



**THE SCOTTISH OFFICE**  
**Department of Health**

**\*\* please note that this circular has been superseded by  
CEL 6 (2008), dated 7 February 2008**

Dear Colleague

**NHS RESPONSIBILITY FOR CONTINUING HEALTH  
CARE**

**Summary**

1. NHS responsibility for continuing health care guidance for the NHS in Scotland is attached.

**Action**

2. The provisions of this circular have immediate effect, except for the proposed new arrangements for review of clinical decisions, which must be in place by 1 April 1996.

3. Health Boards are requested to circulate this MEL to GP Fundholders and GPs within their area.

KEVIN J WOODS  
Director of Purchasing  
NHS Management  
Executive

NIALL CAMPBELL *pp* DAVID HENDERSON  
Under Secretary      Assistant Secretary  
Social Work          Housing Division  
Services Group

Yours sincerely

**NHS**  
**MEL(1996)22**

NHS Management Executive  
St. Andrew's House  
Edinburgh EH1 3DG

**6 March 1996**

---

Addressees

For action:  
General Managers,  
Health Boards

Chief Executives, NHS Trusts

For information:  
General Manager,  
Common Services Agency

General Manager, State Hospitals  
Board for Scotland

General Manager,  
Health Education Board for  
Scotland

Executive Director,  
SCPMDE

Directors of Social Work

Directors of Housing

Chief Executive Scottish Homes

Chief Executives, Shadow Councils

Appropriate professional and  
voluntary bodies

---

**Enquiries to:**

Mr P D Harley  
Directorate of Purchasing Strategy  
NHS Management Executive  
St Andrew's House  
EDINBURGH EH1 3DG

Tel: 0131-244 2426  
Fax: 0131-244 2051

---

## NHS RESPONSIBILITY FOR CONTINUING HEALTH CARE

### Introduction

1. Both NHS and local authorities have responsibilities for continuing care. This circular refines current guidance on the responsibilities of the NHS in the organisation of continuing health care including revised provisions, which have immediate effect, on eligibility criteria for continuing inpatient health care. The circular also introduces a procedure for patients who wish to appeal against the clinical decisions on their continuing health care. In this guidance “local authority” means social work authority unless otherwise indicated.

2. There is much similarity between the provisions of this guidance and that which issued for England and Wales in February 1995 under cover of the Department of Health document HSG(95)8/LAC(95)5. But in Scotland we have had the benefit of guidance issued in 1992 (MEL(1992)55) which covered much of the ground, and which has already helped with the introduction of community care policy here. This circular is therefore a refinement and expansion of existing Scottish guidance rather than something entirely new. The guidance and annex take account of views offered during the consultation process.

### Existing Guidance

3. The Scottish Office has issued extensive guidance on the implementation of care in the community. Relevant Guidance includes:

February 1992:	Guidance on Care Programmes (DGM 1992/9)
September 1992:	Joint Purchasing Resource Transfer and Contracting (MEL( 1992)55)
May 1993:	Bridging Finance Scheme (MEL(1993)67 and ENV 12/93)
December 1993:	Priorities and Planning Guidance (MEL(1993)155)
March 1994:	Continuing Care of the Frail Elderly (letter to Directors of Social Work and Health Board General Managers)
August 1994:	Mental Illness Specific Grant (SW/9/94)
August 1994:	Community Care: The Housing Dimension (NHS MEL(1994)79, SW 7/95, ENV 27/94)

- September 1994: Care Programme Approach (letter to Health Board General Managers, Directors of Social Work and Directors of Housing)
- November 1994: Contracting for Specialist Palliative Care Services (MEL(1 994)104)
- June 1995: Care Programme Approach (letter to Health Board General Managers, Directors of Social Work and Directors of Housing)

Emphasis has been laid throughout on the need for inter-agency co-operation.

### Policy Background

4. The Care in the Community policy is to enable vulnerable people who require professional care and support to live in their own homes or in homely settings in the community as far as is possible and practical. The implications of this are two-fold: firstly developing effective community based services to prevent inappropriate admissions; and secondly transferring people to care in settings more appropriate to their needs. One consequence of this is to arrange the transfer of people from inappropriate care in long-stay NHS hospitals to community based settings with suitable and carefully planned support, when the consultant responsible for their care has decided it will be appropriate to discharge on clinical grounds; and where there has been a multi-disciplinary assessment of the patient's health and social care needs and appropriate support, accommodation and other facilities are available. The patient's General Practitioner, Social Work and Housing Authorities must be fully involved in the decisions about and arrangements for such community placements. The patient's family/carer must also be consulted. Appropriate discharge from NHS continuing care is only one aspect of the spectrum of care required for successful implementation of care in the community. These provisions should be read with all other Guidance that has issued on the organisation of social, health and housing provision for users of community care services.

5. Providing effective care for vulnerable individuals and groups can only be implemented and maintained through collaborative working between the key agencies involved. Health Boards, GP Fundholders, social work and housing authorities and Scottish Homes should continue therefore to work closely in the planning, purchasing and resourcing of care. The significant contribution that is made through the voluntary and private sectors should also be taken into account in assessing the full range of provision that is required to match services to assessed need.

6. Health Boards, in consultation with their social work and housing partners, are expected to have strategies for all priority services. Local housing authorities are required to produce housing plans and capital programmes for their area. Social work authorities for their part are required by statute to prepare community care plans. All these plans should be founded in a common set of agreed principles and objectives and community care plans should be joint between health and social work. This joint approach is intended to provide a co-ordinated strategy for the organisation and provision of care for those people who would

benefit from suitable care in the community. Arrangements should be made to involve users and carers representatives including for example, Community Health Councils, at the earliest stage of strategy development. These strategies and community care plans should focus on the development of services in the community and in some cases enable closure of some outdated NHS wards or hospitals. It is a pre-requisite of this policy that Health Boards must ensure that appropriate community facilities and accommodation have been commissioned by the appropriate authority and are in place, available and properly resourced before any transfers to the community are made from NHS continuing care. Bridging finance and resource transfer have helped facilitate these changes.

7. Since community facilities include appropriate accommodation, Health Boards, social work and housing authorities should share their assessments of future needs including the spectrum of care to be provided and the implications for the type of accommodation and related support services required. Where appropriate, contributions on future needs, should also be considered, from the Voluntary and private sectors. This spectrum of care should cover those already in the community for whom admission to hospital would be a last resort, and for those being discharged from inappropriate NHS hospital care.

8. To ensure the effective implementation of the guidance in this circular, Health Boards and local Social work authorities need to agree joint monitoring of the outcomes. The outcomes should be published each year and for each client group should cover:

- 8.1 the best estimate of the likely number of people in each client group who will need continuing health or social care (including residential and local authority funded nursing home care) during the year;
- 8.2 respective commitments in finance and activity related to continuing care;
- 8.3 contingency arrangements for managing during the year unexpected variations in the number of people requiring continuing care.

9. As with other aspects of community care, there will be occasions where a Health Board or local authority propose a significant change in the pattern of acute and continuing care services, which will impact on other agencies. In such cases the Health Board or local social work authority proposing the change must reach agreement with the other agencies including housing providers. There must be no unilateral withdrawal of current services or provision. Where such changes involve the transfer of responsibility for providing services to an individual or client group, the agencies must ensure that resources are available to provide the new service. This will involve, in appropriate cases, resource transfers in terms of the procedures set out in NHS MEL(1992)55. The aim is to better match care to needs and to provide more appropriate care in more homely settings in the Community.

#### NHS Responsibilities for securing continuing health care

10. The NHS remains responsible for arranging and funding a range of services that match health care to the needs of people who require continuing health care, whether that care is best provided in a hospital setting or more appropriately according to need, in the community.

11. Health Boards retain responsibility for meeting the health care needs of their local population, including the needs of patients discharged to the community that cannot be met by the general practitioner and the other members of their primary health care team. NQ individual discharges should take place until such time as appropriate provision, including accommodation, is available and properly resourced in the community. Patients should not be discharged from NHS in-patient care if they do not have a place to stay and if community health and social work support services required for their care are not in place in the community. As covered elsewhere, the patient's needs are paramount. Every effort should be made to avoid delays in the assessment and transfer process.

12. The NHS services which all Health Boards and GP Fundholders must ensure are available to meet the health needs of their population will include among a range of other services:

- specialist medical and nursing (in-patient, out-patient and day patient) assessment and supervision;
- mental health care;
- rehabilitation and recovery;
- general medical services;
- palliative health care;
- continuing inpatient care under specialist medical and nursing supervision in hospital, or hospice, or in a nursing home or other appropriate facility;
- short term health care (which can bring beneficial respite relief for carers);
- specialist health care support to people in nursing homes or residential care homes or the community;
- community health services, including day care where appropriate, for people at home or in residential care homes;
- primary health care;
- specialist transport services.

13. As for all other areas of NHS care, Health Boards and GP Fundholders after appropriate consultation and discussion 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 Management Executive will review

Health Board's local policies. Health Boards must be prepared to justify the balance and level of services they are proposing to arrange and fund.

#### Responsibility for decisions on discharge

14. 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 is ready to be discharged from hospital. The large majority of people, after a stay in hospital, will be able to return to their own homes.

15. In all cases of discharge from NHS long-stay care social work staff and, as appropriate, housing staff should be involved at the outset. Hospitals and social work staff should work together to ensure the most effective integration between social work assessments and care management procedures and hospital discharge arrangements. Discharges must depend on the availability of suitable housing or other accommodation being available and on the range of support services being in place and properly resourced. Effective discharge is helped by jointly agreed protocols which are regularly monitored.

16. Some patients may need intensive support including the possibility of continuing NHS inpatient care, nursing home or residential care or where practical and possible an intensive package of support at home including in supported housing. Decisions about whether to discharge 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 health, social care and housing needs in consultation with the patient's relatives/carers. It is important also to involve the relevant housing agency where appropriate. In many cases this arrangement 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 normally be responsible for assessing patients referred directly from the community who may require NHS continuing inpatient care.

17. The multi-disciplinary assessment involving patient and family/carer! advocate must be co-ordinated between key professional staff from health and social work and where appropriate, housing. The assessment process must involve consultation with the patient/carer, the patient's GP and where appropriate community health services or social work staff who are familiar with the patient's circumstances. Where a housing need is identified housing providers should be involved in these considerations at the earliest opportunity, where discharge to housing including supported housing is proposed the Health and Safety considerations of the domestic situation should be taken into account. The interests of the patient must be paramount. Where a patient has no form of accommodation to go to or where successful discharge depends on housing suitable to their needs housing information and advice may be necessary to establish if the housing is suitable. The assessment should also take account of the views and wishes of the patient, his or her family and any carer. Where other alternative provision is appropriate the proposed provider organisation should be involved at the earliest appropriate opportunity. As set out in

paragraph 11, no one should be discharged from long stay care unless arrangements are in place and properly resourced for their support, care and accommodation.

18. As set out in MEL(1992)55 and continued to this guidance, ultimately the question whether or not to discharge a patient from the care of a consultant is clearly a matter for clinical decision. Where a consultant (or a GP working in a community hospital) considers that a patient can be discharged from the care of the NHS, the fact that he or she will not be eligible, on discharge, for benefits is not a reason for keeping a patient in hospital. Although this needs to be applied with great sensitivity, it is an important principle which should govern the approach taken by Health Boards.

19. Taking account of the results of the assessment and the patient/carer view 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. In cases of challenging behaviour joint agreement must be reached with all parties on how best to respond to these particular needs and in what setting.

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

20.1 The patient needs continuing inpatient care arranged and funded by the NHS because:

- either he or she needs ongoing and regular specialist clinical supervision on account of; the complexity, nature or intensity of his or her health needs. ie medical, nursing and other clinical needs taken together; or the need for frequent not easily predictable clinical interventions; or where he or she requires routinely the use of specialist health care equipment or treatments which require the supervision of specialist NHS staff; or where he or she has a rapidly degenerating or unstable condition which means that they will require specialist medical or nursing supervision.
- or 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.

20.2 The patient needs a period of rehabilitation or recovery arranged by the NHS to prevent discharge arrangements breaking down;

20.3 The patient can be appropriately discharged from NHS inpatient care.

21. Once that recommendation has been made social work authorities will co-ordinate an assessment of needs which will determine whether the person should be offered:

- either a place in a nursing home or residential care home arranged and funded by the social work authority and/or by the patient and his or her family (paragraph 26 refers);
- 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 Board should be sought for an extra contractual referral to another hospital, hospice, or nursing home as close as is possible to the patient's own community. The Health Board will pay for such provision.

23. Health Boards and local social work authorities should have in place clear agreements on how they will resolve disputes (between themselves as purchasers) about responsibility in individual cases for meeting continuing care needs. These arrangements will be within the context of the overall joint planning agreements.

24. Health Boards, local social work or housing authorities or Scottish Homes should not place younger people inappropriately in inpatient, nursing or residential care or supported accommodation intended for older people.

### Information

25. Through existing arrangements and the development of advocacy services patients and their families and carers must be kept fully informed about how procedures for hospital assessment and discharge will work. They should receive the relevant information they require to make informed decisions about continuing care. This information should be presented in writing and/or other formats appropriate to their needs and be in clear concise terms. Personal explanations should be given on request.

- 25.1 Hospitals should provide clear written information about how hospital discharge procedures will operate and what will happen if patients need continuing care:
- 25.2 Hospital and social work staff should ensure that patients, their families and any carers/advocates have the necessary information, in writing, to enable them to take key decisions about continuing care.
- 25.3 Social work 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). These costs will include housing or other accommodation costs additional to care costs.
- 25.4 Hospital and social work 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.

26. Where patients have been assessed as needing care in a nursing home or residential care home or supported accommodation arranged by a local social work authority, they have the right under the Direction on Choice to choose, within limits on cost and assessed needs, which home they move into. Where, however, a place in the particular home or housing development chosen by the patient is not currently available and is unlikely to be available in the near future (8 weeks), it may be necessary, in exceptional cases, for the patient to be discharged to another home until a place becomes available. Account should be taken of the likely impact of on the health of the individual. The individual should be kept informed at all stages as to the availability of a place at the home of his or her first choice. People who arrange their care without local social work authority help can of course choose any home which is willing to accommodate them.

### Review of Decisions

27. Where patients have been assessed as not requiring NHS continuing inpatient care, they do not have the right to occupy indefinitely an NHS bed. Every effort should be made to reach amicable solutions in all cases.

28. In such cases the social work authority 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 are rejected it may be necessary for the hospital in consultation with the Health Board, social work authority and where necessary the 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.

### Review Procedures

30. In his statement to the Scottish Grand Committee on 1 March, Lord Fraser of Carmyllie announced his decision to introduce a procedure for patients who wish to appeal against the clinician's decision that they can be discharged from NHS hospital care. The following procedures are to be adopted by Health Boards and NHS Trusts to ensure the speedy processing of such appeals.

30.1 Patients are to have readily available information about how to appeal, and to have related help and advice from hospital staff on request. Information on independent advocacy services should also be provided. The patient's GP may also be able to offer advice and guidance as appropriate. This information (in a format appropriate to the patient's needs) should include the name, address and telephone number of the staff member(s) responsible for dealing with the appeal process.

30.2 Where a patient (or his or her relative/carer/advocate) questions the appropriateness of the clinician's decision on his/her future health care, the Director of Public Health at the Health Board in whose area the patient is being treated will in the first instance review the decision process.

- 30.3 NHS care for the appellant is to continue for the duration of the appeal process.
- 30.4 Such appeals to the Director of Public Health should be lodged within 10 (calendar) working days of notification to the patient of the clinician's recommendation on the future health care.
- 30.5 The Director of Public Health will ensure that the criteria set out in this guidance have been correctly applied. The Director's consideration will also extend to the grounds of appeal. The outcome of the initial review to be reported (in writing) to the patient or his/her representative within 14 (Calendar) days of the appeal submission. The Director of Public Health may designate a medical practitioner to assist his consideration of the appeal.
- 30.6 If, following that review, the objection is continued, an independent clinician review will be instituted. This second stage review must be notified to the Director of Public Health within 10 (calendar) days of receipt by the appellant of the outcome of the initial review.
- 30.7 Patients wishing to continue their appeal against their own clinician's recommendation may (after seeking whatever guidance they wish eg from their local health council or UP) select any Health Board area in Scotland (including the one in which they reside) from which a consultant would be nominated to arbitrate on the appropriateness of the decision to discharge for NHS continuing care. The review at this stage to be on the clinical decision only. The Health Board advising the appellant should explain any special difficulties that arise where the Health Board area selected operates on the basis of "single handed" consultants. The Health Board selected, working with its NHS Trust(s) (and Directly Managed Units (DMUs), where appropriate) should ensure that the appeal is considered and a decision announced in writing to parties within 25 (calendar) days of the second stage appeal submission.
- 30.8 NHS Trusts (and DMUs) are to make available consultants (at no charge) to act as arbiters in cases of second stage appeals by patients against proposals for their discharge from an NHS hospital.
- 30.9 The arbiter consultant will restrict consideration to the clinical aspects of the case (decisions on nursing home or residential home placements and the level of social care at home will continue to be made by the Social Work Authority).
- 30.10 For as long as the clinical assessment remains relevant the appeal outcome to be binding on all parties; the NHS Trust (or DMU) providing care to the appellant, the purchaser responsible for funding that care and; on the appellant and anyone representing his or her interests. (Paragraph 32 refers as regards continued access to alternative review and complaints procedures.)

31. Health Boards and NHS Trusts should ensure compliance with these arrangements (both in terms of availability of staff to consider appeals and in terms of service delivery) through their contracts for NHS continuing care services. The arrangement will be kept under regular review.

32. Appeals at either stage of this process will not debar individuals from access to existing procedures for review of cases including NHS complaints procedures or the referral of their case to the Health Service Commissioner.

### Conclusion

33. Health Boards, GP Fundholders and local social work and housing authorities and other contributors of care in the community should use this guidance to review their existing arrangements and practices to consider what alteration in organisation and provision of care for vulnerable groups and individuals is required.

34. Compliance with and the effect of with these procedures will be monitored by The Scottish Office through the Management Executive's monitoring of Health Boards, the Social Work Services Inspectorate and the Community Care Implementation Unit. The working of the review procedures will be reviewed. Any problems experienced will receive early attention.

35. The provisions of this Circular have immediate effect, except for the proposed new arrangements for review of decisions which must be in place by 1 April 1996.

## **NHS RESPONSIBILITY FOR CONTINUING HEALTH CARE**

1. Health Boards' responsibility to match health care to needs was re-stated in The Scottish Office evidence to the Scottish Affairs Select Committee in October 1994.

### Assessment of Need

2. Relevant health purchasers' prime responsibility is to ensure that the health needs of their resident populations are met. In community care terms this involves acting collaboratively with social work and housing partners to develop community health services taking joint account of the availability of resources and agreeing the transfer of responsibilities for those people in their care who have predominantly social care needs. Joint working involved in the preparation of health care strategies and community care plans is designed to provide the means for the necessary agreement on assessment of needs, and the range of services, social, health and housing services and accommodation required to match those needs.

### Balance of Services and Priorities

3. Relevant health purchasers 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 social work and housing 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 strategies should set out the Health Board'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 assessed need.

### Rehabilitation and Recovery

4. The question whether or not a patient should be discharged from NHS inpatient care is always a matter of clinical judgement. Relevant health purchasers must take full account of the need for appropriate services and accommodation 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 re-admissions. Relevant health purchasers should ensure that hospitals have in place mechanisms for routinely monitoring rates and causes of re-admission (in particular amongst older people) and the outcomes of hospital discharge. Details of the monitoring results should be made available on request. Monitoring should be shared with housing and social work partners and performance should also be reviewed through clinical audit. Local policies should include explicit protocols and eligibility criteria for rehabilitation. Health Boards should agree with the relevant local

authorities the need for any additional housing, social or educational support which may be required as part of an agreed package of rehabilitation.

### Continuing inpatient care

5. All relevant health purchasers 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, hospice, or in a nursing home. In addition to the other areas already set out in this Guidance Circular and Annex the NHS is responsible for arranging and funding continuing inpatient care, on a short or long term basis, for people:

- where the complexity, nature or intensity of their health needs (ie medical, nursing and other clinical needs taken together) or the need for frequent not easily predictable clinical interventions requires the regular (in the majority of cases this might be weekly or more frequent) specialist clinical supervision of a consultant, specialist nurse or other NHS member of the multi-disciplinary 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.

6. 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 paid for by the NHS. Health Boards should jointly monitor activity in this area with local authorities and identify areas where inappropriate discharges from NHS care appear to be taking place.

### Palliative Care

7. Where after the multi-disciplinary assessment, the diagnosis reveals that a person is terminally ill and requires specialist palliative health care, it is for the Health Board to ensure that the necessary provision is available. It is for the NHS to meet the full costs of that care whether the care is undertaken by an NHS Trust, a voluntary body, a private sector company or any other provider.

8. Health Boards should continue to work closely with the voluntary sector and other carers in the organisation and provision of palliative health care. The most recent guidance on the arrangements for this care issued in November 1994 under cover of MEL(1994)104.

9. People in the community, whether in their own home or a residential or nursing home or supported accommodation are cared for by their GP and the primary care team. Where an individual living in a nursing or residential care home under the care of a UP is assessed as requiring specialist palliative health care, the Health Board are responsible for arranging such

care. Broadly, for those in residential care homes, Boards will be expected to arrange for specialist palliative health care for them as if those people were living at home. For those in nursing homes, Boards should arrange for the provision of any necessary additional specialist palliative care in addition to general nursing (which will continue to be included in the local authority's contract with the home). Specific arrangements for this should be agreed locally between the Health Board and the local authority. Local discussion and agreement are the key to seamless and responsive care.

### Short Term Health Care (Respite)

10. Social work authorities will in many cases have the lead responsibility for arranging and funding respite care. But relevant health purchasers should continue to arrange and fund short term care where the patient's health needs require it, usually in a planned way but also to meet unforeseen circumstances. Relevant health purchasers in organising short term health care should relate to the health needs of the individual rather than the social needs of the carer(s), although relief for the carer(s) will of course be an important by product of the health care. Social work authorities and health care purchasers should of course work together with housing partners to maximise the social benefits of these planned episodes of care. In addition, they should recognise that social respite care may require regular inputs from primary or secondary health care services.

11. In particular relevant health purchasers should address the health needs of:

- people who 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 short term health care require or could benefit from active rehabilitation;
- people who require day hospice care;
- people who are receiving a package of palliative care in their own homes;
- people with challenging behaviour.

12. In making arrangements for short term health care relevant health purchasers should pay careful attention to the wishes of patients and their carers.

13. Comprehensive policy guidance on the provision of respite care and short term health care is being issued separately.

### Access to specialist or intensive medical aid nursing support for people cared for in nursing homes, residential care homes or supported housing, or their own homes

14. Those appropriately placed by social work authorities in nursing homes and those who have arranged and funded their own care may still require access to specialist medical, nursing or other community health services. This access 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 may also include specialist medical or nursing equipment (for instance specialist feeding equipment) not available on prescription and normally only available through hospitals. Basic equipment such as incontinence supplies if prescribed by the General Practitioner will be provided through the NHS at no charge.

15. Access to specialist medical and nursing services should be available on exactly the same basis for those people receiving social care and community health services support in residential care homes, supported housing, or in their own homes.

16. Assessment procedures and arrangements for purchasing care should take account of such needs and details should be identified in individual care plans. The Health Boards can either provide such services directly or contract with the accommodation provider to provide the additional services required. Such additional NHS services must be free at the point of delivery.

17. Health Boards should collaborate with social work authorities, housing bodies, General Practitioners and independent providers to agree protocols and eligibility criteria for this NHS support.

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

18. Community health services are a crucial part of the provision of continuing care for people at home or in residential care. Health Boards should work closely with users, local social work and housing authorities, Community Health Councils, Scottish Homes, GPs, hospital and community provider units and the voluntary and independent sector to agree the likely demand for continuing community health services support.

19. Factors which must be taken into account in these assessments include:

- 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 care provided to of residential or nursing homes or supported accommodation (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).

20. This should be reflected in Health Boards' policies on continuing health care, relevant health purchasers purchasing plans and in community care plans. Relevant health purchasers 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.

21. Policies should also indicate how Health Boards 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.

### Specialist Transport

22. Within their strategies for continuing care, Health Boards should identify what arrangements are required for securing ambulance and other specialist transport services. These should include, on the basis of the patient's needs as determined by the clinician responsible for their care:

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