

NHS continuing care in Wales Mind the gap?

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Introduction

NHS continuing care is a package of ongoing care, usually provided for an indefinite period for which eligibility is subject to regular reassessment, which is paid for wholly by the NHS without charge to the patient.

Social services care for the purposes of this talkⁱ, is a package of care provided to a person with social care needs which from April 2016 will be provided under the Social Services and Well-Being Act (Wales) 2014. This care is means tested. There is a maximum contribution of £60 from income.ⁱⁱ There is an upper limit to the capital an adult can own which is £23750ⁱⁱⁱ.

The issue of whether a person is eligible for NHS continuing care can make a big financial difference to a person with assets above the capital limit.

It is important that the process of decision making around the question of eligibility for NHS continuing care is accountable and this requires clarity over the basis upon which decisions are made. This talk looks at the scheme for making eligibility decision in Wales and argues that the National Framework for Implementation in Wales (June 2014)^{iv} lacks clarity and may lead to subjective decision making which will be very hard to challenge. It is also inconsistent with the new demarcation provisions in the Social Services & Well Being (Wales) Act 2014 which gives rise to a real possibility of a gap opening up between social services and NHS provision. A good understanding of the issue by practitioners may allow representations to be made to avoid this outcome.

Limitations

This talk looks at the issue of NHS continuing care provided to adults. It does not address issues relating to children.

For reasons of length only, it also focusses on NHS continuing care provided in residential accommodation. It does not look at the provision of NHS continuing care to people living at home.

History

The current legislation

The duty upon the NHS to provide continuing care is provided mainly under section 3 NHS Act (Wales) 2006.

The current duties upon social services departments in Wales to provide care arise under the National Assistance Act 1948. Section 21 sets out the duty of social services departments to provide residential care. Section 29 provides for care in the community.

Community care in Wales for adults is mainly provided under section 2 Chronically Sick and Disabled Persons Act 1970 which was an Act which extended the powers under section 29 National Assistance Act. This talk will not deal further with NHS continuing care provided at home.

The NHS & Community Care Act 1990

The story begins with the publication by the Westminster government of its White Paper, "Caring for People: Community Care in the Next Decade and Beyond"^v

The stated intention of this White Paper was to provide those in need of health and social service care with a community based service. The evidence suggested that care was provided more effectively in community settings.

The unstated intention was that in doing so, it would close down NHS hospitals providing long stay care and save money.

This was enacted in the NHS & Community Care Act 1990.

This Act made several changes to the National Assistance Act and it is these changes that are at the root of the difficulties that have arisen over the demarcation between health and social care provision over the last 25 years.

Before the 1990 Act, the duty under section 21 National Assistance Act was as follows (emphasis added):

(1)It shall be the duty of every local authority, subject to and in accordance with the provisions of this Part of this Act, to provide—

(a)residential accommodation for persons who by reason of **age, infirmity or any other circumstances** are in need of care and attention which is not otherwise available to them;

This provision does not specify a duty to care for people suffering from illness or disability.

Section 21(7)(b) set out the extent to which a local authority may provide a health service to these residents. It stated that a local authority may:-

themselves provide on the premises in which accommodation is being provided such health services, not being specialist services or services of a kind normally provided only on admission to a hospital, as appear to the authority requisite and as may be specified in the scheme under this section;

In summary local authorities could provide residential accommodation with health care for persons who by reason of age, infirmity or any other circumstances could not obtain this care elsewhere so long as those health services were not specialist services or the sort of services that would be provided in a hospital.

Section 21(8) set out a general prohibition on local authorities from providing the other types of health service that the NHS could provide (it didn't matter whether they were actually providing it) under the NHS Act 1977(section 3 of the NHS Act 1977 is reproduced as appendix 1).

The section stated:

Save as provided in the last foregoing subsection, 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.

Local authorities had separate powers under the NHS Act 1977 to provide care for people suffering from mental disorder.

This was an inadequate legal structure to meet the government's aims. The government wanted to discharge people from and close hospitals. The NHS was set up to care for people suffering from illness and people in long stay hospitals were generally suffering from some form of illness or disability. There was no express duty under the National Assistance Act to care for people suffering from illness or disability and there was a prohibition upon local authorities providing care that the NHS was empowered to provide.

This problem led to substantial amendments of section 21.

Section 21(a) was amended as follows:

(1)Subject to and in accordance with the provisions of this Part of this Act, a local authority may with the approval of the Secretary of State, and to such extent as he may direct shall, make arrangements for providing:

(a)residential accommodation for persons aged eighteen or over who by reason of age, **illness, disability** or any other circumstances are in need of care and attention which is not otherwise available to them;

The original section 21(7)(b) which limited the type of health services a local authority could provide was replaced by a much more general clause stating that a local authority may:

"make arrangements for the provision on the premises in which the accommodation is being provided of such other services as appear to the authority to be required"^{vi}

The work in setting the demarcation line between health and social services was now to be done by an amended section 21(8) which stated:

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 1977

The important aspect of this change is the separate treatment of care under the NHS Act. Whereas the previous version stated that a local authority could not provide care where the NHS Act permitted the NHS to provide it, the new provision allowed local authorities to provide health care so long as the NHS had not actually decided to provide it.

The net effect of these changes was to make it legally clear that both local authorities and the NHS could provide care for people who were ill or suffering from disability. But the amended section 21(8) meant that local authorities could provide health care for people who were ill or disabled, only so long as the NHS had not decided that it was going to provide that care.

Demarcation problems

It was perhaps understandable that this new structure suggested that the powers of local authorities to provide health care had been greatly extended. There was nothing new in this historically. Before the introduction of the NHS, local authorities had been heavily involved in health care provision.

The role of local authorities in providing community health services of the type the NHS would provide to people living in residential care had only been removed in 1973.^{vii}

In practice, the result was that the NHS withdrew to a significant extent from providing continuing care services, believing that this was now the job of local authorities.

In consequence, the following question inevitably arose. In so far as the NHS decides not to provide a health service under the NHS Act, can the local authority step in to provide that service?

Essentially this was the issue which came to the attention of the Health Service Ombudsman and the courts in the 1990s.

It was in answering this specific question that the Court of Appeal^{viii} formulated the well known "Coughlan test".

The Court ruled that a local authority could not simply meet health needs up to the point that the NHS decided as a matter of policy that it would meet them under the NHS Act. Rather, the boundaries of local authority health provision were fixed in law.

The Court held^{ix} that:

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.

The interpretation of the Coughlan test in Wales

During the 1990's a number of health circulars dealing with the NHS/social services boundary were produced by the Welsh Office.^x

The Government of Wales Act 1998 established the Welsh Assembly and the first elections were held to the Assembly on 6th May 1999. The Act provided for health and social services to be within the competence of the Assembly.

Following the Coughlan case the Department of Health published additional guidance in 2001 but this did not apply in Wales.

Notwithstanding the attempts by the Department of Health to get to grips with the issue in England, complaints continued to come to the attention of the Health Service Ombudsman who published a report on the issue in 2003.^{xi} This stated:

"A pattern is emerging from the complaints I have seen of NHS bodies struggling, and sometimes failing, to conform to the law and central guidance on this issue resulting in actual or potential injustice arising to frail elderly people and their relatives."^{xii}

In 2004 the Welsh Assembly produced its own guidance^{xiii} to the Welsh NHS regarding eligibility and other matters supported by a framework document.^{xiv}

This provided that (my emphasis):

In certain circumstances where, following a thorough assessment of needs, a person's overall health needs are judged to be **so significant**, the NHS will manage and pay for all the care they need. This is known as 'continuing NHS health care' status.....

Whether an individual is eligible for continuing NHS health care status will depend on the **nature, complexity, predictability, intensity and amount of their health care needs and of the health care inputs which they require, regardless of diagnosis**. The Coughlan judgment and the recent Health Service Ombudsman Special Report emphasised that decisions about the respective responsibilities of the NHS and local authorities for the provision of health and social care must be made on the basis of a careful assessment of the facts in each individual case. This should be borne in mind at all times. This will be explored through a multidisciplinary assessment of the individual.^{xv}

The guidance goes on to describe 4 situations where it expects that a person will meet these criteria. These are reproduced at appendix 2.

The stated position of the Department of Health in the Coughlan case was that it had always accepted that where a person had a "primary health need", the NHS was responsible for the provision of their care.

It represents a departure from established NHS practice for the Welsh Assembly not to use the term "primary health need" in either the 2004 guidance or framework.

The 2004 guidance does refer to the Coughlan case and requires Local Health Boards to ensure that their eligibility criteria conform to it^{xvi}. But it is also significant in my view that when describing the test of eligibility which the Welsh Assembly requires the LHBs to apply, the guidance does not quote any part of the Coughlan test as it is conventionally set out at paragraph 30(e) of the judgement.

Furthermore paragraph 14 which sets out the 4 circumstances in which a person will be eligible is both situation specific and restrictive and it is very difficult to reconcile these with the broader test of scale and quality as a limitation on social services provision as set out in Coughlan.

It may be said that the criteria of the nature intensity complexity and unpredictability of the health care provided, along with consideration of the "amount of their health care needs and of the health care inputs which they require" do approximate to the tests of scale and quality set out in Coughlan. But missing is the specific quantitative threshold, that the health care must be ancillary or incidental to the provision of the accommodation. The use of the term "so significant" does not provide any basis for an objective and accountable judgement.

In my view this guidance reads very much as a statement of what the NHS intends to provide as a matter of policy. It does not read as guidance to LHBs as to how they are to set their own provision at the point that it becomes unlawful for a social services department to provide that care.

In 2006, in the Grogan case^{xvii}, the High Court found that criteria being operated by Bexley NHS Trust did not identify any specific legal test to be applied to the matter of eligibility. The court noted that although there was recognition in the relevant guidance that the question of eligibility for NHS continuing care must be determined before eligibility for a Registered Nursing Care Contribution^{xviii}, a reader of the

criteria could be forgiven for thinking that the criteria provided for RNCC to be a threshold which the needs of the patient must exceed in order to be eligible for fully funded care.^{xix}

The Welsh Assembly provided further guidance^{xx} to Local Health Boards in response. This advice reiterated the legal test as set out in Coughlan stating:

"An individual will have a primary health need where their assessed needs for healthcare, including nursing services which need to be provided by a registered nurse in accordance with section 49 of the Health and Social Care Act 2001) are of a quality or quantity beyond that of the community care services which may be provided by a Local Authority under section 21 of the National Assistance Act 1948 – i.e. are more than incidental or ancillary to the provision of accommodation by a Local Authority and are of a nature which a Social Services authority could not be expected to provide (taking into account the effects of section 49 of the Health and Social Care Act 2001)"

So in response to the Grogan case, the Welsh Assembly saw fit to be explicit about the Coughlan test and to state directly that this should be incorporated in decision making regarding eligibility. This filled a gap in the 2004 guidance.

The response of the Department of Health in England to the Grogan judgement was to undertake a wholesale reform of the guidance on deciding eligibility. The result was the the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care 2007.

This was influential in Wales which in May 2010 introduced the "Continuing NHS Healthcare: The National Framework for Implementation in Wales".

The 2010 Framework

The Framework in Wales is clearly heavily influenced by the English Framework using broadly similar language.

It is my opinion that the 2007 English Framework and its associated secretary of state directions was an exercise in the Department of Health attempting to get its legal act together to produce a defensible and accountable decision making process.

There would be financial implications under this new process. But to the extent that the process attempts to restrict those, this is done in the design of the assessment tool. That assessment tool has been subject to some justified criticism as setting the eligibility bar too high. But broadly speaking, in my opinion the 2007 Framework itself was broadly a fair statement of the law.

In the English scheme there is absolute clarity that the test of eligibility that the NHS must apply is the Coughlan test. This was previously written into secretary of state directions. It is presently written into regulation^{xxi} and states:

(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 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.

On the other hand the Welsh Framework is consistently ambivalent on the impact of the Coughlan case on decision making. It lacks any clear statement that a primary health need starts where the legal responsibility of a local authority ends and that this responsibility ends in accordance with the law as set out in Coughlan.

Although the 2010 Framework discusses the Coughlan judgement and recites the Coughlan test, on the key issue of the boundary it states at paragraph 4.7:

In general, when it has been decided that it is appropriate to provide care services as part of the health service, local authorities cannot then lawfully provide those services to that individual.

This is correct because this is the meaning of section 21(8) National Assistance Act. But as has been set out above, this is not the key point of the Coughlan judgement. That judgement was determining how far it was possible for a social services department to provide services where the NHS was not providing them. The essence of the Coughlan judgement was there was only so far that a local authority could go.

At paragraph 4.13 the Framework does state that:

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 meeting the relevant means test and having needs that fall within the appropriate Fair Access to Care eligibility criteria) will fund care, either separately or together.

But this does not answer the question of whether it is the local authority or the NHS that must move to close the gap.

Appendix 3 of the 2010 Framework contains a discussion of the legal precedents. The discussion of the Coughlan case therein also fails to make the central point that if there is to be no gap in provision, the NHS must place its service provision decision at the point where health provision by a local authority becomes unlawful. It is the NHS that must move its service provision to meet the lawful boundary of social services provision.

Instead the penultimate paragraph of that analysis emphasises the discretion of the secretary of state for health in Wales to determine the extent of provision in accordance with their resources.

The Practice Guidance for the 2010 Welsh Framework^{xxii} document states:

"4.2 Does the 'incidental and ancillary test' still apply now that we have a primary health need approach? Para 3.11 of the Framework describes the "incidental or ancillary" test in the Coughlan case. This "test" is not contained in the National Assistance Act 1948 or any other legislation, although it was developed to give an indication as to the limit of local authority powers to provide

nursing care under section 21 of the 1948 Act. At the time the Coughlan case was decided in 1999, local authorities did have powers to arrange for the provision of general nursing services in nursing homes. However, Section 49 of the Health and Social Care Act 2001 now prohibits local authorities from providing or arranging for the provision of nursing care by a registered nurse in connection with the provision by them of community care services (see para 3.9)

Chapter 4 of the framework describes the primary health need approach. This is the sole criterion for determining eligibility for CHC. In assessing whether a person has a primary health need, it is not necessary to consider whether a person has needs for nursing services which are beyond the powers of a local authority to provide - therefore the "incidental or ancillary" test in Coughlan is not relevant to this."

This is Practice Guidance but the clear meaning is that the Welsh Assembly regards the Coughlan test as redundant in light of the fact that after that judgement, the government changed the law to prohibit local authorities from commissioning registered nursing care.

Is this right?

What is the impact of section 49 Health & Social Care Act 2001?

Section 49 prohibits local authorities from providing nursing care by a registered nurse.

In that section, nursing care by a registered nurse means:

"any services provided by a registered nurse and involving—

(a) the provision of care, or

(b) the planning, supervision or delegation of the provision of care,

other than any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse."

In the Coughlan case there was a discussion of the difference between general and specialist nursing and it is clear that when the court determined the issue of whether local authorities could purchase nursing care, it was referring to both.

The English Practice Guidance is explicit that when assessing the quantity of care provided, the health care provided by all care staff is to be taken into account, including the care provided by care assistants^{xviii}. Absent this, only health care by registered nurses or specialist input would count and since this cannot be provided by local authorities, the Framework would be redundant. Instead it is the totality of all health care provided to the person, including that by care staff, registered nurses, and outside specialist staff, that counts in the ancillary and incidental test.

The 2010 Framework is not explicit about this, because it does not base the eligibility decision on the ancillary or incidental test.

If local authorities are prohibited from purchasing registered nursing care, the question of whether they are purchasing care which is qualitatively "of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide" (ie the second leg of the Coughlan test) is less likely to arise.

But this doesn't take care of the qualitative issue because of two linked issues.

The first issue is the high level of training provided to, and skill exercised by, unqualified staff looking after people with health problems under the supervision of nursing staff.

The second issue is the question of the basic role of a social services department.

These two issues are linked because the question arises as to whether the high level of skill being deployed by unqualified care staff is increasingly allowing the care of a group of patients who really have little or no capacity to benefit from the work that social services departments traditionally do and should therefore be outside their scope.

This issue was inherent in the wording of section 21 which gave social services departments responsibility for the care of persons suffering from illness and disability. In the Coughlan case the Court of Appeal limited the potentially far reaching consequences of that for the role of social services departments in health provision. That boundary is now creaking under the strain of the increasing numbers of elderly persons suffering from very advanced neurological disease such as Alzheimer's disease and other forms of dementia. But it applies equally to some persons suffering from severe brain injury.

For these reasons it is not justified to conclude that the prohibition upon local authorities purchasing registered nursing care makes the Coughlan test inapplicable.

As we shall see below, this point is brought into sharp focus by the introduction of the Social Services & Well Being (Wales) Act 2014 which for the first time has given statutory definition to the role of social services departments and which has repealed section 21 National Assistance Act.

The sole criterion

Rather than follow the Coughlan judgement, the 2010 Framework developed the approach of the 2004 Guidance. The 2006 response to Grogan seems to have been treated as an aberration.

The 2010 Framework stated^{xxiv} that:

"The sole criterion for determining eligibility for CHC is now whether a person's primary need is a health need."

This was new in the Welsh system. The 2004 guidance simply stated that the NHS would fully fund and manage the care where the person's health needs were "so significant."^{xxv}

The 2004 guidance introduced the concepts of the nature, intensity, complexity and unpredictability of care (the 4 factors) as means of considering this significance but as we have seen, it also set out a rigid set of circumstances where eligibility would apply.

The 2010 Framework sets out that the primary health need test is to be determined with reference to the 4 factors. The English Framework also makes extensive reference to the 4 factors. However whereas the English Framework is clear that these 4 factors are only tools with which to consider the proper legal test, under the Welsh Framework, these factors are the test by which practitioners are asked to determine whether the person has a primary health need.

Nowhere in the Welsh Framework are practitioners required to assess eligibility for NHS continuing care according to the test in Coughlan or any rule reflecting that test. This has the effect of detaching consideration of the 4 factors from any mooring to a specific criterion and allowing that judgement to drift into the rising and falling tides of subjectivity.

It may be said that the term "primary health need" itself has a meaning as a matter of plain language which incorporates the considerations in Coughlan.

I do not believe that it does. The plain language meaning of "primary" is "first" and it implies some kind of ranking of health needs. This is certainly not the Coughlan test which applies to the totality of health needs. Absent any further guidance, the plain language does not provide any clear test at all.

Secondly, based on my experience of reviewing eligibility decisions in England, the use by practitioners of the 4 factors to determine whether a person has a primary health need is an exercise in determining whether there is "enough" intensity, complexity or unpredictability to render a person eligible. The problem is that no one really agrees on how much is enough. This gives rise to huge variations in eligibility with different assessment teams often coming to very different judgements even in the same case. It is my own view that in many instances, "enough" often means that more registered nursing care is required than is available under the FNC payment. This is the legal vagueness which the court criticised in Grogan.

Thirdly, the term "primary health need" was used in Department of Health thinking from at least the early 1990's and is referred to in Coughlan. It is clear from the history of this test that it does not convey sufficient meaning on its own to provide a clear and accountable test.

The NHS Continuing Care Framework 2014

The 2010 Framework was replaced by a new Framework document in 2014.^{xxvi}

This makes no substantive changes to the test adopted in the 2010 document.

Nowhere does the 2014 Framework state that the NHS must set its service provision policy for NHS continuing care at the point beyond which a social services authority is prohibited from providing health care services as a matter of law.

The Framework states on several occasions that a gap between NHS and social service provision is not permissible, but all of these references are to circumstances where the person is not eligible for NHS continuing care and there is a requirement for provision from both Funded Nursing Care scheme and from the local authority. This is a different issue relating to the co-ordination of joint commissioning.

Paragraph 4.13 of the 2010 Framework deprecating a gap opening up between what a local authority is able to provide and what the NHS decides to provide in relation to NHS continuing care, no longer appears in the 2014 Framework.

The Decision Support Tool

The Decision Support Tool (DST) is a method of gathering evidence to assist in the decision as to whether a person has a primary health need.

This was introduced in England by the 2007 Framework and the Welsh Assembly introduced its own DST with the 2010 Framework. This was different to the English DST and these differences were subject to criticism. As a result, the Welsh Assembly adopted the English DST under the 2014 Framework. However there are material differences in the introductory notes which explain how a primary health need is to be determined.

Paragraph 32 of the DST for England states:

MDTs are reminded of the need to consider the limits of local authority responsibility when making a Primary Health Need recommendation (see paragraph xxx of the National Framework for Continuing Healthcare).

Notwithstanding that much of the surrounding text of the Welsh DST is copied straight over from the English DST, this paragraph is notably omitted from the Welsh DST in what is clearly a deliberate edit.

The Social Services and Well Being (Wales) Act 2014

This Act is to be implemented in Wales on 1st April 2016.

The Act repeals section 21 National Assistance Act and it is important to appreciate that the duty upon social services departments to provide: "residential accommodation for persons aged eighteen or over who by reason of age, illness, disability or any other circumstances are in need of care and attention which is not otherwise available to them" will no longer exist.

In its place, for the first time an Act provides for a specific statutory definition of the purpose of the Welsh social services departments. Section 5 of the Act states:

5 Well-being duty

A person exercising functions under this Act must seek to promote the well-being of—

- (a) people who need care and support, and
- (b) carers who need support.

"Well being" is defined as follows:

"Well-being", in relation to a person, means well-being in relation to any of the following—

- 2)
- (a) physical and mental health and emotional well-being;
- (b) protection from abuse and neglect;
- (c) education, training and recreation;
- (d) domestic, family and personal relationships;

- (e) contribution made to society;
- (f) securing rights and entitlements;
- (g) social and economic well-being;
- (h) suitability of living accommodation.

(4) In relation to an adult, "well-being" also includes—

- (a) control over day to day life;
- (b) participation in work.

It can be seen then that the responsibility to promote well being in the realm of physical and mental health is applied across the whole spectrum of social services activity but that this is just one of 10 aspects of well being.

The responsibility for physical and mental health well being inevitably gives rise to the boundary issue between social service and NHS provision. Section 47(1) defines the boundary providing that:

"A local authority may not meet a person's needs for care and support (including a carer's needs for support) under sections 35 to 45 by providing or arranging for the provision of a service or facility which is required to be provided under a health enactment, unless doing so would be incidental or ancillary to doing something else to meet needs under those sections."

This is a change from the old section 21(8) National Assistance Act. Under this new provision, local authorities can provide services that the NHS has a duty to provide, but only so long as they are ancillary or incidental to meeting the well being duty in one of the other ways specified in the Act.

The relationship between the Social Services Act and the 2014 Framework

I hope it is apparent to readers who have got this far, that the Act and the 2014 Framework are speaking different languages.

The 2014 Framework makes no reference to the Coughlan test but instead provides that the question of whether the person has a primary health need is the sole criterion. The term primary health need is not defined, but whether a person has such a need is to be determined by looking at the nature, intensity, complexity and unpredictability of their needs.

The 2014 Social Services Act is clear that in providing continuing care health services, the social services department must be mainly attempting to do something with regard to well being that is not the provision of a health service.

If we take the example of a person with very advanced dementia, or a person who is severely brain damaged, and assume that in both cases, as sadly may be the case, their capacity for independence, maintaining relationships and social participation is minimal or non-existent and who are in fact being nursed for the purpose of the maintenance of their life, then the provision of health care by a social services department will not be ancillary or incidental to the provision of a wider social service.

The adult will be provided with suitable accommodation and other services, but this means that the boundary of social services provision will be whether the provision of health services is incidental or ancillary to the provision of the accommodation and those other services - which is of course, the Coughlan test.

It is to be noted further that the decision as to whether an individual has a primary health need is taken by the Local Health Board, not the local authority.

This gives rise to the prospect of LHBs applying their own very subjective test to the question of whether someone is eligible for NHS continuing care which is a different test both in theory and practice, to the test being applied by a social services department as to whether they can meet needs which the LHB is not meeting.

Practitioners must henceforth be wary to mind the gap. It is hoped that my talk and this paper will enable them to understand what may otherwise be a baffling difference of opinions between health and social services agencies regarding eligibility.

This appears to be a matter that ultimately only a Minister with responsibility for health and social services can require to be resolved.

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Appendix 1

Section 3(1)(c) NHS Act 1977 imposed a duty on the NHS to provide nursing services and 3(1)(e) imposed a duty to provide continuing care. These are the same duties as appear in the NHS (Wales) Act 2006.

Section 3 is reproduced here in full for context. Emphasis is added.

"It is the Secretary of State's duty to provide throughout England and Wales, to such extent as he considers necessary to meet all reasonable requirements -

(a) hospital accommodation;

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

(c) medical, dental, **nursing** and ambulance services;

(d) such other facilities for the care of expectant and nursing mothers and young children as he considers are appropriate as part of the health service;

(e) 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;

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

e) 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;

Appendix 2

WHC (2004) 54 - NHS Responsibilities For Meeting Continuing NHS Health Care Needs: Guidance 2004 paragraph 14

In the context of the full assessment and consideration of individual needs in each case, and taking into consideration the total amount of care required, any one of the following criteria may indicate eligibility for continuing NHS health care status:

i. The nature, or complexity or intensity or unpredictability of the individual's health care needs (or any combination of these needs), or the risk to themselves or others means that regular input (such as assessment, intervention or monitoring) is required by one or more members of the NHS multidisciplinary team, such as a doctor, nurse, therapist or other NHS member of the team.

(Note: These health needs require more intense or specialist care than that provided through primary care services or by a registered nurse in a care home e.g. palliative care. The need for supervision by a GP or registered nurse is not in itself sufficient reason to qualify. Regular in this context will normally refer to weekly or more often).

OR

ii. The needs of the individual require the routine use of specialist health care equipment involving the supervision of NHS staff.

(Note: This covers those people who need to use specialist health care equipment regularly- i.e. weekly or more often – and need the supervision of an NHS professional for its safe and effective use.)

OR

iii. The individual has a rapidly deteriorating or unstable medical, physical or mental health condition (or is detained in accordance with Section 17 of the Mental Health Act) and requires regular input (such as assessment, intervention or monitoring) by a member of the NHS multidisciplinary team.

(Note: A person who qualifies under this condition is likely to qualify for a period during which their mental or physical health is rapidly deteriorating or unstable. They may no longer qualify if, following a review, their health has stabilised, unless they qualify under one of the other criteria.)

OR

iv. The individual is in the final stages of a terminal illness and is likely to die in the near future.

(Note: People included here would normally qualify under iii above. Where they do not, and without being overly prescriptive, this would otherwise include those for whom 'near future' may be taken to mean around 6-8 weeks. They may no longer qualify if they improve and are later diagnosed as being likely to live for some time longer, unless they qualify under other criteria).

Appendix 3

Determining Primary Health Need

Sole Criterion for Eligibility

3.57 The policy of Welsh Ministers on eligibility for CHC is based on whether an individual's primary need is a health need (this is known as the "primary health need approach"). The sole criterion for determining eligibility for CHC is whether an individual's primary need is a health need.

Determination of a Primary Health Need

3.58 The following characteristics of need and their impact on the care required to manage them will determine whether an individual's primary need is a health need:

- **Nature:** This describes the particular characteristics of an individual's needs (which can include physical, mental health or psychological needs) and the type of those needs. This also describes the overall effect of those needs on the individual, including the type ('quality') of interventions required to manage them.
- **Intensity:** This relates both to the extent ('quantity') and severity ('degree') of the needs and to the support required to meet them, including the need for sustained/ongoing care ('continuity').
- **Complexity:** This is concerned with how the needs present and interact to increase the skill required to monitor the symptoms, treat the condition(s) and/ or manage the care. This may arise with a single condition, or it could include the presence of multiple conditions or the interaction between two or more conditions. It may also include situations where an individual's response to their own condition has an impact on their overall needs, such as where a physical health need results in the individual developing a mental health need.
- **Unpredictability:** This describes the degree to which needs fluctuate and thereby create challenges in managing them. It also relates to the level of risk to the individual's health if adequate and timely care is not provided. Someone with an unpredictable healthcare need is likely to have either a fluctuating, unstable or rapidly deteriorating condition.

3.59 Each of these characteristics may alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care required to meet the individual's needs. The totality of the overall needs and effects of the interaction of needs should be carefully considered.

ⁱ Care provided under section 117 Mental Health Act 1983 is not covered in this talk.

ⁱⁱ This will continue @ £60 after April 1st 2016 when the Social Services & Well Being (Wales) Act 2016 comes into force by virtue of regulation 22 of the Care & Support (Charging) (Wales) Regulations 2015.

ⁱⁱⁱ This will rise to £24,000 from 1st April 2016 under regulation 11 of the charging regulations.

^{iv} Continuing NHS Healthcare: The National Framework for Implementation in Wales (June 2014)

^v HMSO Cm848 presented to Parliament November 1989

^{vi} In the Coughlan case – see below – this reference to services was held to include health services

^{vii} NHS Reorganisation Act 1973

^{viii} R v North & East Devon Health Authority ex parte Coughlan [1999] EWCA Civ 1871

^{ix} Paragraph 30 (d-f)

^x WHC (93) 23/WOC 27/93 Continuing Care: Boundaries Between Health and Social Services

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- WHC (95)7/WOC 16/95 NHS Responsibilities for Meeting Continuing Health Care Needs.
WHC (95) 38/WOC 47/95 NHS Responsibilities for Meeting Continuing Health Care Needs:
Arrangements for Reviewing Decisions on Eligibility for NHS Continuing Inpatient Care
- ^{xi} The Health Service Ombudsman: "NHS Funding for Long Term Care" HC 399 February 2003
 - ^{xii} Page 1 paragraph 1
 - ^{xiii} WHC (2004) 54 - NHS Responsibilities For Meeting Continuing NHS Health Care Needs: Guidance 2004
 - ^{xiv} The all-Wales Continuing NHS Health Care: Framework for Implementation in Wales 2004
 - ^{xv} Paragraph 13
 - ^{xvi} Paragraph 7
 - ^{xvii} R v Bexley NHS Trust ex parte Grogan 2006 EWHC 44 (Admin)
 - ^{xviii} This is a fixed payment intended to cover the costs of a registered nurse to provide care. These payments resulted from the decision by the government that local authorities should not commission nursing care by a registered nurse, enacted in section 49 Health & Social Care Act 2001.
 - ^{xix} Paragraph 92
 - ^{xx} WHC (2006) 046 annex B paragraph 1(b). Also NAFWC 32/2006
 - ^{xxi} Regulation 21 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.
 - ^{xxii} Continuing NHS Healthcare For Adults Practice Guidance to support the National Framework for Implementation in Wales: Frequently asked questions - September 2010.
 - ^{xxiii} See PG 1.3
 - ^{xxiv} Paragraph 4.1
 - ^{xxv} WHC (2004) 54 paragraph 12
 - ^{xxvi} Continuing NHS Healthcare: The National Framework for Implementation in Wales (June 2014)