility criteria;
- transparency about current spending and future spending plans and effort invested in improving information;
- a genuine attempt to assess needs and to identify and address gaps in current service provision;
- a readiness to challenge the status quo and consider; more effective patterns of care;
- good links with providers over the practical implementation of the guidance including hospital discharge arrangements and the training of front-line staff.

3. Not surprisingly, given the complexity of the task, not all health authorities have progressed well on all aspects of implementation. A number will need to make significant further progress on some issues. Health authorities have received individual feedback from the monitoring process. Ministers are committed to ensuring that the necessary progress is made and NHS Executive Regional Offices will be monitoring performance to ensure that this is achieved.

Section B—Joint working with local authorities, and GPs

4. A key requirement of the guidance has been the need for health authorities to work jointly with local authorities over the details of local policies and eligibility criteria. This has recognised the interdependence which exists between the health and social care sectors. The guidance builds on the annual agreements which since 1993 health and local authorities have reached around continuing care and hospital discharge arrangements.

5. Significant effort has been put in by health and local authorities to joint working on this issue. In many areas work on the guidance has been tackled as a genuinely joint agenda. While sometimes a difficult process it has strengthened joint working between the two agencies. Where this has happened authorities are much better placed to reach an agreed position and manage the impact of the new arrangements.

6. In some areas work has been less joint and some difficulties are envisaged in reaching a mutually acceptable position. In such cases health authorities must ensure that they have met the basic requirements of the guidance.

7. Joint working in this area is crucial to the practical delivery of care and in the interests of users and carers. There are responsibilities on both health and local authorities for achieving this. Our expectation is that an acceptable agreed position for 1996/7 should be possible on the basis that:

- a proper response has been made to the action points raised in the monitoring feedback given to the health authority;
- the health authority's eligibility criteria match the conditions set out in the national guidance and the points raised in paragraph 16 of this letter have been addressed;
- the health authority and local authority have exchanged accurate available data about their 1996/7 spending on continuing care;
- arrangements have been agreed for handling disputes;
- proposals have been agreed for monitoring on a joint basis the impact of the new arrangements have been agreed;
- longer term issues have been identified and a firm commitment has been given for further work during 1996/7 to resolve them.

8. In some areas there are particular issues stemming from the lack of co-terminosity and from the very different patterns of service which some health authorities have inherited. This may involve a number of health authorities with differing historic patterns of services relating to a single local authority or a single health authority relating to a number of local authorities themselves with different patterns of provision.

9. Ministers are committed to ensuring greater consistency in arrangements for continuing care than exists currently and believe that the implementation of the guidance will be a means of achieving this over time.

10. In some authorities it has been possible to use current work on the guidance to achieve a consistent approach. In other cases, where current gaps are too great, it may be necessary for agencies to agree an interim approach based on the following principles:

- for April 1996 each health authority should aim to operate a single set of eligibility criteria;
- some flexibility may need to be used in the application of eligibility criteria to avoid gaps between health and local authority criteria;
- the application of the criteria must be closely monitored on a joint basis between health and local authorities;
- there should be a strategy to move within an agreed timescale to greater consistency in arrangements for continuing care across relevant health and local authority areas.

11. Health authorities are also required to seek the agreement of GP Fundholders to local policies and eligibility criteria. This again reflects the new role of health authorities in working together with primary care interests in implementing national policies and developing a local strategic framework for services. There has been some concern about the difficulties of engaging GPs including GP Fundholders on this issue. Some health authorities are

including continuing care as part of their local work around the **Framework of Accountability for GP Fundholders**. This approach could be more widely replicated.

Section C—Application of eligibility criteria

12. Health authorities are required to develop local eligibility criteria within the framework of conditions set out in annex A of the national guidance. The purpose of eligibility criteria is to confirm and clarify the responsibilities of the NHS for continuing health care and to improve the consistency and transparency of decision making.

These criteria complement the eligibility criteria which local authorities apply for access to continuing social care. Eligibility criteria are required to cover the specific needs of 5 client groups identified in the national guidance.

13. Health authorities have taken a number of approaches to developing eligibility criteria which reflect local circumstances such as local clinical need and practice, the historic variation in local models of provision or the style of local authority eligibility criteria. At the same time there is evidence that the existence of a national framework will produce greater consistency between authorities. Over time, with careful monitoring, there should be further moves to greater consistency as the operation of eligibility criteria and the implementation of phased development plans impact on service provision.

14. Monitoring work has not identified a best model of eligibility criteria but has highlighted a number of features which are present in the best work in this area:

- — the criteria are clearly drafted and well signposted;
- — there has been strong involvement of front line staff in developing the criteria;
- — there are clear and unrestrictive definitions of key terms;
- — there is clarity about how the criteria will be applied (a simple flow chart has been a good way of illustrating this);
- — eligibility criteria are supported where necessary by clear operational protocols;
- — eligibility criteria have been tested against case studies;
- — the eligibility criteria have been presented in a clear and comprehensible format for front line staff and the public.

15. It is important that eligibility criteria or supporting operational protocols make clear for both health and social services staff the basis on which clinical judgement about eligibility, in particular for continuing inpatient care, will be applied.

16. Monitoring work has looked at the clarity, completeness and content of draft eligibility criteria. It will be important that eligibility criteria do not operate over restrictively and match the conditions set out in the national guidance. Monitoring raised a number of points where eligibility criteria could be applied in a way which was not in line with the intention of the national guidance:

- — *restrictiveness in how eligibility criteria are applied.* Eligibility criteria are required to be sensitive to the complexity *or* intensity *or* unpredictability of a person's needs. Some eligibility criteria for continuing inpatient care seemed to place too much emphasis on the need for people to meet multiple criteria to qualify for NHS funded care.
- — *an overreliance on the needs of a patient for specialist medical supervision in determining eligibility for continuing inpatient care.* There will be a

limited number of cases, in particular involving patients not under the care of consultant with specialist responsibility for continuing care, where the complexity or intensity of their nursing or other clinical needs may mean that they should be eligible for continuing inpatient care even though they no longer require frequent specialist medical supervision. This issue was identified by the Health Service Commissioner in his report on the Leeds case and eligibility criteria should not be applied in a way to rigidly exclude such cases.

— *palliative health care.* Eligibility criteria for NHS funded inpatient palliative care should operate on the basis of clinical need. Application of time limits will be inappropriate.

— *discharge arrangements for people likely to die in the near future.* The guidance recognised the needs of an additional group of patients whose clinical prognosis, after completion of acute treatment in hospital or specialist palliative care in hospital or a hospice, would suggest they are likely to die in the very near future and who should be given the choice of being cared for in NHS funded accommodation.

The crucial objective here is to ensure sensitive discharge practice for this group of patients while recognising that clinical prognosis in many cases will be imprecise. Good practice is likely to be best achieved through careful attention to discharge procedures, joint monitoring of outcomes and the use of clinical audit to establish where discharge practice is inappropriate. Very short time limits (for instance of the order of a couple of weeks) are not appropriate and any time limits should be applied flexibly in the light of individual circumstances.

Where patients choose in these circumstances to return home both health and local authorities should work together to put in place an appropriate package of health and social care support.

— *dependency scoring.* A number of eligibility criteria use formal systems of dependency scoring such as Barthel. Such systems can be helpful in supporting clinical judgement and the application of the eligibility criteria. They may be restrictive if used in isolation without the scope for other factors about individual need to be taken into account.

— *rehabilitation and recovery.* Eligibility criteria will be restrictive if they limit NHS responsibility for rehabilitation to post acute care and do not take account of responsibilities to contribute to longer term rehabilitative care which is needed as part of a care package for someone in their own home or in a residential care home or nursing home.

Some eligibility criteria include time limits for rehabilitation or recovery. While perhaps helpful in ensuring that services are well focused such limits will be restrictive if applied rigidly. They will usefully act as a trigger for reassessment.

— *specialist support and equipment.* The guidance made clear the responsibility of the NHS to provide a range of specialist health care support and equipment, including occasional specialist medical treatment or advice, to people in nursing homes, residential care homes and their own homes. Good examples of eligibility criteria in this area have included very clear and explicit lists of what services and equipment the NHS will be responsible for and what should be provided by the nursing home as part of its basic contract with a local authority or person.

— *respite health care.* Some eligibility criteria will be restrictive if they do not cover all three conditions set out in the national guidance, for instance by excluding cases where a person may need a period of active treatment or rehabilitation as part their respite care, where carers have been providing a level of health care which is not reasonably available in a residential setting or where a person has been receiving a package of palliative care at home.

— *specialist transport.* Some eligibility criteria will be restrictive if they limit the use of NHS specialist transport to journeys to and from NHS facilities and exclude the small but important number of cases where an emergency admission is being made to a residential or nursing home.

17. Health authorities should also ensure that they have taken account of the issues raised by the Health Service Commissioner in the cases he has published relating to continuing care (in particular cases E62/93/94 published in February 1994 and E264/94/95 published in Selected Investigations completed April-September 1995). The Health Service Commissioner continues to take an interest in this area and health authorities should take account of issues raised in any further cases he might publish.

18. Many health authorities have tested their criteria against case studies. This is an effective means of identifying and resolving outstanding issues of interpretation and testing the operational robustness of criteria. All health authorities, in conjunction with local authorities, should consider doing this before they are implemented.

19. Undoubtedly some issues will be raised as eligibility criteria are put into operation. The application of criteria needs to be closely monitored so that any areas of concern can be identified and addressed when eligibility criteria are revised.

Section D—Reviewing service provision

20. Health authorities have been required to review their current service provision on the range of continuing health care services against the assessed needs of their population and to identify and address significant gaps in services.

21. This has been a major task and in most cases there will be a need for ongoing work over the next couple of years. In many areas there have been genuine difficulties in putting together reliable information about service commitments reflecting the fact that for the most part continuing care has not been separately identified in contracts with providers.

22. The majority of authorities have been able to put together at least basic quantified data on their continuing care commitments. Health and local authorities need to ensure that they have exchanged information on 1996/7 commitments. Health and local authorities should agree the approach they will be taking to monitoring continuing care agreements. It will be essential that basic monitoring of agreements is carried out on a joint basis between health and local authorities so that the impact on both agencies can be considered.

23. Health authorities were required to review their current services against an assessment of the needs of their population. Many authorities had undertaken work on this but it was clear that in many cases this needed to be further refined and developed taking account of local demographic trends and changes in the delivery and setting of health services. This has been identified as an ongoing priority. In most areas there is scope for greater involvement of public health expertise in this work. There is also scope for closer working with local authorities drawing on their information on local population needs.

Section E—Implementation with providers

24. There has been a major task in preparing to put local policies and eligibility criteria into operation. This involves effective co-operation between

health authorities, hospital and community health staff, GPs and local authorities. Some of this work including the training of front line staff, revision of hospital discharge and assessment procedures and implementation of the review procedure will still be ongoing.

25. In the best cases providers (including acute providers) had been involved from the beginning of the process and had made an important contribution to the development of eligibility criteria. Some attempt had been made to assess the impact of implementation for providers in terms of training needs and changes to procedures and importantly in terms of some changes in throughput and discharge for certain groups of patients. Where health care providers have not been involved from an early stage the risk to successful implementation is greater and the need for action most urgent.

26. Health authorities and health care providers need to pay particular attention to the quality of hospital discharge procedures particularly as they relate to patients with continuing health care needs not in the care of consultants with specialist responsibility for long term care. Poor discharge arrangements are likely to lead to a greater number of decisions being challenged by the review procedure with a likelihood of resulting delays in discharge. There is a need to revisit previous discharge agreements with local authorities and to ensure that any changes needed resulting from the implementation of the guidance are agreed and put into operation.

27. Health care providers should consider their arrangements for managing hospital discharge procedures for people with continuing care needs. One helpful means of ensuring that arrangements work smoothly is to have an accountable manager available within each main provider unit who is responsible for the overall operation of discharge arrangements, who can liaise with the health and local authorities over arrangements for continuing care and who can intervene when problems or disputes are experienced.

APPENDIX A

Priorities For 1996/7

While a number of tasks need to be completed by April 1996 health authorities, working with local authorities and other agencies, will take a longer time to achieve fully all the objectives of the guidance. The implementation of the guidance has been identified in the 1996/7 Planning and Priorities Guidance as a medium term priority. Health authorities and local authorities will need a work programme to address longer term priorities.

The following objectives are suggested, in the light of monitoring work, as key priorities for health authorities in 1996/7.

NHS Executive Regional Offices and SSI will continue to monitor implementation through performance management arrangements.

A Working with local authorities to monitor jointly demand for continuing health and social care including the impact of the application of NHS eligibility criteria. Monitoring should identify the information (including any service shortfalls) which will be required for the formal revision of eligibility criteria and for determining future contracting intentions.

B Monitoring with GPS, hospitals providers and community health services and local authorities the operation of eligibility criteria and in particular:

— the effectiveness of their operation in practice;

— the consistency of their application;
— compatibility between health and social services criteria.

Monitoring should help to identify and resolve any early problems with criteria as well as feeding the formal revision of criteria. Monitoring should include the provision of an opportunity for feedback from front line staff, CHCs and patients and their families.

C Monitoring the operation of the review procedure and in particular:
— the smooth operation of the procedure;
— problems it identifies with hospital discharge procedures;
— problems it signals with current services.

D Further work with social services to refine needs assessment and estimates of service gaps. National monitoring work indicated a clear need to develop further work on needs assessment with greater involvement of expertise from public health and better connections with community care planning and other work in social services. In a number of cases this may require some further reassessment of the level and balance of current services with some impact on spending decisions for 1997/8 and beyond. Work should also involve as appropriate housing authorities and in the case of children's services education authorities.

E Assessing the effectiveness of continuing health care provision focusing, for example, on:
— models of rehabilitation and their impact on long term care;
— interaction between continuing care and acute bed usage;
— provision of specialist support and equipment;
— priorities for joint commissioning.

It will be important for health authorities, in conjunction with local authorities, to assess the effectiveness of what they are purchasing and in particular to assess whether changes in the overall balance or models of provision they purchase, for instance to meet the needs of older people, could result in more effective responses to the needs of individuals, avoidance of unnecessary placements in long term care and better use of NHS and local authority resources. The NHS Executive proposes to encourage a wider debate, involving professional interests, to support local work by health and local authorities.

F Clarifying spending plans for 1997/8 and 1998/9. A significant number of health authorities are likely to need to make changes to the level and/or balance of their spending on continuing health care to address ongoing gaps in services or to achieve a more appropriate balance of services. Particular priorities may exist around community health service and specialist health care support and rehabilitation. The NHS Executive will want to agree with health authorities by the end of 1996 a provisional estimate of their spending intentions for continuing health care for 1997/8 and 1998/9.

G Reviewing and revising eligibility criteria. Implementing revisions for April 1997. Ministers have indicated in the response to the Health Select Committee's interim report on long term care that health authorities will be expected to review their eligibility criteria during 1996/7 and to implement any necessary revisions by April 1997. This work should be informed by the results of a national review of the operation of eligibility criteria (which will be completed by October 1996) and by the results of local monitoring.

Extract from attachment to Health Circular HC(89)5 on Discharge of Patients from Hospital

General Requirements

....

The [discharge] procedures should provide for:

i. any necessary assessment of the patient's home circumstances/situation, (and support likely to be available) to be carried out at the earliest possible stage. They should ensure that any support, help, equipment required to enable the patient (and carer(s)) to cope at home is available by the time the patient leaves hospital. Any immediately necessary adaptations to the accommodation should have been made or at least, a firm timetable agreed with the local authority.

ii. liaison with social services and housing departments about alternative arrangements, if it appears likely the patient will not be able to return to his/her current place of residence or if he/she no longer has a home. Such arrangements must be made in good time and be acceptable to the patient and, where appropriate, the patient's relatives or carers. They should be fully aware of the nature, purpose and likely consequences of them. This also applies to situations where care is arranged in private residential or nursing homes. Where a person moves from hospital to a private nursing home, it should be made quite clear to him/her in writing before the transfer whether or not the health authority will pay the fees, under a contractual arrangement. No NHS patient should be placed in a private nursing or residential care home against his/her wishes if it means that he/she or a relative will be personally responsible for the home's charges.

iii. patients and, with their consent, responsible relatives or carers to be consulted and informed at every stage and before decisions are made. Where the patient has a sensory impairment or his/her mother tongue is not English it is important to ensure that he/she has understood. Written or tape-recorded material may be helpful when communication is difficult.

iv. any special action necessary if patients are to be discharged, at or immediately before weekends or bank holidays, or late in the day.

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