

Consultation response by Belinda Schwehr, Care and Health Law

Introduction

I am an independent consultant and commentator in this field, having been a specialist lawyer in private practice offering expertise in public law, and specifically social care law, for several years.

My career has coincided with a radical change of culture in the field, so far as people's awareness is concerned, of the importance of public and administrative law, and use of it, for asserting their rights and making a difference to their lives.

Since at least *one* measure of a society's development can be gauged from the extent of the rights and opportunities it provides for disadvantaged people (*real* rights, not just theoretical ones) - this is a culture change that I entirely applaud and work to support, in any way I can. The shift though, makes it all the more important that any new 'framework' for funding of care by central government, is derived from a proper explanation to the public of the legal principles that bind both the central government and local authorities, in this regard.

My position on the effect of the case law in this area to date, is (and always has been) as follows, and this obviously informs my overall views of the value of the proposals:

- The DH's 2001 guidance did not actually reflect or implement the *Coughlan* decision either
 - a) in full (regarding the financial consequences of qualifying) or
 - b) accurately (regarding the wording of the criteria it offered to health authorities, in its Annex C).
- The 2001 guidance, in conjunction with the introduction of RNCC - and s49 H&SCA - had the effect of actually making it *harder* to qualify for full 100% funding than it had been before the *Coughlan* case, in practice, although the legislative change actually reduced the scope of what LAs could lawfully provide as chargeable social care in a nursing home - which is difficult to understand, if it was *Coughlan* compliant.
- However it came about that the guidance and RNCC were presented as *Coughlan* compliant, though, the law did then - and does now - permit ministerial change to NHS provision policy, but only if no fresh error of law was, or is now, to be made, on the part of the Secretary of State (as advised by the DH, of course).
- There was a fresh error of law in the 2001 guidance, and that guidance could and should have been challenged by LAs nationally, using Judicial Review proceedings, to protect against being drawn in to arranging health service care and paying for it and charging at least some full cost payers, for that care.
- The aspect of the 2001 guidance that was clearly a fresh error of law was the assertion that all the care ever required to fit the descriptors of need within the newly introduced High and Medium Bands of RNCC had always been lawfully

able to be provided by the LA, within the notion of what was ancillary or incidental to social care.

- This was no small mistake; it was positively untenable, given what Ms Coughlan's serious but not extreme needs 'stood' for, in legal terms. Her profile of need, even if not said, in terms, to justify **full** NHS funding, *had* been held, as a matter of law and legal interpretation of statute, to represent care needs of a scale and type **beyond** that which any LA could lawfully provide.
- The stance that the introduction of RNCC had not altered anything could easily have been tested by reference to asking where Ms Coughlan's needs would have fallen, had she been re-assessed after the introduction of RNCC? If the answer would have been in Medium or High Band RNCC, even though the court had held that as a matter of law, her needs were above the incidental and ancillary line, then it would have been obvious that she could not **both** have been within RNCC **and** above the prior ancillary and incidental line. The indefensibility of the stance in the 2001 guidance would then have been exposed.
- If Ms Coughlan had been re-assessed and been awarded RNCC, (for this she would have had to have been in a nursing home and not a Trust facility where she had been promised a home for life) she would have received only a split package of care and not full NHS funding.
- She could then have been seen as a person in the second category of client which the Court in her own case had held (see paras 43-46) would still have to be covered by criteria for funding by the NHS (whatever that part-paid status ended up being *called*) because one thing was clear: she could not be *fully* funded by the LA sector, in terms of its vires.
- If that had happened, or if the DH had not insisted on the consistency of its new framework, with *Coughlan*, as a case about full cost 100% continuing care, Ms Coughlan's existence and her relative degree of fitness would not then be presenting the insurmountable problem of presentation that DH now finds itself lumbered with. That is, explaining coherently how the new 2006 proposals 'fit' with the case law, and enable someone like Ms Coughlan to qualify for full funding, without the prospect of spending millions of pounds that it does not have, on matching others' expectations.
- Equally, if nursing homes had been encouraged to separate nursing fees from personal care and accommodation, board, and admin costs, or told to do so, as was once proposed, so that they could invoice PCTs accordingly, for proper split packages involving RNCC, then the cost of RNCC would never have been able to have been held down to a flat-rate contribution. Those needing more than average input would be getting bigger packages, approaching 50/50 shares of the overall cost, more often than not. Disputes about 'grey area' clients would probably have been amicably resolved without either organisation suffering disproportionately. LAs and local tax payers (and those still paying full cost for their packages, apart from the RNCC element) would have saved millions. Central government, however, would have had to raise the national tax threshold to pay for this underlining of the central tenet of the health service, and to cope with the bulge in the elderly dependent population, whose properties would have remained their own.

Answering the actual questions in the consultation document

1. What should this funding status be called?

I don't think it is helpful to call this particular status of receiving free care, outside of hospital - '*Healthcare*' at all. There are two problems with the title, in my view.

a) it glosses over the absence of any consensus as to what *ought* to be seen as healthcare, in the sense of both whether it should be free as part of what people have paid taxes for, or whether, in terms of risk and safety, a given task really is something that can *only* be done by qualified nurses.

b) it is inconsistent with the message from the HSC and the Grogan case that whether a person is eligible for the status should not depend on their needs being sorted into personal care needs and health care needs.

It would be better to refer to eligibility for "funding for NHS services" or for "NHS funded care".

2. Who should be making decisions about the criteria, as between SHAs and PCTs?

I don't understand the question. If it is about who sets the *criteria*, the DH will be doing that, centrally, in the new regime, not SHAs OR PCTs. If it is about decision-making against those criteria, which I assume it must be, then SHAs are *not* currently responsible, to the best of my knowledge, so the question is itself puzzling.

I think it is important that the guidance distinguishes between four separate issues (though this particular response is perhaps better seen as part of my section 7, on dispute resolution):

- a) who should be making the decision about the *need* to assess, in the first place, in the sense of **screening**? There is no reason why this should not be done by local authority as well as health service professionals, in my view, once a screening tool is in place;
- b) who makes the decision as to whether a person actually **meets** the criteria once they have been set? This should obviously be people with medical qualifications, working in collaboration with LA care managers, since **all** relevant needs have to be taken into account, not just medical or nursing needs. And there should be access to any panel reviewing or re-hearing that question of meeting the criteria, for LAs disputing the decision, as well as relatives or actual claimants;
- c) who should be making the decision about eligibility for actual **funding**, once criteria have been set nationally? It obviously has to be a health service person or

lawful delegate or agent of the NHS, in my view, because the decision to fund is an NHS discretion, to be exercised subject to available resources.

- d) who should be responsible for adjudication in cases of dispute? The HSC, the Local Commissioners, the CSCI, CHI, or the courts? I favour a tribunal, myself.

My belief is that the legal position, at *present*, is that PCTs already make the decision on all disputed CHC cases, and on all claims, in theory. I am aware that other commentators seem to think that the **clinicians** actually make the decision and of course this is right in one sense - their clinical expertise is used to confirm whether or not people meet the criteria that have been laid down. To my mind, however, it is trite law that no clinician can have delegated, to him or her, a decision which is in law a decision to be made in the discretion of the PCT – whether or not to fund the patient's ongoing care. The decision that someone meets the criteria is not the same as the decision to meet the needs, and there is no legal right to healthcare, as such. The most anyone has is a legitimate expectation that they will be funded, *if* they meet the criteria.

Shifting decision-making responsibility **to** the SHAs, who do not hold the budget for the function, is an option to consider. It would see some limited element of independence injected into the system. But it would alter the advisory nature of the SHA's Independent Review Panel recommendation into a decision-making function. That decision would either have to be accepted as giving rise to a **right** to health care funding (– a radical change of stance, in legal terms, about NHS functions only being target duties, not creating enforceable rights) – OR, alternatively, the decision would have to go back to the PCT, since it holds the budget and has the commissioning role, so far as I am aware.

Beefing up the robustness of the decision-making in so far as removing the actual judgement, as to whether Mrs X meets the criteria, from the budget holder who will actually have to pay for the outcome, is worth considering. It would be one way of avoiding having to spend more resources to allow for more complaints to be made to any of the other relevant bodies, or the creation of an independent tribunal, my preferred choice.

However, the obvious points to be made are that the SHA tier of the health system is not any more likely to be seen as independent by the public, than the PCT, being itself, part of the NHS hierarchy. Any SHA would be amenable to Judicial Review so it would just be inserting another level into the system for the poor patient and their family.

In my view the same assumed intent – making it clear that there is an independent element in the system somewhere - could be achieved simply by spelling out in the final guidance and leaflets for public awareness all the different routes of challenge and (this would be new) that **judicial review** is available against any PCT for error of law, unreasonableness, breach of human rights or procedural unfairness in its decision-making. There is already case law that makes it plain that refusing to follow an advisory complaints panel's recommendation requires a very good reason indeed, in order to be

reasonable (*R v Wigan ex p Tammadge*), and better public awareness of the risk of JR is a useful fillip to clearer thinking.

3. Other factors that should have been considered in relation to providing for eligibility in the new framework

Regarding whether there are any other factors that should have been considered and made explicit in the guidance, a fundamental omission, in my view, is an actual analysis of the legal framework and the case law.

The draft guidance glosses over 4 finding in case law - no doubt inconvenient findings for the finances of the DH, and so just compounds all the problems of ambiguity to date, and makes more litigation more rather than less likely. Namely:

a) The question whether the government itself believes that the effect of *Coughlan* is that Ms Coughlan's profile of needs forms a legal benchmark for its own policy of fully funded NHS continuing care on proof of a primary health need

In fact the judgment simply proceeded on the footing that the government's policy about full funding being right for certain people, was just that – a policy choice, framed by *government* and turning on a person's having needs that were “**primarily health needs**” – that formulation not being one found anywhere in the NHS Act. It did *not* say that this was the statutory test or even the necessary *financial* outcome in law, of Ms Coughlan's having being found to have had needs that were clearly **beyond the remit of the LA's ancillary and incidental powers**.

For support that a clear stance on this interesting question is critical to understanding the DH position, it is instructive to scour the *Coughlan* judgment, in which the only references to Ms Coughlan's personal position are as follows:

“...The **Secretary of State** accepts that, where the primary need is a health need, then the responsibility is that of the NHS, even when the individual has been placed in a home by a local authority. The difficulty is identifying the cases which are required to be placed into that category on their facts in order to comply with the statutory provisions. **Here the needs of Miss Coughlan and her fellow occupants were primarily health needs for which the Health Authority is as a matter of law responsible,** for reasons which we will now explain.

This dictum does not amount to a finding that Ms Coughlan was entitled as a matter of law to **full NHS funding**. All it says is that her needs were primarily health needs, and that therefore, according to NHS policy, which was not being directly challenged, in the case, she - just as anyone else with needs that were primarily health needs - would be offered full funding from the NHS.

That does not have precedent effect in terms of establishing that the test of legality is a test of primary health need, in my view, or that anyone similar to Ms

Coughlan, in terms of needs, *must* qualify, in order for any re-formulated framework for NHS full funding, to be lawfully drawn. It could not have precedent effect because the purpose of Judicial Review cases is review of public bodies' decisions, resulting in a chance for the body losing the case to re-make the decision again, correctly; the court does not sit as a court of appeal *from* its decision, substituting its own.

And further, from *Coughlan*, again:

"Whether it [an LA providing the nursing services] 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.**

.... That this is the position is confirmed by the result of the assessment of Miss Coughlan and her fellow occupants. Their disabilities are of a **scale which is beyond the scope of local authority services."**

These dicta are indubitably findings (and ones which *were* within the proper remit of the judges on a JR matter) as to whether the notion of ancillary or incidental could even possibly be taken to cover someone of Ms Coughlan's profile, and is a firm benchmark, at least, as to the sort of needs that ***cannot*** wholly be met within the vires of the LA. However, the financial *consequences* of that finding were not explored by the Court, as it was not its function to spell out those for the HA concerned, or the DH.

b) The existence of a gap, in theory, between what any LA can legally provide, and whatever resources any PCT may 'prefer' to allocate to providing for the amount or sort of care that goes beyond that notion. I appreciate that the policy line being taken now, is that the gap will not exist in practice, and that is admirable. But I do not think that the government can set the test as having a primary health need, whilst being confident in the real world that this test avoids any gap existing, into which people will still fall. The existence of the legal gap is critical to

- a. The NHS hospital sector, and PCTs, understanding why the LA is not automatically responsible for anyone that the NHS declines to acknowledge as eligible;
- b. Everyone understanding why the long term policy of the DH that NHS money should either fund *all* the costs of care, or merely RNCC (and before that, *nothing* towards the care home package) is a *choice* on its part, and not a legal compulsion.
- c. Public understanding that an LA is simply not able, let alone obliged, to pick up responsibility for someone (and charge them) even though it agrees that the person has been inappropriately assessed by the NHS.

For proof of the existence of this theoretical gap, see the actual *Coughlan* judgment (and the *Haringey* children's services judgment too, although it is currently on appeal, I think):

*(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 Secretary of State is entitled to decide whether something is necessarily offered as part of the duty to promote a comprehensive health service, taking into account that the ancillary and incidental line is derived from the wording of the statutory functions relevant to the interface between NHS care and LA funded care.

Given that the government is publicly determined that there should - in practice - be no gap between the two types of provision, the DH must be saying that the line for NHS continuing care funding **is to be the same** as the ancillary and incidental LA vires line. One is a matter of vires and one is a matter of discretion.

Therefore it is self-evidently logically necessary for the draft policy guidance to *attempt* at least an identification of what CAN be provided by the LA sector, no doubt after research and consultation. The line must be able to be grasped and identified, to be of any use, so that people understand whether they should use political pressure or law to deal with their falling into a gap *between* that free care and eligibility for LA care. In this regard, the draft guidance clearly wholly fails.

It's obviously right in common sense terms that it really is time for nationally applicable and centrally set criteria. The whole thrust of the current proposed guidance is that the decision is for the NHS, in principle at the DH level, and then in an individual sense, PCTs or SHAs as decision-makers as to what a person's needs amount to - because it is the department's policy that the test is whether there is a 'primary health need'.

But, if, in fact, the new guidance is wrong in law, and the test needs to start by identification of whether what is needed by way of input, **can lawfully be provided by an LA** within the relevant statutory functions related to the intended setting (ie own home care or care home care) then that position that the decision about the scope of an LA's statutory functions is for the DH, and ultimately for doctors and nurses, at the front line, is, to say the least, surprising.

It is my position that the case law establishes that the starting point for the test is what is ancillary or incidental to social care, and it makes no sense at all to have nurses or any kind of clinician telling the social care sector what it is or is not allowed to do. The more obvious candidates for the drawing of the ancillary and incidental line, are the LA

sector, subject to unreasonableness or error of law on their part, and ultimately of course the **court** – as a matter of statutory interpretation.

The role of deciding what it is necessary and hence reasonable for the NHS to provide, is clearly for the Secretary of State, under s3(1) of the Act. But that is a *different* line, or it **could** be a different line, in legal theory, from the ancillary and incidental line, unless the existence of any gap between the two would be unlawful. Both *Coughlan* and *Grogan* cases confirm that a gap is inevitable and **not** unlawful (although it would of course be undesirable) because the underlying duty on the Secretary of State is merely to *promote* a comprehensive service, not provide one.

The cases both emphasise that the ministerial judgment as to what s/he wants the NHS to pay for, must not be made in error of law as to what can lawfully be provided by the LA sector. Matters of pure statutory interpretation are invariably for the courts, but I am willing to accept for the sake of argument that social conditions, respect for the choices and aspirations of chronically ill or disabled people, society's view about the cost-effectiveness and purpose of hospital care, and changing politics, are indeed part of the subtle interface between what is provided to meet reasonable requirements with the health service, and what is not, because it **is** able to be seen as ancillary or incidental to social care.

If one goes that far, it probably means that a *sensible* stab at the definition of ancillary or incidental, if one were made in central guidance, would be unlikely to attract a finding that it has been made in error of law.

Unfortunately, no attempt at elucidating the principles has been made in the guidance, and it is an enormously disappointing document, as a result.

Support from the case law for the opinion above that the legal framework clearly gives the Secretary of State the power to withhold services from the remit of what counts as a health service and must be free, so long as no error of law is made en route about LA vires, is as follows, from *Coughlan*, once again:

24. The first qualification placed on the duty contained in section 3 makes it clear that there is scope for the Secretary of State to exercise **a degree of judgment** as to the circumstances in which he will provide the services, including nursing services referred to in the section.

He does not automatically have to meet **all** nursing requirements. In certain circumstances he can exercise his judgment and legitimately decline to provide nursing services. He need not provide nursing services if he does not consider they are reasonably required, or necessary to meet a reasonable requirement.

39. ... In determining what health services are to be provided by the NHS, the Secretary of State may take into account what services are and can be lawfully provided by local authorities as care provision. However, the question remains as to whether the correct boundary has been identified [in HSG 95(8)] between what is the proper responsibility of the NHS and what is the proper responsibility of local authorities.

... Section 21(8) National Assistance Act [the section prohibiting LA provision, in certain circumstances relating to other bodies' own distinct service provision functions, making LA provision a matter of last resort] ... provides the key to this issue. How are the words "or authorised or required to be provided under" the Health Act to be applied?

28. Each word is of significance. The powers of the local authority are not excluded by the existence of a power in the Health Act, to provide the service, but they are excluded where the provision is authorised or required to be made under the Health Act.

The subsection's [ie s21(8)'s] prohibitive effect is limited to those health services which, in fact, have been authorised or required to be provided under the Health Act. **Such health services [prohibited to be supplied by LAs] would not therefore include services which the Secretary of State legitimately decided under section 3(1) of the Health Act it was not necessary for the NHS to provide.**

... The true effect is to emphasise that Care Act provision, which is secondary to Health Act provision, may nevertheless include nursing care which **properly** falls outside the NHS.

... 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 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."

Thoughts in light of the above on how to avoid exposure to an error of law challenge when the guidance is finalised

The policy considerations relevant to defining what is ancillary or incidental to social care in a care home (or what is able to be provided by way of ‘practical assistance in the home’, under the CSDPA 1970) might take in prevailing conditions in sheltered housing and support, extra care growth and the willingness on the part of social care organisations to embrace the normalisation agenda, and do things that would, many years ago, have been seen as within the sphere of nursing.

Consultation with local authorities as to what they find it feasible to recruit for and commission, and insure for, within the resources granted to them for social care, might help the process.

Working with front line staff with hypothetical descriptions of different grades of pressure sores, and various complicating factors, as to whether there is an unavoidable need for qualified health care input, could help.

The process would also take into account the department’s own Directions in LAC 93(10) about the remit of social care, or the need for updating those directions. See *Coughlan* once again:

... The requirements for approval and directions by the Secretary of State in section 21(1) **give the Secretary of State considerable control over both what and how services are provided by local authorities under Part III.** (The necessary directions were given in 1993 in an appendix to guidance issued by the Secretary of State on 17 March 1993.)

These Directions made in relation to Sections 21 and 29 of the 1948 Act are legally binding, and have a higher status than Section 7 LASSA Guidance. The Circular states that it “does not of itself create any additional responsibilities which have not previously been expected of local social services authorities”, and says explicitly that they “take account” of the amendments made to part III of the 1948 Act.

The key paragraph is Paragraph 4 of the Directions on Section 21. Under this Paragraph, setting out how there are to be “Arrangements to provide services to residents”, Local Authorities are directed, for those in Section 21 care, to “...make arrangements.....(c) to enable persons for whom accommodation is provided to obtain – (i) medical attention, (ii) nursing attention **during illnesses of a kind which are ordinarily nursed at home**, and (iii) the benefit of any services provided by the NHS of which they may from time to time be in need, but nothing in this paragraph shall require a local authority to make any provision authorised or required to be provided under the NHS Act 1977....”

Furthermore, although *setting* should not become determinative, the thought process would *have* to acknowledge that an LA’s vires to act at all, in making specific arrangements for particular things or types of input, are different, depending on the

setting for the care. In a care home, or an unregistered National Assistance Act adult placement, the ancillary or incidental test is derived from section 21(5) and (7)(b) NAA, according to *Coughlan*, and in the community, in a person's own home, the CSDPA sets the limit at **practical assistance in the home** and other related services of a more or less domestic nature.

Then, when a conclusion had been reached, as to what to authorise or require to be provided under the Health Act, in the terms of s21(8) of the NAA, the policy author's decision that the line for NHS funding based on the line of what is ancillary or incidental to social care, **would be unlikely to be found to be seen as being made in error of law**, and we could all get on with implementing it.

It is interesting to wonder what the courts would make of an amicable application for a declaration of the legality of whatever guidance is finally provided, say between the ADSS and the Department of Health, with any interested parties paying their own costs.

c) The possibility in law for split packages for at least some people, who do not have what is seen as a primary health need but who do have needs that could be partly funded by the LA up to the limits of its vires.

Those additional needs would have to be funded by the NHS, even though the PCT was not able to be persuaded that they should be 100% funded. Anyone needing exceptional levels of care in a care home, for instance, should have that slice of nurse care overtime paid for by the NHS, so that the other residents are not disadvantaged. There is no reason this should be paid for through flat rate RNCC, since that is for everyone in a nursing home to reflect that all such people need the attention of the registered nurse manager.

The legal possibility of split packages which are not merely divided into the normal RNCC and LA shares has never been properly addressed in guidance since *Coughlan*, only receiving oblique attention in one paragraph of the continuing care guidance, and one paragraph of the FNC guidance.

50/50 packages and other shares used to be common. If split packages had continued to be perceived as legal by LAs and PCTs, there would have been far less likelihood in a joint working era of positions having become so entrenched that more cases ensued, such as the *Grogan* case. The stark difference between 100% and merely RNCC levels of NHS funding would have seemed less important if both sides had been encouraged to have considered the benefits of a two-way (or even a 3-way split, in the community, where ILF would sometimes have been available). The client would still have been chargeable, but only up to the social care percentage of the cost, for those above the capital threshold, as a maximum. The restitutionary liability of health bodies, in the light of the HSC driven retrospective exercise would have been smaller.

For support for the contention that this possibility has wrongly been omitted from the consultation process, see the *Coughlan* judgment, in particular:

43. The fact that there is this background of possible confusion makes it important that **any eligibility criteria should be drawn up with particular care. They need to identify at least two categories of persons who**, although receiving nursing care while in a nursing home, are still entitled to receive the care at the expense of the NHS. 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.**

46. [re the submission that it would be ridiculous for specialist nursing to be free and general nursing not to be]... **if a portion of nursing care can still be provided as a service for which the local authority is responsible, then we do not see anything improper in those services being charged for under the local authority regime. Other services for which the NHS is responsible can still be provided on health service terms.**

I acknowledge that the draft guidance implies that in paying for what the authors still stubbornly want to call RNCC, **any PCT may pay a variable amount**, and that this could be said to be a discreet concession and explicit authorisation to PCTs to negotiate in individual cases.

However, what needs to be made explicit, is that this is not something that should simply be called RNCC, if at the same time, the DH wishes the world to believe that anything *within* that definition was also something that could have been lawfully provided by an LA before s49 H&SCA was introduced.

The essence of the reason for any PCT paying *more* than what they have been given in funding, to *buy* RNCC input, would be that there may be some forms of care that are not needs that inevitably have to be met by a nurse, but which are beyond the legitimate scope of LA's powers, by reference to *quantity* alone.

I appreciate that the benefits system may need to be tweaked, if it did become policy that split packages were a good idea, because benefits law on certain types of benefit currently envisages the NHS paying for all or only RNCC in a care home, even if the NHS Act enables the NHS to buy accommodation for services separately from those services, in s.3(1). Benefits can be lost if there is evidence that the NHS is paying for more than RNCC. I am not a benefits expert, however, and an opinion or suggestion in this regard is beyond my ability.

d) Continuity of need (mere long-termed ness)

Continuity of need was a factor that seemed significant to the Court in Ms Coughlan's case but it is not mentioned in the Decision Support Tool or in the overarching principles document at all.

Questions 4 and 5 - Specific comments on the appropriateness of the preferred factors of nature, complexity, intensity and unpredictability

I think that the first important omission from the current draft is an explicit statement on whether the 'relevant' needs, for the purposes of the assessment itself, are **any** needs related to illness or disability, *regardless of the cause of the client's problem.*

I say this, because in the community, where RNCC will have no application, it is entirely common for assessments for eligibility to commence with a separation by the assessing nurse into nursing and personal care tasks (see *Pointon* for just such a saga). Also, it is not unheard of for NHS professionals to see the same needs in a different light, dependent on whether the condition was a congenital one, an accident outcome, or part of the ordinary process of ageing. Oblique references to 'nature' as a specific factor without spelling whether it extends to that sort of consideration, is very important, and I say a bit more about this below, under 'Nature'.

Someone from the NHS reading *Coughlan* could easily be forgiven for thinking - since the whole case is about the distinction between basic nursing and specialist nursing, and the judges were expressly confining their attention to the concept of '**nursing**' under s3(1)(c) of the Act - that personal care needs were not relevant at all, to assessment for eligibility, although they would be paid for by the NHS if someone turned out to be eligible. That would mean that anything that was not acknowledged to be a nursing need could legitimately be carved off and thus lighten the weight of what had to be 'scored', in the first place. I don't think that this is the intention of the judges, or of the proposed guidance, but it does need to be clarified, because it is often used as a reason why people

with congenital learning disabilities and dementia do not qualify, no matter that the quantity of care they need is very large indeed, in terms of expense. Legislative support for clarifying that nursing for continuing care purposes certainly does not mean the same as *registered* nursing is easy to find – nursing in the NHS is undefined, and there is no limitation of it, by reference to registration or qualification, to be found there.

Secondly, there is a problem, I think, with some of the factors used in the guidance as triggers of eligibility. The *Coughlan* judgment mentioned nature, skill, quantity, quality, intensity, and continuity as factors that a lawful set of criteria would be likely to have to contain, in order to be consistent with the quantity and quality test delimiting the power of an LA to buy any nursing services at all within a care home.

It would have been helpful if the draft guidance had related the preferred factors (which have been used since 2001 ie the Annex C factors from the post *Coughlan* guidance) to that aspect of the judgment. It is my view that those Annex C factors themselves were not a proper reflection of *Coughlan*, and nothing has changed to make them any more consistent, simply through having been carried over into the new draft guidance.

See the *Coughlan* judgment:

"40. We recognise that what services can be appropriately treated as responsibilities of a local authority under section 21 may evolve with the changing standards of society. It is always going to be difficult to identify the limits of those services.

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.

The distinction does not necessarily cater for the situation where the demands for nursing attention are **continuous** and **intense**. In that situation the patient may not require in-patient care in a hospital under the new policy, but the nursing care which is necessary may still exceed that which can be properly provided as a part of social services care provision."

a) **Nature**

I have spent some time considering what the words in the guidance are intended to mean. For instance, it may be suggested that the word '**nature**' comprises both the

skill required and the range of presenting needs, and in this sense, the ‘quantity’. But the judges distinguished between specialism and its relevance for considering the nature or quality of the care needed, from any similarly obvious significance for the *quantity* test, so this is a difficult stance to defend. In my view, the assertion in the draft guidance that the factor of the *nature* of a need incorporates the quantity factor that the *Coughlan* decision stresses, makes no semantic sense – it is needs we are talking about, not services. One does not have a **quantity** of needs, but needs which require a particular quantity of response, by way of input.

Even though *Coughlan* allows for reference to the nature or type of quality of the need in question, it must be obvious that this is meaningless unless the DH puts some flesh on that concept by explaining what its own view is of what makes a need a need for full funding and the ongoing input of the NHS. Using ‘nature’ of the need as a factor for the new framework, without any explicit and articulated indication of what it is the government sees as giving rise to a *health* as opposed to a social care need is not helpful to anyone and simply perpetuates the confusion and culture of non-qualification.

If by ‘nature’, the government intends ‘derived from an accident or an illness’, as opposed to normal ageing, or congenital disability, it needs to say so, with respect, so that the Department may be judicially reviewed about the legality of such a stance. Testing it this way, if Ms Coughlan’s physical needs had derived from a congenital disability defect, instead of a road accident, would she have been intended to be seen as the responsibility of the health service, to the same or any degree?

However, there is a much more fundamental problem of internal inconsistency, in my view with the ‘nature’ factor as described – which is that the guidance tries to assert that the *skill* factor, particularly the qualification factor, involved in RNCC, is simply not relevant, at some points, to eligibility, but IS relevant, at others, where it is euphemistically referred to as manifested in a need for ‘specialist’ input or supervision.

If the skill factor is at least relevant, as *Coughlan* suggests it is, the guidance either has to be explicit about it, and find some *other* distinction between shared care for RNCC clients, and continuing free NHS care for others - or else come clean and say that as care workers become more generically skilled, and relatives do more and more for their loved ones, the departmental *policy*-driven definition of the kind of skills needed to constitute such a need is explicitly x y and z.

The specific problem with combining skill and nature as factors is that the nature factor fails to spell out that there is no definition of health care or what is not health care in English law. In Scotland at least, that which is not personal care but something less than that, *has* been spelt out because personal care is now free. But that’s no use to anyone trying to work out what is more than personal care, and can be called nursing, albeit not registered nursing. Insurers have different ideas, and even LAs and different area offices of the CSCI infamously take different approaches.

Many local authorities embracing the normalisation agenda without regard to the financial consequences for their local taxpayers are cheerfully providing what some people would call nursing, in any objective sense. They are arguably acting ultra vires, and wasting LA resources, and compounding the legal risk, if charging for the services concerned or giving out direct payments to cover self-purchase. Alternatively, they are acting as agents or delegates of the health service, for the discharge of health service functions, not social care functions, under the s2 LGA power or a Health Act partnership, when so doing. Once again they should not be charging, or giving out direct payments for these tasks.

Even the H&SCA definition of RNCC – ie **registered** nurse nursing - is circular and unsatisfactory – starting with a ‘bootstraps’ definition along the lines of RNCC being anything that is provided by a registered nurse, and then turning back on itself, to refer to the concept of things that ‘having regard to their nature, and the circumstances in which they are provided do not **need** to be provided by a registered nurse.’ Is it agreed anywhere, I wonder, whether anyone agrees which tasks it would be madness to attempt, without being a registered nurse?

The difficulty of distinction between that which should be funded by the NHS, and that which need not be, in policy terms given the absence of any legal definition, was acknowledged in the *Coughlan* case itself:

[The HA's policy lists] as examples of specialist nursing: continence care, stoma, diabetic, paediatric, palliative, tissue viability and breast care. It distinguishes these from what it calls 'core' nursing: the work of district nurses, health visitors, practice nurses, community psychiatric nurses, community mental handicap nurses and midwives.

Of those areas identified as specialist, none are recognised as such by the United Kingdom Central Council for Nursing. Those listed as non-specialist are arguably all examples of specialist nursing. It is not for us to resolve this difference of approach, but it is relevant to note that the notion of specialist nursing, **introduced by way of policy guidance and not by statute**, is, on any view, elusive.

[What the HA documentation had asserted, although it was not able to be substantiated with any document, was that] "The National Health Service Executive recommend that the following services are to be regarded as standard, ie. not specialist, in nursing homes: general physical and mental nursing care, artificial feeding, continuous oxygen therapy, wound care, pain control, administration of drugs and medication, catheter care, bladder wash-outs, suction, tracheotomy care, tissue viability."

b) **Unpredictability** equates to skill and frequency and therefore quantity of need, but was not referred to at all by the judges at all in *Coughlan*.

'Unpredictability' ought not to be a separate factor in its own right, in my view. It is better seen simply as ONE possible aspect of complexity, and therefore related to the

skill factor needed to deal with it, and the intensity, or quantity, in terms of the staffing needed to deal with it.

Someone with predictable unpredictability, or indeed, purely predictable, but very highly skilled or wide-ranging needs still needs to be able to qualify.

The principle that successful management of previously unpredictable needs should not marginalise a patient's status is an admirable one to express, but it is not easy to see how that will be interpreted and applied, if unpredictability is a factor in its own right.

Stability as a concept was important for distinguishing between bands of RNCC, when those bands were first introduced, but it ought never to have been seen as detrimental to establishing eligibility for continuing care full funding, or indeed, anything more than RNCC levels of funding. See the Leeds ombudsman findings, in a case where there was nothing unstable about the conditions involved) or instability a pre-condition.

Unpredictability and stability as factors give rise to specific problems for end of life care, which are covered in my section on the Core Values document at the end of this paper.

c) I think **complexity** equates to skill and range, and I have no particular objection to this re-framing of Coughlan approved criteria, so long as it is carefully explored in the guidance when finalised.

d) **Intensity** is a straight match but it wasn't very clearly explained in the case and no-one would be any the wiser looking at the guidance or the DST, in my view. I think it needs to be more clearly defined in terms of relating to the numbers of staff needed given the strain caused by the input, or the numbers of staff needed all at the same time for a particular task, perhaps, such as lifting and handling, or restraining?

e) It will be seen that even if I have guessed right, this leaves out of account **continuity** as a relevant factor at all, though it was probably what convinced the judges, to say, obiter, that Ms Coughlan was not just above the LA line but probably would have been re-assessed as deserving of fully free care, had that been for them to decide (which it was not, in JR proceedings) instead of remitting to the HA concerned.

6. The domains in the guidance

Regarding the description and content of the domains, over which the eligibility factors are to be identified: I think these are very good, personally.

However, I am told that autonomic dysreflexia would be very hard to fit into any of them. It is a blood pressure risk associated with much spinal injury, and requiring very confident and skilled immediate input, although sufferers may be young people injured in

accidents and otherwise able to live in the community, after rehab. The most common cause seems to be a blockage in the urinary drainage device, bladder infection, a bowel that is full of stool or gas, and stimulus to the rectum can trigger a reaction. The result is vasoconstriction, resulting in hypertension, pounding headache, visual changes, anxiety and pallor; and to compensate, the body slows down the heart rate, whilst the brainstem stimulates the heart. It can be fatal.

7. Process and practical matters

To my mind, the process aspects for any new era, should be broken down into screening and assessment, decision-making, dispute resolution, publicity responsibilities, performance management and consequent upon all of this, training of the relevant personnel.

a) Assessment and screening

I agree with other commentators that the NHS responsibility to assess for free care (since it is the NHS's money concerned) **must** be made into a legislative function, not just one in Directions.

One way of explaining why assessment is necessary, in terms that will be understood by the NHS, and private law liability in negligence - springs to mind. When one is in the care of the NHS, one ought not to be discharged from hospital, at least not without negligence, before a professional has made a clinical decision as to what further NHS services are appropriate for the individual. That might be medication, intermediate care, RNCC, primary care/district nursing, medical equipment, out patient appointments, or long term rehabilitation - OR of course, eligibility for funded NHS care, albeit outside of hospital.

That might mean the NHS arranging care from specialist nurses, going into see the ex-patient in a *residential* care home, or into a person's own home or a care home even *with* nursing, if the care home cannot offer the expertise or capacity, or will not make direct arrangements with the PCT for the nursing element.

Logically, it could also involve a full placement in a residential home for a very few ex-patients, such as those severely learning disabled patients who are still to be discharged from learning disability hospitals into the community, but whose condition has not altered at all. They should thus still be seen as NHS in-patients, NOT the responsibility of the LA, merely subsidised by the NHS, through discretionary s28A arrangements that can be reneged on without much realistic fear of come-back by the authority or the clients concerned – a whole *another* story, waiting for a Panorama programme, in my view).

Once assessment became a legislative function, then just as has occurred with assessment for *social* care, preliminary 'screening' mechanisms would then be bound to

be created by managers, as a matter of course, to ensure efficient use of staffing resources. I agree it would be much better to create a national tool, however. Screening for assessment for NHS care is almost automatically the outcome of community care assessment, given that FACS guidance is only about what is able to be given to someone by way of social care, and not any other public bodies' statutory functions, such as NHS funded care, or housing. It would therefore be able to be done by care staff or NHS staff, by OTs, GPs, CMH nurses, ASWs, AMHPs, once it was understood.

In terms of the workforce, I see no reason why any such duty to do a full assessment for those that appear to be in need, could not then be discharged **in practice by LA staff, just as much as by nurses, through agency arrangements or Health Act partnerships, which the DH so widely recommends in all other regards, or even imposes. If nurses can be trusted to do CCAs, why can't LA staff be trusted to do NHS funded care assessments, as part of the Single Assessment Process?**

b) Decision making fairness

The case law already holds that any such decision-making about funding or appropriateness of the proposed care plan, should conform with the rules of procedural fairness and be **documented monitored** and **reasoned** – Wandsworth LBC ex p Goldsmith.

Clinicians need to understand that their role is simply to identify what is needed, not who should be paying for it, or what the implications of a particular score would be.

Any finalised DST should therefore be used by *administrators* to double-check the consistency of the scores with the proposed outcome, and stand back and not miss the wood for the trees, where a cumulative amount of need should qualify someone in any event, despite the discrete outcomes of the tool in relation to specific domains.

I know that financing the manpower will be challenging to the department, but would like to suggest that there would be plenty of junior members of the Bar, nationwide, who would be willing to sit as legal chairs, on internal panels, to provide the essential element of legal re-assurance and minimise judicial reviews of PCT or SHA decisions. That would be cheaper than paying solicitors' firms, I believe.

c) Dispute resolution

I see no justification whatsoever for holding fast to the idea that a review and hearing before an advisory IRP should only be for relatives and patients, and not the LA. The LA sector has lost millions in funding NHS care patients, which it may have a legal liability to pay back, and no chance, it is assumed, of the guidance telling PCTs that they must find money to indemnify authorities against these restitutionary claims. Surely it is sensible, now, to stop this potential occurring, by giving the LA sector the means to point to some Directions-based rights for them to challenge decisions they think are above the *Coughlan* ancillary or incidental line – short of judicially reviewing their partner PCTs?

I would personally favour **an independent health and social care tribunal**, which would hear reviews (as opposed to appeals) from all sorts of decisions across health and community care services, thus taking the strain off the ombudsman systems, the internal complaints systems as administered by public bodies, and the CSCI and CHI, and ultimately off of the Administrative Court. I want to be president of it, however!!

If an independent body is not to be identified or created for this jurisdiction, then at least giving LAs explicit locus to challenge decisions at the IRP stage would mean that an actual JR by an LA against a PCT, for an unusually intractable and outstanding dispute, would be a very rare thing.

I have little faith in mediation in this field, given the premise that a mediator does not have to be expert in the actual substantive field of law involved in the dispute. But **early neutral evaluation**, where someone who IS expert, is asked by all parties to give a view, ought to be able to be funded, in my view, somewhere in the system.

I am personally aware of PCTs unilaterally withdrawing from funding split or full packages without reference to the home or LA concerned, and chief executives who have been offended at the suggestion that such behaviour was worthy of complaint to the Health Care Commission. The finalised guidance, in my view, therefore needs to make it **absolutely clear that it is unlawful (and negligent, in terms of a duty of care in private law) to withdraw from a funding relationship without determining eligibility properly** first, and secondly, that when there is a dispute, the client or patient **must** be cared for, under the arrangements currently in place.

Dispute resolution, if it is not sorted out, will impact on hospital waiting lists, to the detriment of government and individual Trust hospitals, primarily. Local authorities need support in any finalised guidance to be able to be robust about **not** owing a duty of care to people they genuinely and reasonably think have needs outside the vires of the LA. If the input needed is something that any reasonable person would think of as a nursing service, then now we have s49 H&SCA, it clearly cannot be bought for the client, however much the LA would like to help. The recent *Haringey* children's case is relevant here – the judge agreed that he could not define what was health and what was social care, in any determinative way, but he was jolly sure that changing and suctioning of a tracheotomy tube was definitely *not* able to be seen as something able to be provided under the admittedly wide discretion of the Children Act, s17, as social care...

d) Publicity responsibilities

Why is this issue not made a Directions-based obligation on the part of all PCTs? I am fed up, as a consultant to a number of LAs, with having to help them explain why it is not *their* legal duty to ensure that people know their rights in respect of the scope of the Health Service, and what to do about asking for a review and reasons.

No-one, in my view, should be discharged from hospital, without being given information about the existence of funding for those who qualify, and how to make one's claim to deserve full assessment, known to the hospital staff.

Likewise in the community, no-one should be assumed to be the LA's responsibility without information about the possibility that the NHS is responsible; or to be the LA's *ongoing* responsibility, if deterioration is noted on annual review.

At the same time, I think it would help if the public information that is eventually put out by the Department, makes specific mention of the fact that there is no RIGHT to health services, even if one does appear to qualify under the criteria. This would clarify an issue, which the general public finds very difficult to understand, and raise the level of press and political debate.

e) Performance management

Various commentators will be pointing out that there is no organisational or performance-monitoring incentive built into the system to make PCTs *want* to award eligibility for NHS funding of ongoing care. This must be remedied and applied by the Health Care Commission.

It is my view that directors of social services never challenged the validity of the Department's 2001 guidance, or any of their partner PCTs, for local operational failures in the process, through ignorance of the legal framework underpinning their functions, the hiving off of legal departments from social care management, anxiety about the effect on joint working and the fear of incurring the wrath of the Change Agent teams. So I think the CSCI (whilst it still exists) should be performance monitoring LAs in this regard, and separately.

The extent to which LAs stand up for people's rights, even as against their partners from Health, as opposed to colluding with them in relation to at least the care of the elderly, who tend to have property to sell to pay the LA's charges, is a legitimate aspect of social work to measure and reward, in my view.

The comparative numbers of people qualifying for RNCC and any NHS funded community based care, as a percentage of population covered by the new SHAs or PCTs, should be available and used as a performance indicator.

f) Training

I make a good living out of training, nationally, in health and social care law and legal rights, but I have never thought of continuing NHS health care as a subject fit for it.

That is because, in the past, I or indeed any trainer would have needed to make clear which bits of their course were derived from the apparent DH *policy*, which bits

from the local *PCT*'s policy, (or if not collaborated upon by the LA, what the LA management thought of that policy) and which bits from the case law - or whether simply to offer a pragmatic approach about how to get as many people qualifying for it as possible. There was never any possibility of reconciling any of these separate strands.

I can see that the advent of the national criteria will make identifying the right factors to go by, a lot easier, once finalised, but I have to say that I would not want to train PCTs or LAs in the guidance, as currently drafted, because of the many legal issues it glosses over or misrepresents, in my view, still, and because of its core, which I have concluded is essentially still devoid of any clear meaning.

NB Conflict of interest - I have seen no discussion anywhere of the untenable conflict of interest a holder of a joint post in a Health Act partnership or Care Trust will find him or herself in, if s/he has to make the decision about eligibility, at the point when the pooled budget is bare, and the client has a house to sell.

8. A screening tool

In my view, a test like s47 of the NHSCCA would be the only one which could feasibly work, so as to include all those with a chance: does the person appear to the PCT to be a person who may be in need of any continuing NHS service?

That duty would arise whenever anyone was referred by anyone, or referred him or herself. If the state chooses to filter assessment through the medium of professional judgment about the likelihood of qualifying, it would need to pay for GPs or other professionals to be trained in this regard, as a pre-condition of their taking on that new role.

Since Grogan, I have personal knowledge of PCTs suggesting that only the individual can ask for a review – when an LA suggested that it would be important to re-assess the few people to whom the PCT had ever awarded High Band RNCC status. This sort of stance needs to be made impossible by finalised guidance. Time scales need to be included, or back-dating to the date the review was requested, should become the norm.

All the work on (so-called!) self-assessment that the Department is encouraging LAs to instigate (subject to legal principles relating to the LA being the decision-maker, of course) could be equally applicable to PCTs managing this responsibility. In the hospital, it would precede service of any 'fit for discharge' certificate. In the community, it would be triggered on any LA assessment (to which, under s47 already, the LA is supposed to alert both health and housing, in any event, on account of the possibility that *they* may well have responsibilities needing decision-making and implementation...)

9. The Decision Support Tool

In my view, this tool is ultimately devoid of any value, if the purpose is to avoid a lottery depending on where one lives, in eligibility terms, according to PCT area, and to encourage consistency. In my view there is an urgent need for **case studies** that will be part of the guidance, even if the line has to be moved, as times change, as part of supporting decision making. Those case studies need to make a distinction in every client group as between RNCC and what the DH calls full NHS continuing care. My section on split packages above, explains why I think case studies should explore the grey area client group too – somewhere between fully LA funded care and fully NHS, and not necessarily RNCC at all.

There are two obvious problems with the DST as it currently stands. The most serious problem, to my mind, is the lack of any articulation of the reasoning *why* some domains have the possibility of Priority or Severe levels of need, and others simply do not.

I can see, personally, why this has been done – I think it is implicitly related to the likelihood of skilled staff being needed to manage the issues, but that is precisely what the guidance tries to say ought not to matter, at least not in the sense of focusing on the status, employment or qualification of the individuals needed for the tasks. If the identity of the professional needed for the task is not supposed to be relevant, then why is it part of the DST, in that way, in the first place, and why is it specifically mentioned in the behaviour domain? It is just not consistent with the policy as stated in the principles paper. More articulation here, then, is needed.

Being a purist, however, I personally have to acknowledge (and explored it, above) that *Coughlan* said that skill and specialism were obviously relevant factors. I think that the draft guidance needs to distinguish between skill borne of informal training (ie being shown and supervised, before being left to do particular things, and gaining experience this way, so that trained carers could be seen to have that level of specialism, and hence trigger eligibility - and on the other hand, actual qualification or registration, which should *not* matter, in the sense of being required. Of course these latter attributes should be relevant and *helpful* for qualifying, where someone's registered input is agreed by all to be 'needed' and the more needed, the stronger the weightier the claim, obviously). Would it be negligent to leave a person to a non-qualified carer, without any informal training or learning? is a good way of asking this question, in my view.

The second problem is that the draft guidance completely funks the essential question on everyone's mind, for the financial outcome: How MANY moderates make up for 2 severes, or one priority score? **If PCTs are allowed to be the judges of this question, the whole purpose of achieving any degree of consistency will be doomed.** The policy needs to say how many moderates, or whether one High, with a particular number of Moderates, should trigger eligibility, for this tool to be of any use. It is the role of the DH to advise the Secretary of State how to decide lawfully what it is reasonable to provide within the Health Service, as shown above, and de facto delegation of that

decision, through lack of clarity, is simply not consistent with the policy statement that variations should now no longer be permitted.

10 The most suitable part of the process, for the assessment

This is obviously best done before hospital discharge, and in the community, as part of care management, whenever someone deteriorates from something more than temporary passing illnesses, or the nature of their needs changes significantly. I can think of no other alternatives.

11 Melding the 3 bands of RNCC into one

I think it is a very good idea to get rid of a layer of bureaucracy in the system, which potentially delays discharge by hospitals, in any event, and encourages RNCC nurses to think in terms of High Medium or Low, as opposed to Higher than High, or even Lower than Low, needs, when assessing.

However, the department needs to know that there are **very chaotic and varied forms of contracting for RNCC at the moment** (at least 50% of authorities, in my experience, are likely to be contracting, unlawfully, with the home, for the whole package, and simply getting some money back from the PCT, at some point if they are lucky, without any formal agency or Partnership arrangements ever having been put in place). Health Act partnerships and agency relations under the LGA have not been taken up to the extent predicted, or have fallen out of favour through fingers having been burned. There is no lawful reason an LA should commission and contract for NHS functions, let alone care manage the Health Service's clients in the community, or contract or performance monitor any nursing element, for *nothing*, in return.

Given that the department has spelt out how contracting should be done, in the FNC appendices to the guidance, I have never understood why this has not been performance managed or audited, but never mind. **The fact is that many authorities will be inappropriately exposed to having binding contractual commitments to care homes for *high* band RNCC when the new system is finalised**, and your commitment in the draft guidance to paying the PCTs a sum of money for that ongoing responsibility for the then current clients, will not, I fear, ensure that the self funding clients, the care homes or the LAs get the money, in the end...

I think the guidance needs to be more explicit about how - once the melding has taken effect - assessing staff will have to distinguish between **new** clients - who will only be able to count as the new band - or as continuing care - and the then **current** clients who should only be put 'down', if their needs actually *lessen*, and not just because that is the only band existing in which they could be put, after review.

The guidance says nothing at present about the outcome for currently medium band clients whose needs might *worsen* after the bands have been melded. Are such

people the intended beneficiaries of the oblique suggestion that any PCT could choose to pay more than the flat rate funding band, for particular people's nursing, or is that a more general point, applicable to anyone who is seen as a seriously above an average nursing responsibility?

On the actual funding proposals, I think the guidance should state explicitly that the government's decision to spend £xm in funding PCTs to pay for RNCC is merely an executive decision, and not something which limits the amount that they could then choose to pay out.

The fact that the guidance allows them to pay an amount that more accurately reflects the cost of the actual nursing, needs to be explained more fully. Only a very few people, in my experience, in commissioning, understand that this is clear authority, if not actual encouragement, to PCTs, to agree to split packages for those who no-one is really sure about, in terms of the interface between full free care and RNCC/LA shared care.

Why don't we give this client group, including all the historic 50/50 cases, or those with shares in other percentages - a clear name or a status, different from the concept of 'full' NHS continuing care, but different to RNCC, as well - **how about calling them "RNCC Plus"?**

This would put an end to the debate as to whether it is even legal to split packages, as was clarified in *Coughlan*, regardless of what the DH policy on the matter happened to be at that time, and since.

One reason I think it is very important that this whole 'outcomes' area is clarified is that I have heard of LA fears that this 'new' freedom will mean that some PCTs will pay less to homes, than they have been provided with from central funds to pay *out*, because of the NHS financial crisis and performance management fears.

If that *is* the sub-text, and not something that the department would be quick to discourage overtly, and RNCC payments eventually became tied into the *actual* cost of nursing, whether that be more or less than the flat rate band paid to PCTs, the Department will need to make it absolutely clear that PCTs will have to contract directly with care homes and put out proper specifications for the nursing services that are actually wanted and needed, check up on the providers, and understand that ultimately the duty to provide for appropriate NHS care is non-delegable.

This might cause chaos for two reasons, though. First, we all know that PCTs are in no position to do this sort of commissioning, having relied on LAs to organise the care home nursing element in the past. Secondly, nursing homes have been encouraged, ever since flat rate benefits paid for nursing home care, to contract for a blended flat rate fee without separating out their nursing and personal care and hotel and admin costs.

I personally think that there should be Directions telling nursing homes to separate out their registered nursing costs and their hotel and board and admin costs, so as

to highlight the differing amounts of personal care going into different clients. I may be wrong but I think that this was proposed but has never been put into effect. If homes could charge a realistic rate based on the true cost of registered nursing, LAs would have an idea as to what was needed to make up the shortfall between those costs and the full charge. That might bring in an era of fairer contracting as between authorities and care homes, and give a boost to the economic argument underpinning the re-opening of cottage hospitals for long term care – or otherwise stabilise the nursing home market a bit, in the long run, which would be good for discharge statistics and hospital waiting lists.

In conclusion, this practical side of the commissioning arrangements for the new system needs much better thinking out, in my view, before the guidance is finalised.

12. Other documents

The Core Values document

The section on palliative care/end of life care is simply incoherent to me. I cannot tell whether the policy is that such people should qualify regardless of nature, complexity, unpredictability or intensity, etc etc – for instance, because it is unpopular in policy terms, and unedifying, to charge them for the privilege of dying in their own homes, and we don't want them in hospitals taking up beds, unless it's really necessary - or whether they should just be fast-tracked for assessment, but still have to *qualify* just like anyone else?

LAs could be told it would not be appropriate to charge terminally ill people for care in the Fairer Charges guidance, so long as lost income was made up by central government, if the choice above, were to be that *everyone* has to qualify and not just be within a very short time of death, in the interest of equity of application of the criteria.

I am aware of certain PCTs automatically cutting off funding when someone has the temerity to confound the expectation of their doctor that they are within x weeks of death, where x has been the time limit set. This is shocking to me, because it suggests that the NHS fails to see in that situation that it needs to *review* the person – who is of course still alive, but not likely to prove the expert wrong, twice.... and hence is *still* eligible for NHS funding on account of being close to death. . .

The guidance would be assisted by some reference to retrospective funding as between health and LA bodies if a person who had *claimed* but was refused eligibility, on the x week rule, has then died, having been charged for care. This would help in cases where the clinician is reluctant to put a finite number of weeks on any certificate for whatever reason.

The public information leaflet

No comments other than to highlight the absence of references to judicial review for those suspecting unlawfulness of wording or operation.

The power point presentation

This presentation puts the ‘ancillary or incidental’ test in a bullet, without that test having had proper primacy, in the main document, in my view.

The regulatory impact assessment

Is the sum of money being rumoured to be needed, simply intended to cover the small difference between current medium band and new melded band of RNCC, or to pay genuinely full care costs, for all those currently on High Band **and** new people who are expected to qualify, in the new era? Or both? Or what? I would like to see it explained more fully in the final impact assessment.

Who exactly are the personnel who are going to **train senior management, and monitor and audit** performance, and who are the people who are going to train the actual *practitioners* in hospitals and the community, whose entrenched approach to the rarity of NHS care, has never been addressed? The training cost is going to be enormous, in my view. The approach of Mr Justice Charles in *Grogan* was that part of the problem was that “the persons charged with the making of the relevant decisions have not had the benefit of the intensive study of the detail of the relevant guidance, the *Coughlan* case and the argument that has been a part of this case.” If the DH wishes to save on the training costs, its guidance has to be able to summarise the principles in shorter measure than has been done in this consultation response.

13. An additional concern relating to commissioning NHS care in the community

Special attention needs to be paid to the difficulties in commissioning continuing care for people **in their own homes**, such as Malcolm Pointon, in my view. More often than not, the main carer is the best possible person to look after the sick person. They need recompense for so doing, and to be able to buy respite. If they are not actually caring, all the time, the staff who do go in to that home, need to be very sensitive indeed to the views of the main carer.

The usual commissioning solution is that the NHS employs or engages people of its own choice, who are not likely to be acceptable to the person under great stress, in primary charge of the very sick person at home. This naturally causes trouble, and such people often want direct payments, and to get on with the job, so long as they get the money.

However, the department itself emphasises that it is **not lawful** to provide direct payments for NHS services, and the absence of any plans for change is perfectly understandable.

If a person lacks capacity to consent to a direct payment for *social* care, then s/he cannot have one either, however much the spouse or family member wants to be in control of the arrangements, and would probably do a brilliant job. For Mrs Pointon, the rigidity of the English framework led to it appearing to be sensible to acquiesce in re-framing her husband's needs as *social* care (even though the HSC thought that he would have to be seen as qualifying for free care on re-assessment) so as to enable the NHS to provide funding to the LA in order simply that they would be able to return that money to Mrs Pointon as a direct payment, gross, for her husband's care.

This kind of practice is difficult to defend, if it is accepted that there *is* a distinction between needs that the NHS should fund, and purely social care needs. It is also particularly undesirable in cases of mental incapacity because it exposes both the incapacitated person as the supposed employer under the direct payment, and the carer as the supposed employee, to legal risks regarding injury of either or both, which could not be effectively insured against. It also lets both health and social services off the provision hook, entirely. It is just not acceptable in 2006 that it is the best anyone could come up with at the time.

There is a further problem, in my view, with packages of care in the home, especially for dementia sufferers and very severely incapacitated clients of any client group. Even if the NHS accepts that someone in their own home does deserve in-patient status, and NHS money, the classification of what is then to be bought, may trigger **registration consequences** under the Care Standards Act, as the provision of nursing or domiciliary care agency services. The mere fact that the person is an in-patient in their own home does not mean that what is actually needed for meeting his or her needs is *outside* the definition of registrable personal care. The trigger for registration is merely the arrangement of - and not purely the provision - of such care - for another person in their own home. A person doing this for a mentally incapacitated person is not merely helping them sort their *own* care out, as their agent, but is arranging it directly. No-one can really imagine that people's own spouses are going to want to register as an agency and the CSCI has not got the resources to manage that, even if they did apply.

The *Gunther* case says that the NHS can buy care from anyone it approves of, including not-for-profit vehicles such as so-called "independent user trusts", which would be a great way forward. But it is not clear whether the young woman in that case was actually able to direct the purposes of that IUT members, and if not, then those 'Trust' members would clearly have been arranging *registrable* personal care, albeit with legitimate s23 NHS money, rather than with any sham direct payment for social care, and would not have been able to be an 'excepted undertaking', as defined.

Therefore, if the department is serious about the NHS *actually commissioning* long term care for people in the community, legislative change *has* to be made to enable

the main carer/family member to be given the money to buy the care in directly, as commissioning agents of the NHS under s23, without registration consequences, or minimal registration consequences, if that would be preferable to none.

In Wales, there is an exception to the rule of registration for domiciliary care agency status (registration there also being triggered merely by the arrangement of personal care for a person in their own home), for anyone doing it for fewer than four people, which is an ideal solution to the problem, in my view.

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