WRIGLEYS
SOLICITORS

NHS continuing care: why you may lose

The meaning of the phrase "nursing and other healthcare"

Austin Thornton
2019

Austin Thornton, Community Care Solicitor and Court of Protection Deputy

austin.thornton@wrigleys.co.uk

Summary

There is a substantial and growing disconnect between the public who see their relatives suffering from profound disability and illness, often involving neurological disorders such as dementia and stroke, and the view of NHS continuing care teams in Clinical Commissioning Groups that such patients do not mainly have health needs and for whom the NHS will only provide very limited health support. As a result, the care of these patients is mostly privately funded or jointly funded by the social services department and the patient.

The standard justification for this practice is that the health needs of the patient are not intense complex or unpredictable enough to be an NHS responsibility. This rationale has a superficial connection to the method of determining eligibility set out in the National Framework published by the Department of Health but it operates not according to the Framework but to criteria regarding the determination of a "primary health need" that pre-date it and which reflect a longstanding institutional preference to apply resources to acute hospital and specialist care and minimising the provision of long term continuing health care.

This approach holds that a patient is not eligible for NHS continuing care if the nature of the care they require is that which the facility (generally a nursing home) usually provides for this kind of patient and the patient does not require additional skilled/registered nursing or other NHS staff inputs beyond its usual service for patients with these needs.

This paper looks at whether this working practice is lawful. It concludes that it is beyond the remit of local authorities set out in the Care Act 2014 to provide a service for end stage neurological disease patients which is practically indistinguishable in appearance from long term hospital care. This is because the patient has no capacities which a social services department can support in any other aspect of their wellbeing than their immediate needs for health care. The practice relies on a definition of general nursing work done in a nursing home as being not health or nursing care for the purposes of the relevant test of eligibility. This paper holds that there is insufficient legal justification for a view that general nursing care provided to patients with these needs is not nursing care within the meaning of the NHS Act.

The case of AB

AB has advanced Huntington's disease.

Huntingtons disease is a neurological degenerative condition. The pathological hallmark of HD is the degeneration and atrophy of the striatum which is a critical component of the motor and reward systems. As the disease progresses there is also involvement of the cerebral cortex and other structures. Late stage Huntingtons may involve a full dementia.

AB has such a full dementia and a profound loss of mobility. He cannot communicate. He has no understanding of risk, he is doubly incontinent, he is totally dependent for nutrition and hydration, has a pressure sore prevention regime and is administered medication. He is rarely moved from his bed. He is subject to the full set of risk assessment and monitoring protocols necessary to maintain a person's life when the person is totally unable to contribute to this themselves.

Notwithstanding that if he were not cared for, AB's health would deteriorate within hours and he may die within a few days, the health authority and much of the NHS considers that AB is not eligible for NHS continuing care because he has very few health needs.

Instead his needs are considered to be for what is referred to as basic and fundamental cares. These cares deal with such matters as eating, drinking, continence, skin maintenance, hygiene and mobility. Assistance with these basic bodily functions is not considered to be health care because these are functions that every person has. It is not considered relevant that AB is unable to perform any of these functions for himself.

The case of AB is materially indistinguishable from those of hundreds of others suffering from profoundly disabling dementia or other neurological damage with a variety of causes including from stroke and who, because they have been held ineligible

for NHS continuing care, are either funding their health care almost entirely themselves or jointly with a social services department.

This paper looks at whether this approach to identifying health needs and the decision as to whether a person with such needs is eligible for NHS continuing care that follows from it is correct.

The legal problem

The decision as to whether a person is eligible for NHS continuing care is the application of a legal test to a body of evidence about needs. As such it is a legal judgement.

The legal test, which is described more fully below, is set out in some leading court cases, in regulation and in the Department of Health Framework guidance.[1]

It is uncontroversial that underlying the test of eligibility is a balancing judgement as to whether the individual has a primary health need. The decision is, on a basic level, about whether the person's needs are mainly health needs. The controversial question in cases such as AB, is that when the balance is judged, which aspects of care go on either side of the scales?

In making this judgement, it is necessary to answer the question, what is a health need? This paper argues that this issue is at the heart of so much of the concern about the operation of the NHS continuing care scheme.

The level of sophistication with which individual health authorities make decisions on eligibility varies greatly. At the simplest level, a health authority may believe it is acting correctly if it considers whether the so called "4 factors" of the nature, intensity, complexity and unpredictability of the care require the facility delivering the care to provide more than their routine service. In this judgement, the requirements of routine care appear on the side of the scales which is "not health care"; whilst the specialist support and additional registered nursing requirements, or care assistant work of an equivalent level of skill, weigh in favour of eligibility.

Buried in this approach is an unstated definition of the term "nursing" as it appears in the NHS Act 2006 (the Act). This view does not treat general nursing care provided by care assistants in residential care as a health care activity, the provision of which comes within the purposes of the Act.

In the example case, this argument can be formulated to the effect that AB is not suffering from "illness" within the meaning of that term in the Act. That is, AB does not require *medical treatment* or *nursing* for his conditions within the meaning of those terms in the Act. In the conventional parlance of eligibility discussions, these are "social care needs" and are the responsibility of the local authority social services department.

Whilst there must be some basic understanding of what constitutes treatment and nursing underpinning the operation of the Act, this definition can create a significant barrier to the provision of care if that definition is construed restrictively, in particular to exclude what is often referred to as generalist, ie non specialist, nursing tasks. It is argued below that although there is some case law in support of this, to substantially rely on a definitional approach to the eligibility test in order to shift care tasks from one side of the scales to the other, is likely to be wrong in law.

A different approach to demarcating the scope of NHS provision relies on the discretion afforded by the NHS duty set out in section 3 of the Act. That discretion allows the NHS to determine what health cares shall be considered a necessary and reasonable requirement upon the NHS. In deciding this, it is established law that the NHS may take account of its resources.

Relying on these discretions, the approach would be that the care of AB can properly be described as health care which the NHS could provide under the Act, but it is also care of a nature that a social services department can provide. As a matter of policy, the NHS (in its guise of the local Clinical Commissioning Group), decides that the provision of this health care is not a necessary or reasonable requirement such that the NHS should provide it. It is argued below that the NHS properly restricts its health provision relying on its discretion in this way.

[1] The latest edition of the guidance is March 2018 and took effect on 1st October 2018.

Under this approach, general nursing commissioned by a local authority counts on the health care side of the scales when considering the primary health need test.

Any health authorities who adopt a restrictive definition of health care that shifts general nursing to the "not health" side of the scales are failing to apply the key principles identified in the Coughlan case.

Since this practice is increasingly widespread, and is perhaps the dominant interpretation at local level, cases such as AB are being wrongly assessed.

The gulf between public perception and NHS practice

Whether or not it is described as such, the definitional approach has wide acceptance amongst health authorities and NHS England. The Health Service Ombudsman appears to accept the NHS view that this approach is good practice.

Yet as a matter of ordinary language, most members of the public would consider it obvious that AB is suffering from illness and has substantial health needs, indeed does not need anything other than health care. They are likely to believe health care for a person so severely disabled by neurological disease should be provided by the NHS. They would not regard it as the function of a social services department to provide end stage care for persons so profoundly disabled, or that having wealth above the capital limit, they should be required to pay for their own health care.

It is argued that there has thus developed a substantial disconnect between the public and the NHS over eligibility for NHS continuing care which it is necessary to remedy, either by the Department of Health creating clarity or by a new substantive challenge via judicial review.

What is NHS continuing care?

NHS Continuing Healthcare means a package of ongoing care that is arranged and funded solely by the NHS where the individual has been assessed and found to have a 'primary health need' as set out in the National Framework for NHS continuing care 2018.[2]

What is NHS continuing care?

The primary health need test is an attempt to render in more accessible language, a legal test that is set out in regulation.

The regulatory test is set out in Box 1.

Box 1 - The regulatory definition of a primary heath need

National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 regulation 21(7)

"In deciding whether a person has a primary health need in accordance with paragraph (5)(b), a relevant body must consider whether the nursing or other health services required by that person are--

(a) where that person is, or is to be, accommodated in relevant premises, more than incidental or ancillary to the provision

[2] Framework page 7 – Key Definitions

of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide; or

(b) of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide,

and, if it decides that the nursing or other health services required do, when considered in their totality, fall within sub-paragraph (a) or (b), it must decide that that person has a primary health need."

Regulation 20 provides definitions for this part of the Standing Rules. It includes the following definition:

> "nursing care" means nursing care by a registered nurse and "nursing care by a registered nurse" has the same meaning as in section 49(2) of the Health and Social Care Act 2001

It is submitted that this definition is not intended to apply to the reference to "nursing" in the definition of a primary health need set out in regulation 21(7) for the following reasons.

- "Nursing" and "nursing care" are different expressions.

- The definition of "nursing care" follows a definition which states that: ""National Framework" means the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care issued by the Secretary of State and dated 28th November 2012."

This is a reference to the scheme by which all registered nursing care is funded by the NHS.

- The definition is followed by a definition of the old guidance which states: ""old Guidance" means the documents entitled "Guidance on Free Nursing Care in Nursing Homes" dated 25th September 2001 and "NHS Funded Nursing Care Practice Guidance and Workbook (August 2001)" dated 5th September 2001"

- The definition of free registered nursing funding in regulation 20 also contains the phrase "nursing care". It states: ""RNCC determination" means a determination as to the Registered Nursing Contribution to Care taken in respect of a person in accordance with the National Health Service (Nursing Care in Residential Accommodation) (England) Directions 2001".

- The exact phrase "nursing care" is used in regulation 28 setting out the procedures by which free Funded Nursing Care must be assessed

- Regulation 21(7) seeks to recreate the Coughlan test. Nursing was not defined as registered nursing in that case.

- PG1.3 of the 2013 practice guidance is specific that general nursing provided by local authorities is considered health care under the regulatory test.

The definition of "nursing care" contained in the regulations therefore refers specifically to the Funded Nursing Care scheme which is referred to elsewhere in this Part of the regulations.

The Coughlan case

The regulatory test enacts the decision of the Court of Appeal in the well known case of Pamela Coughlan.[3] The corresponding section of the judgement of Lord Woolf is reproduced as appendix 1.

Lord Woolf MR gave a more succinct summary in his conclusions at the end of the judgement as follows:

[3] 1999 EWCA Civ 1871

(a) The NHS does not have sole responsibility for all nursing care. Nursing care for a chronically sick patient may in appropriate cases be provided by a local authority as a social service and the patient may be liable to meet the cost of that care according to the patient's means. The provisions of the Health Act and the Care Act do not, therefore, make it necessarily unlawful for the Health Authority to decide to transfer responsibility for the general nursing care of Miss Coughlan to the local authority's social services. Whether it was unlawful depends, generally, on whether the nursing services are merely (i) incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide and (ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide. Miss Coughlan needed services of a wholly different category.

It is important to note that this conclusion is not attempting to define the meaning of "nursing" within the NHS Act.

The judgement contains the following assessment of the practical problems of applying the test that had been set out earlier (emphasis added):

"41. The distinction between general and special or specialist services does provide a degree of non technical guidance as to the services which, because of their nature or quality, should be regarded in any particular case as being more likely to be the responsibility of the NHS. **Where the issue is whether the services should be treated as the responsibility of the NHS, not because of their nature or quality, but because of their quantity or the continuity with which they are provided, the distinction between general and specialist services is of less assistance**."

"43…….First, there are those who, because of the scale of their health needs, should be regarded as wholly the responsibility of a health authority. Secondly, there are those whose nursing services in general can be regarded as being the responsibility of the local authority, but whose additional requirements are the responsibility of the NHS.

44. As to the second of those two categories, in her affidavit Dr Morgan states:

"Nursing Homes do not generally divide their charges between accommodation and care. In my view, it would be very difficult if not impossible to distinguish between the elements of nursing care and what otherwise might be called social care – for example help with eating or washing. The difficulty is particularly acute in the context of work carried out by nursing auxiliaries or other carers under the supervision of qualified nurses. This will generally parallel the equivalent arrangements in NHS hospitals where care is delivered by a range of individuals including nursing auxiliaries and others who are not professional nurses. I therefore seriously doubt whether a coherent and consistent division could be maintained between what is a nursing task and what is a carer's task if it were proposed that there should be a different funding regime for the two types of care."

45. We are not in a position to comment on the correctness of this view of Dr Morgan. However if she is correct, then the position can be remedied by the Health Service taking responsibility for the whole cost. Either a proper division needs to be drawn (we are not saying that it has to be exact) or the Health Service has to take the whole responsibility. The local authority cannot meet the costs of services which are not its responsibility because of the terms of section 21(8) of the 1948 Act.

This seems clear enough. Much of nursing care provided in nursing homes is a team effort performed by a range of staff including unqualified staff. Just as is the case in hospitals, significant category problems arise in deciding what can and cannot be provided by a local authority. Either the NHS must find a way of distinguishing between the types of care that, qualitatively a local authority can and cannot provide, or it must fund the whole package. This distinction is however a problem of the qualitative test and "of less assistance" in relation to the quantitative test

Therefore, the Coughlan case does not address the boundary between NHS and social services provision with reference to a definition of nursing that is within or outside the scope of the NHS. On the contrary, the judgement is based on the difficulty expressed in the evidence before it, being the impossibility of dividing the nursing process in this way.

Figure 1 in the Framework and the DST explains how a judgement about the quantitative and qualitative aspects of the health care are derived from the 4 factors criteria. The more domains in which a person has needs and the higher the weightings in those domains, the greater the intensity, complexity and unpredictability of the care.

There is nothing in the Framework or the Coughlan case suggesting that the health care activities that can be called nursing should be identified having regard to the 4 factors.

The rationale of Coughlan can be summarised as stating that:

1. A local authority could provide and charge for nursing services so long as the level of skill required for that nursing task did not make it inappropriate for it to provide that service having regard to the general purposes of social services provision and
2. So long as the main service the local authority was providing was other than this general nursing type care.

The gap

A key aspect of the Coughlan judgement was its acknowledgment of the potential gap that could arise between the extent of the health service the NHS decided to provide under its section 3 duty and the health service that could be provided within the legal limits imposed on the local authority.

The Court agreed that a health authority has discretion as to the extent of the service it provides subject only to the duty upon the secretary of state to promote a comprehensive health service. In theory it could position its service offer beyond the legal limit applicable to local authority health provision. This would create a gap where no health provision was available.

The position of the Department of Health was that NHS provision should start at the boundary where local authority health provision became unlawful. This remains NHS policy.

The Framework states:

> "There should be no gap in the provision of care. People should not find themselves in a situation where neither the NHS nor the relevant local authority (subject to the person's means and the person having needs that fall within the eligibility criteria for care and support) will fund care, either separately or together."[4]

The Care Act 2014 & the NHS Act 2006 - demarcation

The Care Act 2014 sets out the legal boundary for social services health provision. It states that:

> (1) A local authority may not meet needs under sections 18 to 20 by providing or arranging for the provision of a service or facility that is required to be provided under the National Health Service Act 2006 unless—
>
> (a) doing so would be merely incidental or ancillary to doing something else to meet needs under those sections, and
>
> (b) the service or facility in question would be of a nature that the local authority could be expected to provide.[5]

Understanding this gives rise to 2 questions:

1. What is a service that is required to be provided under the NHS Act 2006?
2. When providing a service that the NHS has a duty to provide, what is the "something else" that the social services department must be mainly doing in meeting needs?

<u>What is a service that is required to be provided under the NHS Act 2006?</u>

The service "required to be provided under the NHS Act 2006" is contained in 2 provisions.

[4] Paragraph 57
[5] Section 22

Section 1(1) states that:

The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement—

(a) in the physical and mental health of the people of England, and

(b) in the prevention, diagnosis and treatment of physical and mental illness.

The term "illness" is defined as including "any disorder or disability of the mind and any injury or disability requiring medical or dental treatment or nursing."[6]

The second provision is the NHS duty set out in section 3. This provides that:

(1) A clinical commissioning group must arrange for the provision of the following to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility —

(a) hospital accommodation,

(b) other accommodation for the purpose of any service provided under this Act,

(c) medical, dental, ophthalmic, nursing and ambulance services,

(d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children [as the group considers] are appropriate as part of the health service,

(e) such other services or 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 the group considers are appropriate as part of the health service,

(f) such other services or facilities as are required for the diagnosis and treatment of illness.

The NHS duty is therefore focussed on maternity care and the prevention, treatment, care and after care of persons suffering from illness.

The Care Act provision can be read in 2 ways.

The service the CCG is required to provide is subject to the discretion of the CCG as to what is *necessary to meet the reasonable requirements* of the population it covers. Furthermore its requirement under subsection 1(e) to provide "services and facilities" for the care and after care for people suffering from or who have suffered from illness is subject to their additional discretion as to what they consider is *appropriate as part of the health service*.

The service the CCG is "required to provide" under the NHS Act 2006 can therefore be read as meaning the service that the CCG decides to provide.

Therefore it is possible to read section 22 Care Act as saying that a local authority cannot provide a health service that the CCG *has decided to provide* unless in providing that overlapping service it is mainly doing something else.

On this interpretation, the balancing exercise required by section 22 does not consider health services that the CCG could provide under the Act but has decided not to cover. Such services are not taken into consideration when the social services department decides whether it is mainly doing "something else." This would mean that those services provided in a nursing

[6] NHS Act 2006 section 275. This is an inclusive rather than an exclusionary definition.

home that the CCG has decided not to provide would be moved to the "not health care" side of the scales and weigh against eligibility for NHS continuing care.

In my opinion, having regard to the history of the demarcation provision between local authorities and the NHS over health provision, that interpretation would be wrong.

The Department of Health has stated that section 22 is not intended to change the law applicable before the Care Act came into force.[7] Therefore section 22 should be read as being broadly consistent with the previous demarcation provision in section 21(8) National Assistance Act 1948 and the Coughlan case. Section 21(8) states:

> "nothing in this section shall authorise or require a local authority to make any provision authorised or required to be made (whether by that or by any other authority) by or under any enactment not contained in this Part of this Act or authorised or required to be provided under the National Health Service Act 2006 or the National Health Service (Wales) Act 2006."

This provision was interpreted by the Court of Appeal in Coughlan to mean that a local authority *could not provide* a service that the NHS had actually decided to provide. This was distinguished from a service that the NHS could provide but had decided not to provide.[8] The court's interpretation of this issue gave rise to the question as to whether a local authority could provide any service that the NHS had decided not to provide. The Court determined that the reach of a local authority was subject to additional limitations relating to the overall purpose and function of a social services department.

It should be apparent that if section 22 Care Act is interpreted to permit a local authority to substantially provide a service that the CCG has *decided to provide*, as well as any health provision that the CCG could provide but has *decided not to provide*, this is a great extension of its previous powers. By permitting the provision of a health service combining services a minority of which overlapped NHS provided services and in addition, health services not provided by the NHS, it would allow a social service department to provide a non specialist health service as a primary purpose.

Since the Department of Health was clear that no such extension of powers was intended, section 22 Care Act must be read as an attempt by the drafters to combine the demarcation provision in section 21(8) National Assistance Act with the test set out in Coughlan (and incorporated in regulation in the Standing Rules).

Therefore, in section 22; "a service or facility that is required to be provided under the National Health Service Act 2006" should be taken to refer to the classes of service referred to in section 3 NHS Act and not to the extent to which the CCG decides to provide them.

This means that a local authority cannot make provision in these *classes of service* unless it is mainly doing something else to meet needs. It is consistent with an expectation that a social services department will provide health care services that the NHS is not providing.

On this interpretation, general nursing commissioned by a local authority weighs on the "health care" side of the scales.

Notwithstanding this however, section 22 does not mirror its predecessor provision in preventing a local authority from also providing services that the NHS has decided to provide under its section 3 duty. It allows the local authority to provide a health service, including a health service that the CCG has decided to provide. But it is restricted in doing so by the requirement that it must mainly doing something other than providing health services.

Whilst this still allows a local authority to overlap existing NHS provision and this does represent a change in the law, this difference is not likely to have much practical effect.

The local authority will be further limited as to the nature of the health service it can provide by section 22(b) Care Act which restricts such provision to "a service or facility [that] would be of a nature that the local authority could be expected to provide." This is a reference to the limits on the qualitative aspects of the care referred to in Coughlan.

---

[7] Department of Health: May 2013: The Care Bill explained: paragraph 79
[8] Paragraph 28

The restrictions on local authority health care imposed by the whole arrangement including the Standing Rules definition of a primary health need, the NHS Continuing Care Framework, the prohibition upon local authorities in providing nursing care by a registered nurse and further by local agreements framed by the co-operation arrangements between social service and health authorities, have the practical effect of restricting local authority care to nursing services by staff who are not qualified nurses.[9]

When providing a service that the NHS has a duty to provide, what is the "something else" that the social services department must be mainly doing?

Section 1 Care Act 2014 provides for the first time, an overarching purpose for a social services department - to promote the individual's well-being.

Section 1(2) states:

"Well-being", in relation to an individual, means that individual's well-being so far as relating to any of the following—

(a) personal dignity (including treatment of the individual with respect);

(b) physical and mental health and emotional well-being;

(c) protection from abuse and neglect;

(d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);

(e) participation in work, education, training or recreation;

(f) social and economic well-being;

(g) domestic, family and personal relationships;

(h) suitability of living accommodation;

(i) the individual's contribution to society.

Only one of these outcomes is to meet the health needs of the person.

Section 8 gives illustrative examples of the sort of services a social services department may provide to meet needs as follows:

(a) accommodation in a care home or in premises of some other type;

(b) care and support at home or in the community;

(c) counselling and other types of social work;

(d) goods and facilities;

(e) information, advice and advocacy.

The purposes of a social services department are given more specificity by statutory eligibility criteria.

[9] Care Act 2014 section 22(3)

The Care & Support (Eligibility Criteria) Regulations 2015 regulation 2 states that:

> (1) An adult's needs meet the eligibility criteria if—
>
> (a)the adult's needs arise from or are related to a physical or mental impairment or illness;
>
> (b)as a result of the adult's needs the adult is unable to achieve two or more of the outcomes specified in paragraph (2); and
>
> (c)as a consequence there is, or is likely to be, a significant impact on the adult's well-being.
>
> (2) The specified outcomes are—
>
> (a)managing and maintaining nutrition;
>
> (b)maintaining personal hygiene;
>
> (c)managing toilet needs;
>
> (d)being appropriately clothed;
>
> (e)being able to make use of the adult's home safely;
>
> (f)maintaining a habitable home environment;
>
> (g)developing and maintaining family or other personal relationships;
>
> (h)accessing and engaging in work, training, education or volunteering;
>
> (i)making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and
>
> (j)carrying out any caring responsibilities the adult has for a child.

It is clearly intended that a local authority may provide health care in meeting these needs.

The Care & Support Statutory Guidance provides an overall interpretation of these functions: It states:

> 1.1 The core purpose of adult care and support is to help people to achieve the outcomes that matter to them in their life.
>
> 1.8 A local authority can promote a person's wellbeing in many ways. How this happens will depend on the circumstances, including the person's needs, goals and wishes, and how these impact on their wellbeing. There is no set approach – a local authority should consider each case on its own merits, consider what the person wants to achieve, and how the action which the local authority is taking may affect the wellbeing of the individual.

Having regard to the legislation and guidance, the meaning of the demarcation provision in section 22 begins to emerge clearly from the mist. Both the NHS and local authority social service departments have purposes.

The purpose of the NHS set out in section 1 of the NHS Act is to secure improvement in the physical and mental health of the people of England, and in the prevention, diagnosis and treatment of physical and mental illness.

The purpose of a social services department is to secure the improvement of a person's well being by helping them to achieve the outcomes that matter to them in their life. This may include providing them with health care. However if the local authority is mainly providing them with health care, it moves outside of its own purposes and onto the territory of the NHS.

It should be obvious that AB (and others suffering from advanced neurological disease) has neither the capacity to express a desire to achieve other outcomes, nor can any such outcomes be determined on a best interests basis, other than the management of his health needs. AB's brain damage is of a nature that places his outside the remit of a social services department and firmly in the territory of the NHS.

The definition of nursing

We have seen that the Coughlan case did not identify any basis for defining the meaning of nursing in a restrictive manner such that there was a form of nursing that was not capable of being provided by the NHS.

Is there any other basis for a asserting that there is a restrictive definition of "nursing" as the term appears in section 3(1)(b) NHS Act.

The meaning of "illness" and nursing in the NHS Act 2006

The NHS Act 2006 is directed to the provision of a service to address illness.

It is noted above that the Act defines the term "illness" to "include any disorder or disability of the mind and any injury or disability requiring medical or dental treatment or nursing."

The meaning of the terms "treatment" and "nursing" have received judicial attention.

Minister of Health v General Committee of the Royal Midland Counties Home for Incurables at Leamington Spa [1954] [10]

This case involved an appeal by a care facility against the local decision that it was a hospital and therefore fell to be taken over by the newly founded NHS on 5th July 1948, its inception date.

The facility catered for "incurables". A rule of the home was that "no case shall be admitted unless it requires medical supervision and nursing." Cases with diagnoses likely to have a short life expectancy were excluded. The facility was in effect one for the provision of what would now be called "continuing care."

In a split decision (Lord Denning dissenting), the Court of Appeal determined that the facility was a hospital. Central to that determination was whether the facility met the definition of a hospital in the NHS Act which included the requirement that it was "an institution for the receipt and treatment of persons suffering from illness or mental defectiveness…." [11]

Denning LJ did not draw a distinction between treatment and the relevant aspects of nursing and therefore considered only whether the facility was providing treatment. In considering the difference between treatment and care he stated that:

> "Where is the line then to be drawn between "treatment" and "care"? Neither is defined in the Act but "treatment" means, I think, the exercise of professional skill to remedy the disease or disability, or to lessen its ill effects or the pain and suffering it occasions; whereas "care" is the homely art of making people comfortable and providing for their well-being so far as their condition allows."

[10] [1954] 1 Ch.
[11] Section 79

He went on to discuss the meaning of the term nursing:

> "Nursing," too, is not defined; but it covers, I think, both treatment and care. Some part of it, indeed an important part, is the exercise of professional skill; but a goodly part, perhaps the larger part, is just kindness and attention. When the Act therefore defines "illness" as including any disease or disability requiring mental or dental treatment, or nursing, it means, I think, a disability which requires the exercise of professional skill, as distinct from a disability that requires care or attention."

The majority held that since the definition of "illness" in the Act referred to a requirement for treatment *or* nursing, there must be a meaningful distinction between treatment and nursing. Therefore in the view of the majority, the facility could still be a hospital if it provided nursing but not treatment. It was therefore necessary to define nursing separately to treatment.

Referring to the term "nursing" associated with the definition of illness, Romer LJ stated that:

> ""nursing" means more than mere "care" of persons suffering from illness (see sections 24 and 28 of the Act) and presumably refers to nursing of a professional character…"

Evershed MR approved the opinion of the Lord President of the Inner House in the case of Royal Victoria Hospital, Dundee v Wheatley quoting the following section:

> "By a hospital for incurables I mean a hospital for the reception of patients whose recovery is not expected….and for whom all that can be normally be done is to provide skilled nursing and alleviation of suffering…."

He noted that:

> "It is true that from other sections of the Act a distinction may be discerned between "treatment" and mere "care" (which I assume to comprehend "looking after" by persons not professionally trained for such purpose – see for example the reference to "the care of persons suffering from illness in section 28."

In support of Lord Denning's view, it is to be noted that section 1 NHS Act 1946 provides that the objective of the NHS includes the prevention, diagnosis and treatment of illness. So it is an understandable source of confusion if the definition of illness in the Act is taken to imply that it has any further task outside of this objective, to provide nursing which is different to "treatment." Lord Denning may have been correct that nursing is a hybrid function which can involve treatment as well as other functions. Nursing does involve the administration of "treatments." It certainly involves preventive work.

However it is submitted that attempting to split nursing into separate functions in this way, some of which are within the statutory purposes of the NHS and some of which are without it or only ancillary to that function, in particular suggesting that the humanistic aspect of nursing is outside it, is to miss its holistic nature of nursing practice and is inconsistent with the practice and purposes of nursing itself.

It is submitted that in the definition of illness, nursing is listed separately to the provision of medical treatment precisely to make clear that nursing as a holistic practice is an integral part of preventive work and treatment. It would be uncontroversial amongst NHS professionals to accept that once the doctors have left the bedside, essential aspects of the treatment, recovery and management process are delivered by the quite distinct skill set of nurses. This is only to acknowledge the whole person model of treatment and recovery. It is submitted that it would be a serious error to assume that aspects of medical care that are not the kind of treatments performed or ordered by doctors, are unskilled and therefore only an ancillary service within the NHS. In defining "illness" in this way, the NHS Act reflects this by making it clear that the nursing of people suffering from illness is as much a core part of the work of the NHS in treating them as is the diagnosis and direction of interventions by doctors.

This is dealt with further below in relation to the literature regarding the nature of nursing.

Changes since Leamington Spa was decided

Before leaving this case it is necessary to consider the historic context of the Leamington Spa case. There have been significant changes both in the practice of nursing and in legislation.

Changes in nursing practice

The Leamington Spa case records that the facility in question had 48 full-time and 29 part time members of the nursing staff and that the "nursing required was more routine and of a slower tempo" than other facilities. It is said that on 5th July 1948, there were 112 "inmates".

It is inconceivable that a modern continuing care nursing home would employ 63 full time equivalent registered nurses to care for 112 residents. Modern registered nursing is a degree level profession on account of the ever increasing sophistication of health care. Therefore when this case refers to the need for professional skill, it does so in the context of its time.

Professional nursing at this time was a much less medically sophisticated profession than it is today. What was regarded as professional skill then may not be so regarded today. It was customary to train up unskilled staff to operate and be designated as nurses because the base line training and competency level expected of unskilled staff would have been significantly less than in modern times.

Just as the cost of training nurses to modern standards has increased, so has the importance of delegating what were once considered professional nursing tasks, to staff who are not qualified a registered nurses. Many modern care assistants operating in facilities catering for residents with very advanced conditions, receive significant training from their employers so that they can deliver safe care. That they do so is necessary to meet regulatory requirements in the competent delivery of care.

Legislative changes

So far as I was able, I tracked the developments in NHS and social care legislation in my 2017 book.[12] Space does not permit a repetition of that but the following is sufficient for this paper.

The NHS was founded predominantly as a service providing hospitals. It also provided other "specialist" services for the prevention, diagnosis and treatment of illness which included the provision of such services in a person's home.

GPs remained a private contracted service.

The role of providing general medical services in the community was retained by local authorities. Local authorities were required to provide health visitors (NHS Act 1946 section 24), home nursing (section 25), a vaccination service (section 26) and ambulance services (section 27). There was no provision for charging for these services.

Under section 28 a local authority had discretion to (or was required to if directed by the Minister): "make arrangements for the purpose of the prevention of illness, the care of persons suffering from illness or mental defectiveness, or the after care of such persons…". Local authorities were permitted to charge for this service.

In practice this provision was used in relation to the care of people suffering from mental illness, including organic brain disorders giving rise to mental illness.

This "tripartite" structure was reformed in 1974 following the NHS Reorganisation Act 1973. The community health provision role of local authorities was abolished. Thereafter, health services in the community were delivered by the NHS.

[12] Austin Thornton - Paying For Residential Care: A Guide for Private Client Practitioners - Ark 2017

The NHS Act 1977 was a consolidating Act. The NHS duty under section 3 was amended to include a new subsection (e) which included the previous powers of local authorities which had been provided by section 28 of the 1946 Act. This new section made it a duty of the NHS to provide:

> "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;"[13]

There is no provision for the NHS to charge for this service.

This is the service that Evershed MR, in discussing the distinctive role of the NHS as a hospital and specialist treatment service, referred to as "mere care" which he distinguished from nursing.

After 1974, such a service would be provided by the NHS subject to the following discretions:

1. So far as necessary to meet the reasonable requirements of the persons for whom the health authority has responsibility.
2. To such an extent as was considered appropriate as part of the health service
3. Subject to the overriding duty upon the secretary of state to continue the promotion in England of a comprehensive health service designed to secure improvement—

    (a) in the physical and mental health of the people of England, and

    (b) in the prevention, diagnosis and treatment of physical and mental illness.

Relying on this case, the argument that AB's needs are not the responsibility of the NHS, would therefore be that:

1. "Care is to be distinguished from nursing. AB's needs are for "care" and not for nursing.
2. The health authority has decided that it is not appropriate as part of the health service for it to meet these needs for care.
3. Coughlan does not apply because that case only considered nursing provision.

I address this argument below but it is first necessary to consider what other guidance we have on this issue.

Airedale NHS Trust & Bland [1992]

This case considered what actions may be considered medical "treatment, and introduced a new term being "medical care."

Anthony Bland suffered a severe brain injury at Hillsborough in 1989 and was later determined to be in a persistent vegetative state. In 1992, Airedale Trust sought the permission of the Courts to withdraw clinically assisted nutrition and hydration (CANH) in the full knowledge that this would cause his death within a few days.

In the judgement of Sir Stephen Brown his needs were described as follows:

> "He is fed artificially and mechanically by a nasogastric tube which has been inserted through his nose and down into his stomach. All the natural bodily functions have to be operated with nursing intervention. He is fitted with a catheter which has given rise to infection necessitating surgical intervention…..He requires 4-5 hours nursing attention by two nurses every day."[14]

An issue arose as to whether Tony Bland was received medical treatment. As I understand the case, the reason for this point being discussed, was that it is one thing to withhold medical treatment with the result that a person dies, but a different matter to with hold the basic necessities of life such as air, food warmth and hygiene which are not delivered artificially.

[13] The Coughlan cases did not consider the effect of section 3(e).

[14] At 795 paragraph G & H

With one exception, all the expert medical witnesses considered that the artificial nutrition and hydration regime constituted medical treatment.

Professor Jennet was said to have described nasogastric feeding as "a form of medical treatment just as is a ventilator or a kidney machine. It is a means of substituting a function that has naturally failed."[15]

Dr Keith Andrews gave evidence that feeding by tube was not in his view medical treatment. "The use of the equipment might be thought to be medical treatment but not the supply of food which is a basic human requirement."

Sir Thomas Bingham said that

> "The overwhelming consensus of medical opinion in this country and the United States is that artificial feeding by nasogastric tube is also medical treatment. This is a readily understandable view. The insertion of the tube is a procedure calling for skill and knowledge, and the tube is invasive of the patient's body to an extent which feeding by spoon or cup is not. An intubated patient certainly looks as if he is undergoing treatment, and the mechanical pumping of food through a tube is a highly unnatural process. It does not, however, seem to me crucial whether this is regarded as medical treatment or not, since whether or not this is medical treatment it forms part of the patient's medical care and I cannot think the answer to this problem depends on fine definitional distinctions.
>
> It is relevant to consider the objects of medical care. I think traditionally they have been (1) to prevent the occurrence of illness, injury or deformity (which for convenience I shall together call “illness”) before they occur; (2) to cure illness when it does occur; (3) where illness cannot be cured, to prevent or retard deterioration of the patient's condition; (4) to relieve pain and suffering in body and mind. I doubt if it has ever been an object of medical care merely to prolong the life of an insensate patient with no hope of recovery where nothing can be done to promote any of these objects."[16]

Lady Butler Sloss said:

> "If we describe what is being done by the doctors and nurses for Anthony Bland and others in his condition as medical care rather than treatment, it may to the layman make more sense and avoid the uncomfortable attempt to draw a line between different forms of feeding such as spoon-feeding a helpless patient or inserting a tube through the nose or direct into the stomach.
>
> The definition of medical treatment does not, in my view, of itself resolve the problem. The underlying issue is whether, under the extreme circumstances of this case, there is a duty upon his doctor to continue to provide to Anthony Bland nutrition and hydration by an artificial method. Mr. Munby argued that there are basic needs which are the right of a patient, the need for air and the need for nutrition. That is in my view too narrow an expression of basic needs, which cannot be seen in isolation from general care including for instance warmth and hygiene."[17]

It is arguable that the difference described above between medical care and medical treatment goes some way to addressing the difference between medical treatment and nursing. But it is submitted that it does nothing to delineate a form of "care" that is neither treatment nor nursing since both are clearly directed to the overall aim of maintaining the life of Anthony Bland and preventing him developing further illness.

Rather, the case provides support for the contention that both medical interventions designed and ordered by doctors and also the holistic caring skills of nurses are involved in the prevention and treatment of illness.

Extending the rationale of the above, it would appear that feeding a person though a PEG[18] is also likely to be medical treatment because it is an artificial method. If this is medical treatment, why is it that spending 40 minutes feeding a person orally with a spoon where the person cannot do this themselves and where the situation needs to be monitored because of a choking or aspiration risk, is not. Whether or not the latter qualifies as medical treatment, it certainly presents as medical care.

---

[15] Page 798 paragraph G
[16] At page 809 E-H
[17] At page 818 para C
[18] Percutaneous endoscopic gastrostomy – a form of tube for feeding inserted through the abdomen directly into the stomach.

R (TDB) v Haringey [2005] [19]

Here Mr Justice Ouseley considered whether tracheostomy care provided to a child could be a responsibility of the local authority childrens services department under the Children Act 1989. The care was provided by the mother following training but the mother needed some nights off to sleep and the question arose as to who should provide the respite care.

He stated that:

> "I accept, first, that there is a broad distinction to be drawn between health and social care provision which illustrates the true interpretation of those provisions. It does so even though there may be an overlap between the two in any given case.
>
> The scale and type of nursing care is particularly important as is the question of whether its provision is incidental or ancillary to the provision of some other service which the social services authority is lawfully providing, and whether it is of a nature which such authority can be expected to provide.
>
> Second, this is care designed to deal with the continuing medical consequences of an operation, which if not met will give rise to urgent or immediate medical needs: tube replacement and unblocking, to avoid very significant risks of a life threatening nature. The advice on management is provided by a hospital. The training is provided by the medically qualified.
>
> The largest part of the provision actually made is made by the HPCT as part of the NHS obligations to patients, i.e. twenty hours a week plus the 7 hours a week related to T. I see that as clearly signifying acceptance by HPCT, LBH and indeed the Claimants, that D is receiving medical care.
>
> To my mind, it also shows how the purpose of the care should be regarded. It is spoken of as respite care for the mother. From one viewpoint, the purpose of its provision is so that the mother can have a few nights of unbroken sleep per week or some time by herself a week or to look after T. That could be seen as social care for the mother. But its nature and purpose is to provide medical care for D; the intention behind the provision of that medical care is her safety while her mother enjoys respite. There is nothing different in quality or care about the disputed provision.
>
> The gravity of the consequences of a failure in care, the duration of the care need, which required her carer always to be present lest something had to be dealt with rapidly, underscores the medical rather than social service nature of the provision.
>
> It has in fact always been provided by nurses except where the mother has had specific training. The reluctance of others, whether teachers, close relatives or health care assistants, to be trained in the particular procedures serves only to emphasise the medical nature of the provision without itself being determinative. The nurses themselves require specific training in tracheostomy care. While it is possible for others to be trained in that specific care, it would still clearly be an important medical procedure in which they were trained.
>
> Those factors, taken together, show this particular care for D to fall outside the scope of the general obligation in section 17(1) of the Children Act…."

This is a rare and hence useful example of the Court applying the quantitative and qualitative approaches described in Coughlan. The judge considers whether the qualitative nature of the care is beyond what a children services department could commission relying on the purpose of the care, the level of skill, who provides the training and the significance of the care in terms of the risks to the child.

Usefully for this case, the funding split in the joint package previously organised by the local authority and the PCT was a good indicator of the quantitative split. This only applies in domiciliary packages. In residential accommodation, joint packages are rare. CCGs rely on the Funded Nursing Care Contribution to deal with their funding responsibilities.

[19] [2005] EWHC 2235 (Admin)

R (M) v Slough 2008 [20]

In the case of R (M) v Slough, Lady Hale addressed the question of whether a person subject to immigration control who is HIV positive but whose only needs, other than for a home and subsistence, are for medication prescribed by his doctor and a refrigerator in which to keep it; is “in need of care and attention which is not otherwise available to [him]” within the meaning of section 21(1)(a) National Assistance Act 1948. Prior to the Care Act 2014, this was the enabling provision for local authority residential care.

Lady Hale stated that:

> "I remain of the view which I expressed in Wahid, at para 32, that the natural and ordinary meaning of the words “care and attention” in this context is “looking after”. Looking after means doing something for the person being cared for which he cannot or should not be expected to do for himself: it might be household tasks which an old person can no longer perform or can only perform with great difficulty; it might be protection from risks which a mentally disabled person cannot perceive; it might be personal care, such as feeding, washing or toileting. This is not an exhaustive list. The provision of medical care is expressly excluded."

In using the term "medical care" Lady Hale presumably intended to follow Coughlan and meant by excluded medical care, either care that was being provided by the NHS and thus excluded by section 21(8) National Assistance Act 1948 or care of a nature beyond what it was appropriate for a social services department to provide.

It is submitted however that this concept of "looking after" cannot create a sufficient basis for making a distinction between nursing and "care."

The Coughlan case determined that local authorities were entitled to provide nursing care under section 21(1)(a) National Assistance Act. As a matter of law they could only provide nursing care, if this came within the definition of "care and attention" under the Act. So if care and attention means "looking after", looking after must include nursing.

That the duty to provide "care and attention" included nursing was confirmed by the Department of Health. Paragraph 10 of the Slough case recites Health Service Guidance 92(50) which stated that:

> "When, after April 1993, a local authority places a person in a nursing home after joint HA/LA assessment, the local authority is responsible for purchasing services to meet the general nursing care needs of that person, including the cost of incontinence services (eg laundry) and those incontinence and nursing supplies which are not available on NHS prescription."[21]

Professional definitions of nursing?

The Royal College of Nursing 2014 publication "Defining Nursing" defines professional and non professional nursing.[22]

It is significant that in the following definitions, the role of nursing in health care delivery is recognised as a co-operative effort between a number of different professionals. The efficient delivery of health care is rightly organised according to a division of labour. But this does not mean that those tasked with delivering the lower skilled aspects of health care are not delivering a type of nursing or health care. The division of health care tasks according to the type of staff required to meet the need, does not of itself render those tasks "not health care."

Registered nursing is defined as follows:

---

[20] UKHL 2008 57

[21] This passage is also strongly suggestive that incontinence care was considered by the Department of Health to be part of general nursing.

[22] The original publication was 2003. The two versions are broadly similar.

> "The use of clinical judgement in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death."

This is a purposive definition related to the provision of health outcomes.

It is a definition of professional nursing in the UK. Professional nursing is governed by the Nursing and Midwifery Council and so this is, and is intended to be, a definition of the scope of registered nursing.

The publication recognises that nursing itself is wider than this stating that:

> "Not all nursing is undertaken by qualified nurses, anymore than all teaching is undertaken by qualified teachers. Other people who nurse include relatives, other informal carers, and a variety of care assistants and support workers. Their contribution to care is invaluable, but it is different from that of the professional nurse. The distinction between professional nursing and the nursing undertaken by other people does not lie in the type of task performed, nor in the level of skill that is required to perform a particular task. As for all professional practice, the difference lies in:
>
> - the clinical judgement inherent in the processes of assessment, diagnosis, prescription and evaluation
>
> - the knowledge that is the basis of the assessment of need and the determination of action to meet the need
>
> - the personal accountability for all decisions and actions, including the decision to delegate to others
>
> - the structured relationship between the nurse and the patient which incorporates professional regulation and a code of ethics within a statutory framework" [23]

The publication refers specifically to the issue of nursing in NHS continuing care stating that:

> "A particular issue has been the distinction between the nursing care and the social or personal care provided for frail older people. As a result of the 1990 NHS and Community Care Act (which gave local authority social services departments the lead responsibility for the provision of such services) much of the basic nursing care that used to be provided by nurses has been re-designated as social care and is provided by care assistants working under the supervision of social workers or lay managers."[24]

This does not mean (or should not be taken to mean) that this care that was previously general nursing and which is now often referred to as social care, is not health care and is thus excluded from consideration as such when applying the Coughlan test.

Rather the point of the 1993 reforms was that by amendment to section 21 National Assistance Act, local authorities were given specific responsibility for meeting the needs of adults suffering from illness and disability in residential care.

As we have seen above, HSG 92(50) referred to this transfer of responsibility as local authorities taking responsibility for general nursing care. This was an issue of responsibility for commissioning, not one of service definition. [25]

As we have seen, the Coughlan case agreed that subject to limits, this permitted local authorities to provide nursing services.

Defining Nursing quotes the Henderson definition of nursing as being:

> “to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible... This aspect of her work, this part of her function, she initiates and controls; of this she is master.

---

[23] Page 4

[24] Page 5

[25] In the Pointon case the PHSO established that, contrary to the view of the health authority concerned, nursing care which counts towards CHC eligibility can be provided by an unqualified relative.

> In addition she helps the patient to carry out the therapeutic plan as initiated by the physician,
>
> and
>
> She also, as a member of a team, helps others as they in turn help her, to plan and carry out the total program whether it be for the improvement of health, or recovery from illness, or support in death."[26]

This is also a purposive definition – "contributing to health or its recovery" explicitly linking nursing to the performance of activities contributing to health or its recovery that the patient would perform himself unaided if he had the necessary strength, will or knowledge. It accurately describes the whole team of workers in a care home including the registered nurse and outside professionals such as the GP and other specialists, dealing with seriously ill people.

Defining Nursing notes that the International Council of Nurses adopted the Henderson definition of nursing but also established an official definition of nursing for international use as follows:

> "Nursing, as an integral part of the health care system, encompasses the promotion of health, the prevention of illness, and care of the physically ill, mentally ill, and disabled people of all ages, in all health care and other community settings. Within this broad spectrum of health care, the phenomena of particular concern to nurses are individual family and group responses to actual or potential health problems. These human responses range broadly from health restoring reactions to an individual episode of illness to the development of policy in promoting the long-term health of a population."[27]

These definitions of nursing support the suggestion that nursing should be seen as a practice dealing with the whole person having its proper place within the purposes of the NHS for the prevention, treatment and recovery from illness.

The available definitions of nursing therefore point to nursing as an activity whose purpose is to address health needs where a health need is an activity contributing to the prevention of ill health and the recovery from illness.

The Framework states that:

> "Whilst there is not a legal definition of a health need (in the context of NHS Continuing Healthcare), in general terms it can be said that such a need is one related to the treatment, control, management or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional)."[28]

This definition of health care mirrors the language of the sections 1 & 3 NHS Act including section 3(1)(e). Presumably this is intentional.

These definitions in Defining Nursing and in the Framework have the great merit in the English context of linking the registered nurse and nursing assistant workforce in the NHS to the statutory functions set out in section 3 that the NHS is required to perform.

One might reasonably define nursing in the NHS in England as any type of clinical or caring activity carried out by an individual, whose purpose is to fulfil the functions of the NHS in the prevention and treatment of illness and which is not carried out by another designation of medical professional.

It may be objected that this does not give an explanation of the difference between care as referred to in section 3(1)(e) and nursing in section 3(1)(c) and this brings us back to the Leamington Spa case.

---

[26] Page 6
[27] Page 7
[28] Paragraph 50

Should the Leamington Spa distinction between nursing and care be followed?

It is submitted that the rationale in Leamington Spa should not be followed. Interestingly the case was not mentioned in Coughlan and appears rarely cited elsewhere.

There was no support in the Coughlan case for a meaningful distinction between the treatment and caring aspects of nursing. The available academic literature and professional publications considering the definition of nursing do not proceed on the basis that it is possible to make such a distinction. It is arguably wrong in principle because nursing is and should be regarded as a whole person practice which is precisely its distinction from treatment aimed at a specific condition.

It may be argued that there is no distinction implicit in section 3 NHS Act, between "nursing" and "care".

The derivation of the current section 3(1)(e) can be traced from its origins in the 1946 Act and it is submitted that this history suggests that rather than creating a different form of care, it is a duty intended to enable the staffing provision in section 3(1)(c).

The distinction between sections 3(1)(c) and 3(1)(e) of the 2006 Act, is between "nursing" and "such other services or facilities".

In the 1946 Act, home nursing provision by local authorities was authorised by section 25, and section 28 referred to the making of "arrangements" for prevention, care and after care of personal suffering from illness.

Section 28 was repealed and became section 12 Health Services & Public Health Act 1968 which emphasises the provision, equipment and maintenance of such care services in residential accommodation, training facilities for relevant patients, ancillary and supplemental services and the appointment of mental welfare officers for persons suffering from mental disorder under the Mental Health Act 1959.

When local authorities were removed from community health provision, by the NHS Reorganisation Act 1973 section 12 was repealed and section 2 introduced a new duty upon the secretary of state which is the precursor wording of the current NHS Act duty. Section 2(2)(c) of the 1973 Act referred to nursing and (e) referred to "facilities." When these provisions were consolidated in the NHS Act 1977, the new section 3(1)(e) referred to "facilities". The current wording in the 2006 Act refers to "services and facilities."

It may be said therefore that the NHS duty has always been structured with reference to the constituent parts of health provision. In the current duty, sections 3(1)(a) & (b) refer to the buildings, (c) refers to the people providing the service including doctors, dentists, eye specialists and nurses, (e) refers to anything else needed to provide the preventive care, care and after care in relation to patient illness and (f) refers to anything else, other than staffing, required for diagnosis and treatment.

This would mean that the reference to "care" in the current section 3(1)(e) is simply intended as a catch all phrase referring to those health care purposes of the NHS that are not contained in the phrase "diagnosis and treatment". It would follow that this section was not intended to designate a lesser form of medical attention than nursing but simply to allow the NHS to do whatever was necessary to meet its purposes. The use of the term "care" is equivalent to what Lady Butler Sloss in the Tony Bland case called "medical care" when she found that the term "treatment" was too limiting to describe his care notwithstanding that it was clearly within the purposes of the NHS.

If that is correct, the problematic distinction between nursing and care raised by the Leamington Spa case dissolves. Under the Act, nursing simply means medical care that is not diagnosis and treatment delivered by other (usually more specialist) staff. The holistic nature of that care is implicit in that distinction. Whether care is "medical care" is determined with reference to the purposes of the activity which includes as is discussed below, a consideration of the remoteness of the health effect from the caring activity.

Personal care as health care – the relevance of remoteness of purpose

The term "personal care" is often used to create a distinction between a social service and a health service activity.

The term "personal care" is both a term of art with no statutory definition, and a regulatory category with a statutory definition.

As a term of art it refers to any physical care given by one person to another. If I brush my child's hair, that is personal care. It makes no difference whether or not I do so because they have an illness or disability.

Personal care is also a regulated activity under the Health & Social Care Act 2008 (via the Regulated Activity regulations[29]).

The Health & Social Care Act 2008 section 9 contains definitions of health care and social care for the purposes of that Act. The purposes of the Act include the regulation by the Care Quality Commission of health care and social care providers.

Since these definitions exist for their own specific statutory purpose, they do not relate directly to the question of eligibility for NHS continuing care. They are however tangentially relevant because they also demarcate areas of activity carried out by social care and health care providers. They read as follows:

> (2) "Health care" includes all forms of health care provided for individuals, whether relating to physical or mental health, and also includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition.
>
> (3) "Social care" includes all forms of personal care and other practical assistance provided for individuals who by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances, are in need of such care or other assistance.

No attempt is made to demarcate health care and social care with reference to the skill level or the specific type of activity. The distinction is purpose based. Social care provision has a much wider client group than health care and a much wider range of activities to support them. Social care is said to include personal care.

Subject to a series of exceptions (including of friends and relatives acting for no consideration) it is an offence to provide personal care unless the provider is registered with the Care Quality Commission. The creation of an offence requires that there be a reasonably tight definition of the activity which is as follows:

> "personal care" means—
>
> (a) physical assistance given to a person in connection with—
>
> (i) eating or drinking (including the maintenance of established parenteral nutrition),
>
> (ii) toileting (including in relation to the process of menstruation),
>
> (iii) washing or bathing,
>
> (iv) dressing,
>
> (v) oral care, or
>
> (vi) the care of skin, hair and nails (with the exception of nail care provided by a person registered with the Health and Care Professions Council as a chiropodist or podiatrist pursuant to article 5 of the 2001 Order), or

[29] Health & Social Care Act 2008 (Regulated Activities) Regulations 2014

(b) the prompting, together with supervision, of a person, in relation to the performance of any of the activities listed in paragraph (a), where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision;[30]

Is this a basis for a distinction between health care and "basic and fundamental" care which is not nursing care?

Certainly personal care is not necessarily nursing care because it can be delivered outside of the purpose of contributing to the prevention, diagnosis, treatment and recovery from illness.

In some instances the distinction between personal care and health care is obvious. Brushing my healthy child's hair is personal care but not health care.

When considering the care of disabled adults, this distinction may become more difficult. In making this distinction the remoteness of the impact on health affects the consideration of purpose.

A person who washes the hair of their frail mother is probably not directly addressing a health need. Any health consequence of having unwashed hair, such as the development of a skin condition is remote. Helping one's frail mother to dress well enough to attend a social function is also personal care but is not meeting a health function. It cannot be said that dressing a person for this purpose is a health need and so cannot be a responsibility of the NHS. On the other hand this could certainly be identified as a well being issue and therefore, subject to eligibility criteria, within the remit of a social services department.

There are of course gradations where an act of personal care performs both a social and a health function.

Helping ones frail mother who cannot dress herself to put on warm clothing in a cold winter before going out is addressing a health function because the elderly are susceptible to direct and immediate health consequences of the cold. In these circumstances, dressing is preventing an adverse health outcome. The public and the nursing profession would certainly expect practitioners to dress patients in a manner that addressed such risks. Sanctions for neglect would certainly lie against a professional whose patient suffered exposure as a result of not doing this.

Clearly being properly dressed also involves the social functions of delivering dignity in the public sphere and assisting a person to access the community.

But even in these circumstances, for NHS purposes, my frail mother is not necessarily suffering from "illness", being any disorder or disability of the mind and any injury or disability requiring medical or dental treatment or nursing. Her care in this respect may be outside the NHS remit. Again however it is clearly a "well being" issue potentially within the remit of a social services department.

If however, she were incapable by reason of neurological disease from dressing properly and perhaps even prone to walking about naked, as is not uncommon in dementia patients, maintaining body temperature through the use of appropriate clothing would certainly be directly meeting a health purpose for a person suffering from a disorder. It is submitted that this type of care is general nursing care because although not diagnosis or treatment, it is at a fundamental level, medical care.

Changing the pads of a doubly incontinent adult suffering from advanced Huntingtons disease including cleaning seems to me to clearly be a health requirement since unchanged pads give rise to risks of infection and immediate and significant skin damage. On this point there is of course a dignity function but most people would see the purpose of this task as primarily directed at a health outcome.

Schedule 1 Regulated Activity regulations provides for specific classes of activity that require registration with CQC and hence are regulated. A care provider must be separately registered with CQC to provide each class of service unless otherwise stated. The delivery of different classes of service require different skills and qualifications. Personal care will be ancillary to many of the various operations described in the schedule. For example, the category, "treatment of disease disorder or injury"

[30] Regulation 2(1)

[31], applies to personal care conducted in the person's home that is supervised by a registered nurse. This is a separate category to "personal care".

It follows that whilst the definition of personal care provides a basis for explaining how an activity can be care but not health care, it does not of itself create a useful distinction between health care and non health care tasks. It is clearly envisaged that health care incorporates personal care but that the reverse is not necessarily true.

Whether or not something is health care is based on an assessment of its purpose, including the directness of the link between the activity and its health consequence.

There will always be grey areas where judgement is to be exercised. But it is submitted that the care afforded to AB is clearly delivered in consequence of his "illness" and is directed to health outcomes. It is required to be performed by general nursing care staff and supervised by a registered nurse. It is care that "counts" as nursing care in the quantitative assessment of the nursing care referred to in the Coughlan case.

The Royal Commission and Funded Nursing Care

The care system was the subject of a Royal Commission report published in March 1999.[32]

One reason the Coughlan case was brought was to challenge the proposition that a local authority could provide and charge for nursing care. This was considered anomalous because nursing care provided in a nursing home would be charged for whilst nursing care provided in a hospital would be free.

The Royal Commission report highlighted this anomaly, describing it as unfair and recommending it be abolished by making all nursing care in nursing homes free.[33]

The report also sought to reform payment for non nursing residential care. Excluding NHS therapeutic care, it proposed dividing the costs of residential care into 3 parts as follows:

1. living costs, (food, clothing, heating amenities and so on);
2. housing costs (the equivalent of rent, mortgage payments and council tax) and;
3. personal care costs (the additional cost of being looked after arising from frailty or disability). [34]

It made a key recommendation that personal care should be paid for by government, explaining this as follows:

> "6.33 The justification for our view is based on considerations of both equity and efficiency. Whereas the state through the NHS pays for all the care needs of sufferers from, for example cancer and heart disease, people who suffer from Alzheimer's disease may get little or no help with the cost of comparable care needs. All these conditions are debilitating, but Alzheimer's disease cannot yet be cured by medical intervention. However, a mixture of all types of care, including personal care will be needed. This is directly analagous to the kind of care provided for cancer sufferers. The latter get their care free. The former have to pay.

---

[31] Schedule 1 paragraph 4

[32] With Respect to Old Age: Long Term Care - Rights and Responsibilities A Report by The Royal Commission on Long Term Care March 1999

[33] The Commission does not seem to have been aware of the judgement of Hidden J in the High Court in the Coughlan case delivered in December 1998. Either that or it chose to ignore it pending the appeal. Hidden J had held that it was unlawful for a local authority to provide any nursing care under the National Assistance Act. This was a dramatic and game changing judgement for local authorities and the NHS and caused much comment at the time. It would have created the need for a critical distinction between nursing care which the NHS must provide and activities that were not nursing care which could still be provided by local authorities. The Court of Appeal judgement in July 1999 overturned the judgement of Hidden J on this point.

[34] Paragraph 6.29

6.34 For this reason, the distinction between the way care is offered for different diseases has no justification. The situation must be put right. The proposal to exempt personal care costs from means-testing would do that."

The Commission then went on to attempt to define personal care. Their treatment of this issue is important because of the response of the government. This section of the report is set out in full in Box 2, overleaf.

Box 2

Definition of personal care

6.43 By "personal care" in this option the Commission mean the care needs which give rise to the major additional costs of frailty or disability associated with old age. We deliberately do not use the term "health care" or "social care" because of the confusion which now surrounds those terms and their association with particular agencies or forms of funding. Personal care is care that directly involves touching a person's body (and therefore incorporates issues of intimacy, personal dignity and confidentiality), and is distinct both from treatment/therapy (a procedure deliberately intended to cure or ameliorate a pathological condition) and from indirect care such as home-help or the provision of meals. This type of care is the main source of contention in the debate about the distinction between health care and social care. It falls within the internationally recognised definition of nursing, but may be delivered by many people who are not nurses, in particular by care assistants employed by social services departments or agencies.

6.44 Personal care, because it directly involves touching a person's body, incorporates issues of intimacy, personal dignity and confidentiality. Because of risks associated with poor personal care (e.g. risks of infection or skin breakdown), it is important that when the level or type of care needed becomes greater than can normally be provided at home by a relative or informal carer, careful assessment is made of how best it can be provided and by whom. It, therefore, differs qualitatively from living costs and housing costs. In recommending that personal care should be exempted from means testing, we are not recommending that this should happen on demand. Far from it, we have stressed throughout our report the importance of proper assessment of need.

Definition of Personal Care

Personal care would cover all direct care related to:

- personal toilet (washing, bathing, skin care, personal presentation, dressing and undressing and skin care);
- eating and drinking (as opposed to obtaining and preparing food and drink);
- managing urinary and bowel functions (including maintaining continence and managing incontinence);
- managing problems associated with immobility;
- management of prescribed treatment (e.g. administration and monitoring medication),
- behaviour management and ensuring personal safety (for example, for those with cognitive impairment - minimising stress and risk).

6.45 We acknowledge that this definition could be regarded as on the tight side. It would, for example, exclude costs attributable to:

- cleaning and housework;
- laundry;
- shopping services;
- specialist transport services (e.g. dial-a-ride);

- sitting services where the purpose is company or companionship.

6.46 However, the Commission have had to draw the line in a practical way. We consider it reasonable that the state should not meet such costs other than through means-testing, on the basis that although they may contain an element of care they are in principle "living" costs.

It is submitted that the Commission did a disservice to clarity in this section of the report. It could be read as treating the discrimination against Alzheimers patients as legally justified in the then current system. It stated that it was attempting to avoid the confusion over the distinction between health care and social care by defining a new category of funded care called personal care that was delivered in residential care homes without nursing. However in doing so it created a different source of confusion between the meaning of the terms personal care and nursing care. For what was the distinction between a nursing home and a residential care home, other than the presence in a nursing home of a 24 hour duty registered nurse? It was inevitable that the recommendation for nursing care to be publicly funded, would be taken as a recommendation that registered nursing care should be funded whilst nursing that did not need to be managed or delivered by a registered nurse would be categorised as "personal care."

Contrary to its intent, this fed into the myth that there is a genuine legal distinction to be drawn between health care delivered for health purposes and social care delivered for health purposes.

The reality was, as the Court of Appeal in the Coughlan case made clear a few months later, that this was a confusion of categories where different commissioners were conflated with qualitatively different types of service. Certainly social care was care commissioned by a local authority to meet social care objectives. But Coughlan made it clear that a local authority could commission nursing care to meet social care objectives just as it could commission services that were not nursing care.

The real distinction that is material to the test of eligibility for NHS continuing care where the NHS takes responsibility for the full package, is not between health care and social care, but between care that, being health care, is potentially a responsibility of the NHS under the NHS Act, and care that is not health care and so does not form part of the NHS duty.[35] It is only in this context that the question of whether the majority or main aspects of the care are addressing health needs, can properly be answered.

The response of the government was to allow that nursing care by a registered nurse would henceforth be free. However it rejected the proposal to fund personal care.

Unfortunately, it appears that thereafter, in a confused field, this contributed to the development of a practical distinction between nursing care by a registered nurse that the NHS paid for, and personal care that was not health care and was means tested. The real distinction was that recognised in Coughlan - between nursing care of a nature that a local authority could commission, and nursing care that it could not.

The Commission defined personal care as:

> "care that directly involves touching a person's body (and therefore incorporates issues of intimacy, personal dignity and confidentiality), and is distinct both from treatment/therapy (a procedure deliberately intended to cure or ameliorate a pathological condition)"

This is as accurate a description as one is likely to find of the practical distinction prevalent across the NHS between health care and "basic and fundamental" cares. It legitimises the shift of general nursing care from to the "not health care" side of the scales when making the balancing judgement about the overall purpose of the service.

To treat such work as not nursing and therefore outside the NHS Act is to restrict the NHS duty to the direct treatment of their diagnosed health condition. It excludes the medical care required by a person suffering from illness which is in place to

[35] The NHS does of course have a responsibility to meet non health care ancillary needs when providing for people suffering from illness such as obtaining and cooking food, cleaning etc but these are not services that it is required to meet other than in that context.

manage bodily functions in those unable to do so themselves and to prevent them developing other conditions or suffering injury.

This is precisely why bedridden advanced Alzheimers disease patients, and AB in our example, are considered not to have a primary health need, or indeed any significant health needs at all.

The physical care of a resident suffering from advanced Alzheimers disease is not treatment for their Alzheimers. The turning of such a patient in bed and other skin care; their continence care; feeding and hydration; hoisting and close supervision to prevent injury; though undertaken to prevent illness and injury, are not considered treatment of the condition itself or another established condition.

Whilst it is true that they are personal care within the Commission's definition[36], they are clearly also an aspect of the general medical care of the patient and clearly come within all accepted definitions of nursing.

The Funded Nursing Care scheme

The government response to the Royal Commission recommendation that nursing care should be free was implemented in section 49 Health & Social Care Act 2001.

In Coughlan the court queried the attempts made by the NHS to describe specialist and non specialist nursing.[37] The qualitative distinction as to the types of nursing a local authority could or could not provide was considered problematic. The Court suggested that if this distinction was too difficult to make, the NHS should take responsibility for all of the care.[38]

The introduction of the Registered Nursing Care Contribution (RNCC) scheme[39] mostly addressed this quality issue by making all registered nursing the responsibility of the NHS. By including all registered nursing under the RNCC scheme it is possible that it included nursing of a type that the court would if pressed have allowed a local authority to provide. But this now appears a matter of historical interest only. The net effect of section 49 has been that the question of what types of care a local authority can and cannot provide has crystallised around the definition of work required to be carried out by a registered nurse or an equivalent health professional.

Other health provision such as assessment by speech and language therapists, nutritionists, tissue viability specialists, behaviour specialists, are all now easily identifiable as beyond the role of a local authority because these staff are now exclusively employed by the NHS.

It is easy to see how it came about that health authorities started to see:

- the balance test inherent in the concept of a "primary" health need and

- the balancing exercise required of the Coughlan test

as being on the one side of the scales the extent of the professional nursing and other NHS staff deployed, with due regard to the input of care assistants doing work that was especially skilled - balanced against on the other scale, the "social care", in the form of care assistants commissioned by the local authority. This approach does not address the quantitative issue correctly because it treats all local authority commissioned general nursing work as work on the non health side of the scale.

The test of eligibility remained one of whether all the health care being provided, was an incidental or ancillary aspect of the whole service.

---

[36] It must be emphasised that this definition has no legal force.
[37] Paragraph 41
[38] Paragraph 45
[39] Called Funded Nursing Care after 2007

It seems easy to appreciate why the adoption of this interpretation meant that the eligibility test soon became one of whether the needs of the patient can be met by the care provider using a registered duty nurse with care assistants and if it can, that is "social care."

These issues came to the attention of Charles J in the High Court in 2006 in the Grogan case.

The Grogan case [40]

In 2006 the High Court ruled on the challenge of Maureen Grogan to a decision made by Bexley NHS Trust that she was not eligible for NHS continuing care. This involved consideration of the eligibility criteria of South London Strategic Health Authority.

RNCC was initially designed as a three tiered arrangement where the amount of payment for registered nursing care was banded according to the extent of registered nursing care required. There was a fourth level of care, NHS continuing care.

In defending the claim for judicial review, Bexley maintained that a decision was first made as to whether the adult qualified for NHS continuing care and only thereafter was it determined which of the three RNCC bands applied.

Charles J found it impossible to determine from the SHA criteria and the workbook used for the test, what test of eligibility was meant to be applied. He held that the SHA criteria were unlawful on that basis. However he suspected that the RNCC criteria were used as a threshold. A key passage of the judgement in this respect is set out in Box 3.

Box 3

70. In my view when these paragraphs of the Guidance are read together with the RNCC Workbook (against the background of the sequential approach) they (and in particular paragraph 22) indicate that by itself a need for nursing care in the high (and medium) bands does not qualify a person for Continuing NHS Health Care and thus that:

> i) the nature and extent of such care does not indicate a primary health need,
>
> ii) by reference to *Coughlan* such nursing services are merely (a) incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide and
>
> (b) of a nature which it could have been expected that an authority whose primary responsibility is to provide social services could have been expected to provide prior to the enactment of s. 49 HCSA 2001, and
>
> iii) such nursing services are not on a par with the nursing needs of Miss Coughlan (which in *Coughlan* were found to be nursing services of a wholly different category to those which a local authority could lawfully provide).

Further in my view this indication, and the message or steer it gives, is likely to promote the practical effects that:

71. i) the persons charged with making the relevant day to day decisions will take the view that the care described in *all* the RNCC bands could have been lawfully provided by the local authority applying the *Coughlan* test prior to the introduction of s. 49 HSCA 2001. This would have the following knock on practical effects on them, namely:

> (a) if the bands are wide, and in fact go beyond the *Coughlan* test as to what a local authority could have lawfully provided, of extending the amount of nursing care that they consider could have been lawfully provided by a local authority in accommodation it provides, and
>
> (b) setting the limit of social services at that level, and thus of affecting their view on where the line should be drawn between on the one side social services and on the other health services and, in particular, as to the assessment

[40] Grogan, R (on the application of) v Bexley NHS Care Trust & Ors [2006] EWHC Admin 2006

concerning which public body should be responsible for providing accommodation, or alternatively

ii) the persons charged with making the relevant day to day decisions will focus their minds on the balance of the nursing care provided in the accommodation over and above that covered by the RNCC (because the practical effect of s. 49 HSCA 2001 and the guidance in respect of it, is that nursing care by a registered nurse will be provided by the NHS), rather than on the question whether *all* the nursing care provided in the accommodation, and thus the nursing care so provided by registered nurses and by health care assistants and others under the direction or supervision of registered nurses and generally (a) could have been provided by the local authority applying the test set out in the *Coughlan* case, and/or (b) could alone or with other factors found the conclusion that the person has a primary health need that qualifies him for Continuing NHS Health Care.

It is submitted that this practice identified by Charles J is now fully entrenched. It involves the wholesale disregard of healthcare work done by care assistants when conducting the quantitative balance test.

The writer does not have a copy of the SHA criteria that were subject to analysis in Grogan. I rely on the quotes from those criteria contained in the judgement. However the South Yorkshire SHA published in 2006 [41] appeared to contain substantially similar text.

The South Yorkshire criteria gave a series of levels of care need which continuously referred to "social care" as a type of need that by implication was not health care.

The criteria defined social care as follows:

> "Social Care involves the assessment of an individual's needs and the provision and management of a package of personal care and support to assist the person and his/her carer(s) to achieve, maintain or restore an acceptable level of social independence or quality of life. This is primarily the responsibility of the LA but working in partnership with other agencies."

The obvious problem with this approach was that it did not recognise that in providing social care, or personal care, the local authority may be commissioning health care. Social care and personal care were implicitly defined as something other than health care.

Level 4 (level 5 was NHS continuing health care) described:

> "Someone whose primary need is for accommodation and 'social' care' but who is likely to have a high level of needs which could be a combination of health and social care factors and may require additional staff resources to those normally provided by the community services or in a care home. However, the individual's need for health care remains ancillary or incidental to their primary need for accommodation or social care, which a local authority could be expected to provide."

Level 5 explained the requirements of eligibility for NHS continuing care as follows.

> "To be eligible the individual must have health needs which are of a nature beyond that which a local authority can be expected to provide i.e. they:
>
> 'have extensive health care needs of a nature, intensity, continuity or range which is beyond that which falls within the criteria for the provision of social care under section 21 of the National Assistance Act 1948. The individual will have severe, multiple health needs that arise from a single disease process or from a range of disease processes/disorders and/or emotional, physical, behavioural and psycho-social conditions.' (DH 2001)

[41] Replaced by the NHS continuing care Framework in 2007

For example

1. The nature and/or complexity or intensity or unpredictability of the individual's health care needs (and any combination of these needs) requires regular supervision by a member of the NHS multidisciplinary team, such as the consultant, palliative care, therapy or other NHS member of the team.

Or

2. The individual's needs require the routine use of specialist health care equipment under supervision of NHS staff.

Or

3. The individual has rapidly deteriorating or unstable medical, physical or mental health condition and requires regular supervision by a member of the NHS multidisciplinary team, such as the consultant, palliative care, therapy or other NHS member of the team.

The quotation from Department of Health criteria from 2001 was okay. But the examples used to illustrate it show that its meaning was not understood. Under these examples, only specialist NHS care contributed to a person having a primary health need.

The quantitative test was ignored. It was wrong to say that to be eligible for NHS continuing care the person's needs had to be of a *nature* beyond what a local authority can provide. That was to apply the qualitative test only.

That social care could be health care, was not explained. They appeared as if they belonged to mutually exclusive categories of care.

This was a fundamental misunderstanding of the Coughlan case.

In its application of a quantity as well as a quality test, the judgement in Coughlan was concerned with protecting social services departments from a form of mission creep that could if unchecked, lead them into becoming an alternative community health service provider by reason of the withdrawal by the NHS from areas of continuing health care provision. That issue was settled after decades of debate by the NHS Reorganisation Act 1973 which removed responsibility for the provision of community health services from local authorities.

Nothing in the National Health Service & Community Care Act 1990 intended to change that fundamental distinction. Yet adopting a practice that classified almost all of what local authorities provided as not nursing or other health care, led local authorities to take on this role, providing end stage health care in many cases of very advanced disease. This had the knock on effect that many people who should have been looked after by the NHS were forced to pay for their own care.

The NHS continuing care Framework

Following the Grogan case, the Department of Health recognised a need for a wholesale rewriting of the criteria for eligibility and the provision of a consistent framework across England.

The current Framework [42] requires that assessment of eligibility is completed using a "Decision Support Tool". This tool contains 12 health "domains" where evidence of need is recorded. The evidence in these domains is weighted by a comparison to a series of general descriptions of the health needs, each of which carries a weighting from "no needs" to a maximum of "priority." Not all needs falling into these domains can achieve a severe or priority level. For example the maximum level for psychological and emotional needs is high.

These weightings are then to be compared to an indicative standard so that a priority need or 2 severe needs are expected to result in eligibility. A severe need and other needs may also indicate eligibility as can a number of highs and other needs.

[42] October 2018

In all cases an overall judgement must be exercised as to whether a person meets the legal test of eligibility. The DST states that this judgment involves a consideration of the nature, intensity, complexity and unpredictability of the need.

The current Framework gives the working answer to the question of what are health needs at paragraph 50 stating:

> "Whilst there is not a legal definition of a healthcare need (in the context of NHS continuing healthcare), in general terms it can be said that such a need is one related to the treatment, control or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional)."

The link between this description and the language of the NHS Act set out above is obvious.

The Framework provides a lay version of the test of eligibility as follows:

> "An individual has a primary health need if, having taken account of all their needs (following completion of the Decision Support Tool), it can be said that the main aspects or majority part of the care they require is focused on addressing and/or preventing health needs. Having a primary health need is not about the reason why an individual requires care or support, nor is it based on their diagnosis; it is about the level and type of their overall actual day-to-day care needs taken in their totality."[43]

This is an attempt to create a simplified version of the test that can readily be understood by practitioners and the public alike.

It is submitted that this lay test is clearly purpose based; "the care they require is focused on addressing and/or preventing health needs." It does not attempt to designate specific types of services as health care or not health care.

If the Framework expected assessors to consider the balance between NHS provided services plus other services of an equivalent clinical level, against services that could be provided by a social services department, it would be easy to say so. In fact it specifically deprecates such an approach.

At paragraph 65 it states:

> In summary, the reasons given for a decision on eligibility should not be based on the:
>
> • individual's diagnosis;
>
> • setting of care;
>
> • ability of the care provider to manage care;
>
> • use (or not) of NHS-employed staff to provide care;
>
> • need for/presence of 'specialist staff ' in care delivery;
>
> • the fact that a need is well-managed;
>
> • the existence of other NHS-funded care; or
>
> • any other input-related (rather than needs-related) rationale.

[43] Framework paragraph 55

PG 2.2 makes it clear that there is no lower level of health care that the NHS cannot provide. It states:

> "2.2 Whilst there is no legal lower limit to what the NHS can provide, there is a legal limit to nursing and healthcare that can be provided by local authorities. This is a complex area of law. The powers and duties of local authorities derive from statute and case law, including the Coughlan Judgment"

PG 2.4 makes it clear that the work done by care assistants is capable of being considered general nursing. It states:

> "…. whilst local authorities can and do commission care in care homes (with or without nursing) where the person's needs to be met include elements of 'general nursing' which can be provided by healthcare assistants or care assistants, this can only lawfully occur when this 'nursing care' is both incidental and ancillary to the individual's accommodation and of a nature that a local authority can be expected to provide.

This point is also made in a joint publication of NHS England and the Association of Directors of Social Services titled "NHS Continuing Healthcare: Guide for Health and Social Care Practitioners: Ensuring a consistent person-centred assessment (September 2014)."

At paragraph 3.3 this states:

> "…because there is a legal upper limit to the amount of general nursing/healthcare that local authorities are allowed to provide (and charge for), and because the government has decided that there must not be a gap between what the LA can provide and what the NHS will provide, decisions on "primary health need" have to take account of the limits of local authority responsibility. In simple terms the Court in the Coughlan judgement said that LAs could provide/purchase some nursing care (in the broad sense, not just registered nursing) or other healthcare services but only in situations where these did not form a major part of the care that the individual required, and so long as the tasks involved were the sorts of things that you would expect a social care organisation (rather than a health care organisation) to do."

Paragraph 37 of the 2013 Framework[44] stated that:

> "There will be some circumstances where the quantity or the quality of the individual's overall general nursing care needs will indicate a primary health need, and thus eligibility for NHS continuing healthcare."

In summary there is no support in the Framework for a suggestion that the term "nursing" in Standing Rules regulation 21(7) should be defined to include only a set of tasks that achieve a certain level of skill equivalent to work done by a registered nurse or any other NHS professional.

Why you lose - summary

Continuing care has long been a Cinderella service in the NHS.

The NHS was formed as a hospital and specialist service. Care in the community was the responsibility of local authorities. NHS continuing care substantially took place in hospitals.

Two landmark Acts changed the responsibilities of the NHS for continuing health care. The NHS Reorganization Act 1973 gave the NHS responsibility for continuing care in the community, removing this responsibility from local authorities.

The NHS & Community Care Act 1990 had a gestation in policy discussions of many decades whose aim was to close most long stay NHS continuing care facilities, particularly those providing accommodation for patients with mental health problems and those suffering from learning disabilities.

[44] I have not found this specific paragraph repeated in the 2018 Framework.

Guidance published by the Department of Health following implementation focussed on the requirement of persons for hospital and specialist services. Many in the NHS took the view that the implementation of this Act in 1993, giving local authorities responsibility for providing care and attention in residential accommodation to people suffering from illness and disability where this was not otherwise available, largely passed the responsibility for continuing care to local authorities.

The Coughlan case held that this was incorrect. The NHS & Community Care Act 1990 did not change NHS responsibilities for continuing care. Local authority health care provision was limited both as to the type of health service it provided and by the requirement that its nursing provision was incidental and ancillary to its wider purpose as a social services provider.

The problem created by Coughlan of distinguishing between nursing care that a local authority could provide and the nursing care that was qualitatively beyond their remit, was substantially resolved by the introduction of free registered nursing care in the Health & Social Care Act 2001.

It was considered by the Charles J in the Grogan case in 2006 that Strategic Health Authority Guidance appeared to suggest wrongly that if needs could be met within the limits of the free nursing care scheme, the person did not qualify for NHS continuing care. RNCC eligibility appeared to have been used as a threshold which a person must go beyond in order to be eligible for full NHS funding of their care. The court considered that these criteria led nurses not to consider the general nursing care commissioned by the local authority.

SHA guidance in this period focussed on a requirement for specialist and NHS services as indicative of eligibility for full NHS funding.

Following the Grogan case, the Department of Health introduced the National Framework to make the process legally compliant. It is the position of this paper that although the Decision Support Tool, introduced in 2007, represents a change of documentation, in principle nothing much changed in health authority practice as a result of the introduction of the Framework. Any tendencies toward a broader legal and Framework compliant approach to eligibility have been widely eliminated as pressure caused by the funding issues affecting the NHS continues to mount from 2010 onwards. Instead an increasingly standard practice has emerged whereby the 4 factors test has been used simply to apply pre Framework criteria in the final judgement.

2 features of the Framework have facilitated this.

The Framework specifies that whilst the DST gives an indicative standard where CCGs should be closely considering eligibility, the actual decision is left to the judgment of practitioners.[45] The DST then states that this judgement is to be based on the 4 factors of the nature intensity, complexity and unpredictability of the care.

Unfortunately these factors were not new features of the Framework but have long existed in NHS guidance and practice. The earliest reference I have seen to the 4 factors is in HSG 95(8) at paragraph 21. This is reproduced in Box 4.

In my experience, there seems to be very little difference between the criteria set out in this superseded guidance and the current practice of CCGs and review panels.

Box 4 Extract HSG 95(8)

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;

[45] The availability of discretion is of course a requirement for the policy to be lawful.

- 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;

These factors naturally focus the mind of the assessor on issues of skill and complexity. Reliance on the 4 factors was simply an invitation to continue the previous practice of assessing the registered nursing or specialist requirement of the care without paying any attention to the manner in which the legal principles expressed in the Coughlan and Grogan cases were incorporated in the Framework.

The result has been that the indicative standard set out in the Framework and the DST is not properly applied.

Whilst health authorities are likely to find eligibility where a person has a priority or 2 severe needs, certain disease processes commonly encountered in elderly care will only rarely achieve such weightings, no matter how physically and socially disabled and dependent is the individual. Precisely because of this complete and profound level of disability, such individuals may not require specialist care.

This often applies to very advanced dementia patients. They will not be held eligible on that basis, even though it is obvious that the only service they require is general nursing. It is equally obvious that due to extensive brain damage, they have no capacity to benefit from the non health social support of traditional social services.

The DST has been criticised for its design. But the problems with the weightings would matter less if proper consideration were given to cases without a priority or 2 severe weightings. But the potential for eligibility in cases with a severe weighting and other needs or a number of high weightings, is overlooked where more routine care is dismissed as a class of care called "social care" which is not health care to be considered in the balancing judgement.

It is my opinion that behind these problems is the longstanding institutional prejudice of the NHS founded on its original purpose that its role is to provide a hospital and community specialist practice and it is this that separates it from the continuing care function of a social services department, which was originally run by local authorities in the tripartite system.

This expects a local authority to provide all general nursing care that is considered to be outside the specialist service remit of the NHS. It is a qualitative test only.

The reason that AB is not considered eligible for NHS continuing care, is therefore simply that the health authority considers that his care does not have a sufficient requirement for the registered nursing or other specialist services that the NHS provides.

The regular and routine care that he receives counts in the "not health care" side of the scales. The question is never asked by the health or local authority whether a social services department actually has any business commissioning care for an end stage neurological disease patient who has no capacity for any social functioning.

As a result, local authorities in England have taken on broad responsibilities for continuing care for neurological disease including dementia and stroke that are not their responsibility in law.

It is the patients who lose out by being required to pay for care that should be free under the NHS.

What can be done?

NHS England is seeking to save £855m from the expected continuing healthcare budget for 2020-21. This is a reduction of about 16%. Its proposed methods include cuts in care packages and more consistent application of the eligibility criteria.[46]

Anecdotally, it is my view that there has been an increasing acceptance across CCGs of a method of assessing eligibility which mostly excludes local authority commissioned health care in the scale test assessment of eligibility. Notwithstanding what the Framework actually says, it is certainly the case that this interpretation of eligibility is widespread in health and local authorities. It appears to represent a return to the pre Framework approach to eligibility but it should be noted that on the analysis contained herein, in many health authorities, it is unlikely that the Grogan case was ever properly understood or the Framework ever properly implemented. This is facilitated by an over concentration on the "4 factors" criteria to the exclusion of all other considerations.

It should be obvious that this method will permit a substantial tightening of eligibility but it is argued here that this is unlawful.

Since health and local authority managers make up 2 of the 3 members of Independent Review Panels, few independent panel chairs will contend for a different interpretation when faced with disagreement from their wing members.

The Health Service Ombudsman now appears to rely to a significant extent for advice on external advisors who are or who have been NHS continuing care eligibility practitioners working in health authorities or their commissioning support units. These practitioners inevitably present the health authority line that they have been trained to apply.

The redress process thus appears to be substantially the subject of institutional capture. It is unlikely that without reform, especially in the training of panel chairs, the dispute resolution process can give rise to a change of practice.

There is no doubt that there is a very significant disconnect developing between the public and the NHS regarding the funding of patients with continuing care needs. The public does not understand why profoundly ill and disabled people who will rapidly deteriorate and die without continuous health care and for whom a social services department can do nothing other than commission general nursing care, are not considered to fall within the remit of the NHS. As a result, NHS continuing care has become a political issue.

As a lawyer it would be nice to think that there could be a Coughlan 2 judicial review that resolved these issues but the reality is that there have been very few reported NHS continuing care judicial review cases. There are significant obstacles to bringing such cases including the following:

- The permission stage includes consideration of whether there is another redress process. There is a real risk that permission may be refused in favour of the NHS redress process being used.

- Being concerned with a particular decision, a court will never get to see the pattern of decisions. The inherent complexity of these cases, the opaque nature of DST recommendations, the sometimes low standards expected by the courts of non legal staff writing up their rationales and the existence of a slippery and ill defined discretion in the final decision, all make it difficult to pin down the rationale of a particular case as unlawful.

- The claimants who feel strongly enough to pursue these cases almost always have capital to defend in obtaining or maintaining free NHS care and that interest probably disqualifies them from legal aid.

Instead, institutional interests are likely to continue to influence the process. If this is to be challenged, it will probably be as a result of political interest resulting from the discontent of patients. MPs and voluntary sector organisations are likely to experience the brunt of this.

The secretary of state has taken powers under section 22 Care Act to regulate the health and social care boundary. If the proper application of the current eligibility test gives rise to problematic funding issues then the secretary of state has the

[46] National Audit Office: Investigation into NHS continuing healthcare funding; 5th July 2017

ability to change the regime. If necessary, problems should be dealt with in this manner and subjected to consultation and parliamentary scrutiny rather than by internal NHS bureaucratic measures. However it would be better to deal with that boundary issue on the basis of a proper assessment of the needs of current care users and it is hard to see how this will be done until people's real health needs are properly assessed under the current Framework.

Institutional responses to public concern have so far expressed themselves only in matters that are essentially customer service issues of delay, lack of transparency and poor communication. Whilst important, expressions of concern about service quality issues rather than eligibility, do not get to the issue that is driving public dissatisfaction.

Concerns have been raised about the application of eligibility but there has been no publicly available analysis of health service practice to underpin these concerns. The obscurity of the decision making process has thus far prevented the public and representative bodies from understanding this. It is important that such representatives understand how to interpret the accounts of decision making that are put to them.

This paper is a contribution to that work. I would certainly welcome feedback whether that be from those defending health and local authority practice or those wishing to take this further.

I can be reached at: austin.thornton@wrigleys.co.uk

APPENDIX 1

R(Pamela Coughlan) v Bexley & Others

The limits of local authority nursing care provision

(a) The Secretary of State can exclude some nursing services from the services provided by the NHS. Such services can then be provided as a social or care service rather than as a health service.

(b) The nursing services which can be so provided as part of the care services are limited to those which can legitimately be regarded as being provided in connection with accommodation which is being provided to the classes of persons referred to in section 21 of the Care Act who are in need of care and attention; in other words as part of a social services care package.

(c) The fact that the nursing services are to be provided as part of social services care and will have to be paid for by the person concerned, unless that person's resources mean that he or she will be exempt from having to pay for those services, does not prohibit the Secretary of State from deciding not to provide those services. The nursing services are part of the social services and are subject to the same regime for payment as other social services. Mr Gordon submitted that this is unfair. He pointed out that if a person receives comparable nursing care in a hospital or in a community setting, such as his or her home, it is free. The Royal Commission on Long Term Care, in its report, With Respect to Old Age, (March 1999 chapter 6 pages 62 et seq. Cm 4192-1) not surprisingly agrees with this assessment and makes recommendations to improve the situation. However, as long as the nursing care services are capable of being properly classified as part of the social services' responsibilities, then, under the present legislation, that unfairness is part of the statutory scheme.

(d) The fact that some nursing services can be properly regarded as part of social services' care, to be provided by the local authority, does not mean that all nursing services provided to those in the care of the local authority can be treated in this way. The scale and type of nursing required in an individual case may mean that it would not be appropriate to regard all or part of the nursing as being part of "the package of care" which can be provided by a local authority. There can be no precise legal line drawn between those nursing services which are and those which are not capable of being treated as included in such a package of care services.

(e) The distinction between those services which can and cannot be so provided is one of degree which in a borderline case will depend on a careful appraisal of the facts of the individual case. However, as a very general indication as to where the line is to be drawn, it can be said that if the nursing services are (i) merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide to the category of persons to whom section 21 refers and (ii) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide, then they can be provided under section 21. It will be appreciated that the first part of the test is focusing on the overall quantity of the services and the second part on the quality of the services provided.

(f) The fact that care services are provided on a means tested contribution basis does not prevent the Secretary of State declining to provide the nursing part of those services on the NHS. However, he can only decline if he has formed a judgment which is tenable that consistent with his long term general duty to continue to promote a comprehensive free health service that it is not necessary to provide the services. He cannot decline simply because social services will fill the gap.