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NHS Continuing Care of Elderley People

HEALTH NEWS BRIEFING

NHS Continuing Care of Elderly People

Report of a survey of CHCs

December 1990

NHS CONTINUING CARE OF ELDERLY PEOPLE

C O N T E N T S

Introduction

Whilst the Government White Paper, "Caring for People"[1], affirmed that there will continue to be an important role for continuing NHS care of elderly people, the reality is somewhat different. As a result of a combination of factors, the situation facing many elderly people in need of long-term nursing care is deteriorating in terms of quality and choice. The supply of continuing NHS care of elderly people is falling well short of the demand and there is evidence from several sources that much provision which is available is of poor quality. Pressure is too often placed on elderly patients and their relatives to move out of hospital into private nursing homes with little or no consultation, choice or information. Once they are receiving private nursing care, many residents experience financial difficulties and consequent distress.

ACHCEW sent a questionnaire to its members to examine the extent of these problems and the results confirm that there is a shift occurring away from NHS continuing care of elderly people and towards private provision. Many health authorities are pursuing an overt policy of reducing their provision of continuing care beds, with the justification that this is part of the necessary move towards caring for more elderly people in the community. However, this shift is taking place with more expediency than planning and without sufficient consideration of the preferences and needs of the users concerned.

The future role of health authorities in providing, and after 1991, purchasing continuing nursing care for elderly people remains unclear. It is recognised that continuing care NHS hospital wards may not always be the ideal form of provision for people needing continuing nursing care and in many cases it may be more appropriate for some people to move into smaller, private or NHS nursing home units. Nevertheless, NHS beds still need to be available as an alternative for those elderly people who cannot or choose not to move to private care. Some continuing care wards are also used for respite care, enabling reassessment of the needs, medication and capabilities of the patient.

As the implementation of the new arrangements for community care have been delayed and the extent of funding available to local authorities to fulfil their enabling role has yet to be made explicit, it seems premature to relinquish so many NHS beds. This is particularly important whilst the responsibility of NHS authorities to provide and purchase continuing care for elderly people remains unclear. It would seem that many health authority policies in this regard are motivated more by financial considerations than philosophical principles of community care.

SUMMARY OF QUESTIONNAIRE FINDINGS

Over half (55%) of CHCs responding stated that overall NHS continuing care provision for elderly people is getting worse.

Three quarters (77%) of respondents reported a reduction in the number of continuing care beds over the last 3 years.

82% of respondents reported an increase in the number of private nursing home places over the last 3 years.

One third (32%) of respondents stated that their health authority places some elderly people in contractual beds.

Over half (59%) of respondents said that they receive complaints from elderly people about feeling pressurised into finding a private nursing home place.

Over half (53%) of respondents stated that elderly people are experiencing problems with discharge arrangements, in terms of lack of information and choice.

61% of respondents reported that they provide information for elderly people on private nursing homes.

17% of respondents stated that their health authority employs "homefinders" to help elderly people find a private nursing home place.

64% of respondents stated that elderly people in their district are having problems with meeting the full cost of their care in private nursing homes.

27% of respondents stated that private nursing home places in their district are covered by DSS payments.

39% of respondents reported that private nursing homes in their district have procedures to deal with complaints.

QUESTIONNAIRE RESULTS

75 CHCs returned the questionnaire, a response rate of 38%. A sample copy of the questionnaire is in Appendix I.

1. Reduction in continuing care NHS beds

"Caring for People" confirmed the Government's commitment to make available a wider range of options for people needing continual nursing care. However, the White Paper made the following assertions in relation to the need for NHS continuing care provision for elderly people and the responsibilities of health authorities:

> "...there will be others, in particular elderly and seriously mentally ill people and some people with mental handicaps together with other illnesses or disabilities, whose combination of health and social care needs is best met by care in a hospital setting. There will be a continuing need for this form of care." (Cm 849, para 2.5)
>
> "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." (Cm 849, para 4.21)

In practice, the commitment to providing NHS continuing care is less convincing. There is little incentive for health authorities to make available provision for continuing care, when Government policy is encouraging the development of independent provision. In fact there is an incentive for health authorities to move highly dependent elderly patients to the private sector so as to avoid the drain on NHS budgets. As a consequence the numbers of continuing care beds are being reduced, whilst the elderly people or their relatives are often bearing the cost.

> **77% of CHCs who responded to the questionnaire reported a reduction in the provision of continuing care beds over the last three years.**

The breakdown of responses was as follows:

No. of beds closed in last 3 years	% of CHCs
No reduction	23%
Not known, but reduced	14%
1-19	12%
20-49	21%
50-99	11%
100-199	14%
200 +	5%

This overall reduction in many health authorities' continuing care facilities would not in itself be a problem if suitable alternatives were available in the community and if enough beds were retained for the purposes of respite care. However, the beds are being closed without other forms of provision being offered in their place, such as smaller, residential or nursing home units run by the NHS. This means that some elderly people, their relatives and carers are faced with the discovery that there is no NHS provision for non-acute nursing needs.

This fact should be considered within the context of demographic changes. Population projections (Office of Population and Censuses and Surveys 1987) suggest that there will be a 32% increase in the number of people aged over 85 between 1988 and 1995. A report by the National Association of Health Authorities[2] states that the most likely significant demographic effect of this increase will be on the demand for long-stay care.

2. Contractual beds

Health authorities have powers to take out contractual beds in private nursing homes, where the health authority pays for the full cost of the place. However, as ACHCEW's survey shows, this practice is not very common.

Only one third of CHCs said that their health authority has contractual beds and of these, over half have 30 beds or less through this arrangement.

CHCs have access to registered premises where the NHS has contractual arrangements, on similar terms to those on which they visit NHS premises. Recent Department of Health guidance[3] (EL(90)185) affirms this, stating that district health authorities should secure visiting rights for CHCs to private sector premises through contracts. In these cases CHCs can monitor the level and quality of service being provided.

If health authorities took out more contractual beds, not only would this provide elderly people with more choice, but there would also be a greater opportunity for CHCs to gauge whether the needs of NHS-supported residents in private nursing homes were being met. At present, very few elderly people are informed that the health authority has the power to take out contractual beds and therefore they are not in a position to ask for this arrangement.

There is some confusion between the terms "contractual" beds and "contracted" beds in private nursing homes. The former are beds for which the contracting health authority will pay - the person occupying the bed is not charged. In contrast, "contracted" beds are those for which the health authority pays a flat rate to keep an agreed number of beds available for patients it may refer. The convenience of keeping some beds available is paid

for, but the resident is still liable to pay for his or her own place.

3. Quality of NHS continuing care

Compounding the problem of the lack of NHS continuing care for elderly people is that of poor quality of care which is sometimes encountered. A review of Health Advisory Service reports by Age Concern[4] documents the failings of much continuing care provision. Particular problems which were highlighted were inappropriate buildings with overcrowding and shabby surroundings, inappropriate care both in terms of the mix of patients and local accessibility, traditional, custodial daily routines and inadequate staffing levels and lack of training.

Many of these points were picked up by CHCs who have the statutory right to visit hospitals and monitor the standard of services. Stockport CHC noted the problems experienced in mixed sex continuing care wards, where there is acute embarrassment over the use of bed pans - some elderly patients feel very uncomfortable being in bed next to a patient of the opposite sex. Staffing shortages generally, and the lack of suitably trained staff in particular, were also highlighted as a factor contributing towards poor quality care. Many private nursing homes will not (and perhaps cannot) accept the most frail, dependent and demented patients. The NHS then has a more profoundly aged and dependent population of patients requiring highly trained staff. With staffing shortages and inadequate numbers of continuing care beds already causing difficulties, lack of training in the necessary skills exacerbates the problem.

In 1983 the Health Care Research Unit at the University of Newcastle was commissioned by the DHSS to undertake an evaluation of the three experimental NHS nursing homes set up by the DHSS in 1983 and 1984. The evaluation report in 1989[5] indicated that residents in the three NHS nursing homes were not disadvantaged; this form of care was preferred by both residents and relatives; and it was no more expensive than continuing care provided in NHS hospitals. The report recommended that NHS nursing homes should be developed as continuing care accommodation.

4. Increase in private nursing home places

Partly because of the inadequacy of NHS provision and partly because of the financial incentives created by the social security system, there has been a dramatic and unprecedented growth in private nursing homes. This expansion has not necessarily met the gap between the demand and the supply and has engendered further potential problems for elderly people, particularly in the areas of personal financial contributions towards their health care.

Responses from CHCs to the questionnaire bear out this trend towards greater private continuing nursing care of elderly people.

82% of CHCs who responded reported an increase in the number of people entering private nursing homes over the last three years.

The breakdown of responses was as follows:-

(12 respondents did not answer this question and one CHC reported that there were no private nursing homes in its district).

Increase in number of places	No. of CHCs
0-49	4
50-99	7
100-199	5
200-500	13
over 500	9
unknown, but increased	24

This increase in private nursing home provision has various implications for the care of elderly people and the work of CHCs. Quality of care in these homes is difficult to gauge as the needs of the residents become "invisible" and cannot usually be monitored by Community Health Councils. Although some CHCs have developed good working relationships with the proprietors of private nursing homes and in some cases are allowed to visit, this is not a formal right. CHCs instead can monitor DHA policies towards the private sector, making reference to good practice in discharge procedures.

Another issue affecting the quality of care in private nursing homes is the gap between social security payments to residents eligible for income support and the true cost of fees. There are fears that inadequate income for homeowners is more likely to result in falling care standards rather than home closures; the quality of life for many elderly people could be affected by savings on staff, more shared rooms and "extras" like outings. Financial pressure could also precipitate the development of larger units or homes which provide economies of scale but do not conform to the small scale homely environments envisaged in the White paper. And of course there is the issue of "topping up" by elderly people and their relatives and carers to meet this shortfall, as explained in section 7.

5. Discharge from hospital

The Health Circular HC(89)5[6] and accompanying booklet set out guidelines for ensuring good discharge arrangements,

including the provision of information to families with the necessary information and reassurance about the care of the patient after discharge. District health authorities were to agree up to date discharge procedures and to report to their regional health authorities by 31st March 1990. Of particular importance to this survey is the statement in the accompanying booklet to the guidance as follows:

> **"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."**

The questionnaire asked CHCs whether they were aware of any particular problems in relation to elderly people being discharged from continuing care beds into private nursing homes.

> **Over half of those CHCs which replied stated that they were aware of problems in relation to the discharge of elderly continuing care patients into private nursing homes.**

The following were seen as particular problems:

Patients, relatives and carers not being fully consulted before the patient is discharged (63%)

Patients not being given adequate information on their rights, in relation to discharge procedures and financial contributions towards private care (63%)

Patients not being given a choice of other alternatives (70%)

> **61% of CHCs who responded saw no improvement in discharge procedures and in user involvement in the process.**
>
> **16% of CHCs who responded stated that the extent of user involvement in discharge arrangements is diminishing**
>
> **76% of CHCs who responded said that hospitals in their district had written discharge procedures in place.**

Of the hospitals where there are written discharge procedures, there are still those where procedures break down. It is clear that there is some way to go before elderly patients are fully informed about their rights and choices when preparing for

discharge from continuing care and also acute wards in hospitals. The delay in introducing the new community care arrangements can only compound difficulties in implementing hospital discharge procedures.

An example of good practice which other health authorities could look to was reported by South Birmingham CHC. In this case, the DHA set up a panel of health authority members to oversee its proposed closure of two elderly continuing care wards with patients being moved to a new nursing home. The member panel oversaw individual assessments carried out by staff on all one hundred continuing care patients and twenty were identified as those who "could benefit" from nursing home care. The families were invited for an individual interview with the District Nursing Service, doctor and community placement officer and the CHC or Citizen Advocacy representatives. This is a vast improvement on about fifty other discharges, made on a one-off basis over the last couple of years, about which the CHC received several complaints.

The responsibility of the NHS to provide, and after April 1991, to purchase nursing care for elderly people remains unclear. For example, in East Cumbria up to fifty elderly mentally infirm patients were discharged into a private nursing home. The consultant who medically discharged them visits the home once a week to monitor the patients and a hospital doctor visits daily. Although the DHA has no contract with the home to pay for these patients, the visits by the consultant and hospital doctor are carried out as part of a service normally available to NHS patients and appear to imply that continuing regular medical care is needed beyond that which a primary care team could offer.

ACHCEW sought clarification from the Department of Health as to whether it would be more appropriate for the DHA to take out a contract with the nursing home for the care of patients transferred to the home, as the DHA has a continuing medical responsibility for these patients. The response did not clarify the extent to which health authorities have a responsibility for the continuing nursing care of elderly people; the Department's reply stated that it is for individual health authorities to decide the extent to which they make such arrangements.

6. Help with finding a private nursing home

If a health authority makes it clear to an elderly patient that there is no alternative but to move into a private nursing home, it is important that there is as much independent advice and information available to that person as possible on nursing homes available and their personal financial responsibility. This will enable the person concerned to make an informed choice about their future care. It is the policy of some health authorities to employ "homefinders" or placement officers who are responsible for helping elderly people find places in private nursing homes.

Less than one fifth of those CHCs which responded stated that their district health authority employed "homefinders".

Of these, three quarters felt that the homefinders were useful, placing emphasis on patient choice and taking an independent and balanced approach. One CHC commented that these homefinders would also be very useful for people moving from home into private nursing homes in addition to those moving from hospital. Several of those CHCs whose DHAs do not employ homefinders stated this role was fulfilled by hospital and other social workers. One CHC from this group said that a "resettlement team" exists, mainly for people with a learning difficulty, whilst two other CHCs said that their DHAs were hoping to or considering setting up such a post.

The questionnaire also sought to determine the extent of CHC involvement in providing elderly people with information and advice about private nursing homes.

61% of CHCs who responded said that they provided elderly people with information on choosing a private nursing home.

Information provided is very varied, ranging from a straightforward list of homes (one third), to more detailed leaflets and factsheets (39%) posing questions which elderly people should ask themselves when choosing a home. There are also even more comprehensive consumer guides to homes, which cover such things as the size of homes, type of food, medical and personal care, activities, visiting, charges and admission arrangements.

7% of those CHCs which provide information said that they were rarely asked for it. A small minority of those which responded felt it difficult to comment on the quality of care provided in private nursing homes, particularly as there is the risk of complaints if a referral turns out to be a bad choice.

7. "Topping up" payments

Residents in private nursing homes with savings of less than £8000 are eligible for income support. With social security payments for private residential care now exceeding £1.1 billion a year, the Government is looking for ways to curb total payments even though home owners and residents have been claiming for some time that the grants are inadequate to cover the full cost of fees.

A recent seminar was held by Age Concern, "What price care?" , in which ACHCEW participated. A joint statement was produced, calling on the Government to introduce a substantial, immediate

increase in the level of income support for those in residential and nursing home care which takes into account increases in running costs, particularly staffing and servicing mortgages and taking greater account of geographical variations in costs of care provision.

Some progress has been made in this area. There was a £10 increase in August 1990 bringing the grant up to £200 a week for nursing home care. The British Federation of Care Home Proprietors estimated that even after this rise there would still be a shortfall of £30 to £50 a week. Following pressure from numerous groups who called for further increases in levels of income support, an additional increase was announced in October. Nursing home residents can now claim £255 a week in income support and the London supplement has risen from £23 to £33 a week. This may have narrowed the gap between benefits and fees to some extent, but there are still some places whose fees exceed DSS limits.

The statement in the discharge booklet mentioned earlier makes it clear that no NHS patients should be placed in a private nursing home against their wishes if it means they, or a relative, will have to contribute towards the costs of care. However this is rarely made clear to the users concerned. Considerable pressure is often placed on patients and relatives to "find" a place in a private nursing home after hospital discharge assessment has ascertained that they need care, but it is not available through the NHS. It is often the case that the elderly people themselves, or relatives and carers, feel obliged to find the necessary resources to meet their fees in full, or if they are on income support, to "top up" the difference between social security payments and the full cost of fees.

These problems have been well documented elsewhere, but the questionnaire confirmed the scale of the difficulties faced by elderly people.

64% of CHCs who responded were aware of residents in private nursing homes in their districts who are experiencing, or have experienced, difficulties with "topping up" payments.

40% of CHCs who responded said that the situation was getting worse.

The remainder felt the situation was the same or were not sure - only one CHC reported that the situation with regard to "topping up" was improving.

Many examples were cited of the type of problems being encountered. These are just some of the examples:

St. Helen's & Knowsley CHC has produced a dossier of case studies highlighting the pressure put upon patients' relatives to move them into private nursing homes. In some cases relatives discover that, contrary to what they were led to believe, DSS payments only cover part of the cost and that they have to make up the considerable shortfall.

Dewsbury CHC - a wife is paying £10 a week out of her pension towards her husband's fees in a nursing home, whilst a daughter is paying £200 a week for her mother's nursing home place (in both instances, residents get DSS payments).

Gloucester CHC - a family were "topping up", but while the sale of property was going through, (in order to free more money to pay for fees) interim DSS payments were stopped and the family was told to take out a bank loan to cover the costs until the sale of property was completed.

Bolton CHC - some private nursing homes take all the residents' DSS money, including "pocket money". Residents are usually given one month's notice if they cannot meet the difference between DSS levels and home fees.

North Tees CHC - a form of "elderly apartheid" is developing in a single unit, as homes have wings allocated for residents receiving DSS payments.

Merton & Sutton CHC - charitable funders are beginning to limit their contributions towards "top ups".

Redbridge CHC - The expense of many local private nursing homes means than many elderly people have to look outside London to those where DSS levels cover the full costs. One elderly couple were effectively separated in their last days when the 80 year old husband was terminally ill in a remote nursing home, whilst his wife in her seventies was left with £49.50 a week after paying his fees, and still had to meet the cost of travelling to see hims

Only a quarter of CHCs who responded said that there were places in private nursing homes in their district where social security payments completely cover the fees.

Of these, half said that only a very few places were covered, whilst the other half said that over 50% of places were covered.

The results of a survey by Bath CHC in 1989, showed that there were relatively few beds available in the Bath District at the DSS rate of fee support.

There is considerable disparity in the practice of private nursing homes in relation to the provision of the full range of medical care.

43% of CHCs who responded said that nursing home fees did not cover the cost of chiropody, whilst 44% of CHCs said that incontinence aids were not included in fees.

Physiotherapy and occupational therapy were also mentioned by some CHCs as being services for which extra charges were levied - in Aylesbury Vale private nursing homes the charge is £12 a half hour for physiotherapy.

ACHCEW is continuing to seek clarification from the Department of Health regarding the provision of medical care in private nursing homes, in particular the free provision of incontinence and other ancillary medical services to residents. These are services to which people would have free access were they living in their own homes or cared for in NHS hospitals. It is the evidence of CHCs that many health authorities consider that because private nursing homes are required to provide appropriate levels of care for their residents, the cost of providing ancillary services should be met by the homes and reflected in their fees. Health authorities are therefore making charges to private homes for the provision of NHS medical care. However, private nursing homes are not including these charges in their overall fees and residents and their families are being asked to make additional payments for essential health services.

8. Complaints

We asked CHCs whether they had received any complaints from elderly people, their relatives or carers, who feel that they are being pressurized by hospital consultants or other health staff to find a place in a private nursing home.

Over half (59%) of CHCs who responded reported that they had received complaints.

The type of problems that were cited included the following:

patients and relatives given impression that there is no alternative to private provision;

the onerous expense of funding a place in a home - some patients were advised to sell their homes or to take out a second mortgage;

private care is not always appropriate, for example in cases of terminal illness or severe dementia, but the option to stay in hospital is not always available;

the lack of support services in the community leave private provision as the only option;

the demand for acute beds increases the pressure on the NHS to try and move patients out of continuing care beds;

poor condition of wards due for closure.

Bradford CHC conducted a survey of the transfer of patients from Heaton Royd and Stoney Ridge hospitals[8]. The CHC found that relatives of the patients concerned felt they were not given enough information, and what was given was not sufficiently sensitive. Relatives felt rushed into making a decision, whilst others were not even given a choice - private nursing home was the only option offered.

39% of CHCs who responded reported that private nursing homes in their area had procedures in place to deal with complaints.

One fifth said that there were no such procedures, whilst 13% reported that some homes did and others did not. Procedures vary from verbal instructions to nurses about what should be done if a complaint is made to more formal written procedures.

One instance of good practice is in East Surrey, where the CHC was asked by the health authority to include guidance on making a complaint in the CHC's leaflet about nursing homes. This leaflet is then used by the Registration Officer.

9. Overall picture of continuing nursing care of elderly people

Over half (55%) of CHCs who responded stated that the overall picture of NHS continuing care of elderly people was getting worse.

For those who are able to afford private provision, there may be improvements in the quality of care, but for those who are less well off it is clear that NHS provision is diminishing in terms of beds available and quality. There is little or no choice for people who cannot afford private nursing care.

Elderly people who are in receipt of DSS benefits may find this lack of choice further compounded. In a survey carried out by Eastbourne CHC in 1989 it was found that those people with no private financial resources who are reliant on DSS funding were far less likely to be admitted to private nursing home care. 65%

of those nursing homes surveyed reported that they no longer admitted DSS-funded residents.

ACHCEW is very concerned at this picture of inequitable access to nursing care, whether private or publicly funded. The Association considers that appropriate care should be available to elderly people, regardless of their ability to pay.

RECOMMENDATIONS

In the light of this survey and other evidence, ACHCEW recommends that

1. Any closure of continuing care NHS hospital wards should only proceed when appropriate alternative provision is made available;

2. Elderly patients should be given all the information they need to decide whether or not they wish to stay in hospital or transfer to alternative provision, including private care or care at home in the community with the necessary support services;

3. Specialist staff should be introduced to provide dispassionate advice and information for elderly people moving out of hospital and into alternative provision;

4. Sections 1 and 2 of the Disabled Persons Act 1986 should be implemented immediately so that elderly patients can have access to advocacy services they may require and request in order to make informed choices about their care;

5. Discharge procedures should be vigorously monitored and good practice encouraged;

6. Adequate resources must be forthcoming for these options to be a reality;

7. The Department of Health should clarify the responsibility of health authorities to provide, and after April 1991, to purchase continuing nursing care of elderly people, and make clear whether this responsibility extends to the provision of other ancillary services, such as incontinence aids, to elderly people in private nursing homes.

8. The Department of Health should continue to promote a role for NHS nursing homes as an alternative form of provision.

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6. DEPARTMENT OF HEALTH (1989), HC(89)5, Discharge of Patients from Hospital.

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APPENDIX I

QUESTIONNAIRE ON CONTINUING NHS NURSING CARE OF THE ELDERLY

This questionnaire is designed to elicit the problems you have in your District in relation to long-stay NHS care for the elderly. If you cannot complete all the sections, please do as much as you can and return to Carole Auchterlonie at ACHCEW by **30 September.**

* * * * * *

Name of CHC _____

1. Reductions in long-stay beds

Can you state or give an estimate of the number of long-stay NHS beds which have been closed in your District in the last 3 years?

_____

_____

2. Increase in private nursing home places

Can you state or give an estimate of the increase (if any) in people entering private nursing homes in your District in the last 3 years?

_____

_____

3. Contractual beds

Does your DHA pay for any contractual beds in private nursing homes? **YES/NO**

If YES, how many? _____

4. Discharge

a) Are you aware of problems in your District with elderly people being moved from long-stay wards in NHS hospitals into private nursing homes? **YES/NO**

If YES, are the following seen as being particular problems?

* patients, relatives and carers not being fully consulted before the patient is discharged? **YES/NO**

* patients not being given adequate information on their rights, in relation to discharge procedures and financial contributions towards private nursing care? **YES/NO**

* patients not being given a choice of other alternatives? **YES/NO**

Do discharge procedures and user involvement in the process appear to be getting worse or better?

BETTER/SAME/WORSE

b) Do hospitals in your District have written discharge procedures? (These should have been in place by March this year) **YES/NO**

5. Help for elderly people in finding a private nursing home

a) Does your DHA employ "homefinders" or placement officers, who are responsible for helping elderly people find places in private nursing homes? **YES/NO.**

If YES, how many? Are they useful (do they inform patients of their rights in relation to discharge procedures?) or seen as biased? Please give details _____

_____

_____

_____

b) Does the CHC provide elderly people with information on choosing a private nursing home? **YES/NO**

If YES, please give details (for example, directories and information on local private nursing homes, advice on benefits and financial payments).

_____

_____

_____

_____

6. Problems with "topping up" payments

a) Are you aware of any residents of private nursing homes in your District who are experiencing or have experienced difficulties with "topping up" payments (i.e. the financial contributions made by either residents or their relatives to make up the difference between the social security payments towards their care and the actual fees of a private nursing home place). **YES/NO**

If YES, please give details _____

_____

_____

Is this situation getting better or worse?

BETTER/SAME/WORSE

b) For how many places in private nursing homes in your District do social security payments completely cover the fees?

_____

c) Do private nursing home fees in your District cover the full range of medical care? For example, do they cover:

chiropody services: **YES/NO**
incontinence aids: **YES/NO**

other _____

7. Complaints

a) Has the CHC received any complaints from elderly people, their relatives or carers, who feel that they are being pressurized by hospital consultants or other health staff to find a place in a private nursing home? **YES/NO**

If YES, please give details _____

_____

_____

_____

b) Do private nursing homes in your District have procedures to deal with complaints? **YES/NO**

8. Long-stay NHS provision

a) Is the overall picture in terms of long-stay provision for the elderly getting better or worse?

BETTER/SAME/WORSE

b) Are you aware of any other problems in your District in relation to long-stay NHS provision for the elderly? **YES/NO**

If YES, please give details (for example, if there is an overall lack of provision, where do elderly people go for continuing nursing care?)

_____

_____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE

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