The Law Society

National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care

Comments by the Law Society of England and Wales

September 2006

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National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in England

Comments by the Law Society of England and Wales

Introduction

The Law Society regulates and represents solicitors in England and Wales. This response is from the representation arm of the Law Society.

We welcome the publication of this consultation and the opportunity to set out our views on the proposals for a National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in England (the National Framework). The Law Society has an interest in this area of law because solicitors are increasingly becoming involved in disputes over eligibility for fully funded NHS Continuing Healthcare. We hope our comments will be of assistance in improving the proposals.

The Law Society welcomes the creation of a single national criteria for NHS Continuing Healthcare. We are however extremely concerned that the proposals are not fully compliant with the *Coughlan* judgement.[1] Indeed we believe it is highly unlikely that Ms Coughlan would qualify for NHS Continuing Healthcare funding under the new regime.[2] Unless the legal position is properly understood and consistently applied, the core problems in relation to NHS Continuing Healthcare will continue and many vulnerable people and their families will continue to pay for health care which should be the responsibility of the NHS and free at the point of delivery.

Questions

Q1 We recognise that terminology can be complex in this area, and the names given to particular packages of care (for instance, 'NHS Continuing Healthcare') can cause confusion. We are keen to receive any suggestions for how these core concepts could be re-named to better describe the services they provide.

We agree that the definitions provided of core concepts are crucial. In particular the language used should be unambiguous and must correspondent with the wording used in statute and case law. We are therefore concerned that the Consultation Document places at its centre the proposition that entitlement to NHS Continuing Healthcare is based upon the test of whether a person's 'primary need is a health need'.[3] This approach however is not the one adopted in *Coughlan*. In this judgement, the Court of Appeal only referred to this approach on one occasion, where it noted that 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'.[4] The court however immediately went on to suggest that such an approach presented difficulties and ultimately it opted for an altogether different test – namely that entitlement to free NHS Continuing Healthcare is triggered when an individual's overall care needs require services which are more than

[1] R v. North and East Devon health authority ex p Coughlan [2000] 3 All ER 850
[2] In Appendix 1 we include analysis carried out by Luke Clements of four key cases using the National Framework – including Ms Coughlan.
[3] For example see para 13
[4] Para 31

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'merely incidental or ancillary to the provision of accommodation' which the social services authority are under a duty to provide under section 21 of the National Assistance Act 1948 and are not 'of a nature which it can be expected' a social services authority to provide. The correct legal test therefore should primarily be a 'social care needs test' which considers whether it is lawful for social services to fund this care.

It is also essential that there be a clear statement in the guidance that if either the quantity *or* the quality thresholds are crossed the local authority cannot lawfully fund the care. The Consultation Document however upends this proposition or at the very least severely confuses it by suggesting that there is an 'and' between the quality and quantity tests.[5]

The 'primary health need' test is not only inappropriate in that it is not justified by the case law but it also wrongly suggests that the NHS is the arbiter of the NHS Continuing Healthcare determination. This is the approach taken in the Consultation document which states that the 'NHS should make the decision on responsibility for NHS Continuing Healthcare' - albeit 'working in collaboration with Social Services'.[6] This however does not correspond to the judgment in *Coughlan* where the key question was whether the care required went beyond that which social services could lawfully provide – as delimited by section 21 of the National Assistance Act 1948 (the 'social care needs test'). We accept that it would not be appropriate for the social services authority to make this decision on their own since there would be a financial incentive to find NHS Continuing Healthcare entitlement – just as the NHS should not make this decision on their own since there is a financial incentive to find no entitlement. We therefore believe that entitlement to NHS Continuing Healthcare should be a joint decision between the NHS and social services with immediate access to independent and binding arbitration if the two cannot agree (see response to question 13 below).

Q2 Currently, Strategic Health Authorities hold policy responsibility for local Continuing Care policies. Following the introduction of the National Framework, we are considering moving this overall responsibility to Primary Care Trusts as the local commissioning bodies for NHS services. We would welcome your contributions on this proposal, and any particular benefits or potential obstacles to achieving this.

To be effective the National Framework must provide one assessment method for NHS Continuing Healthcare. It is unacceptable that in one part of the country a person with a specific set of care needs would be assessed as qualifying for fully funded health care, while a person with identical needs living in a different part of the country would be deemed ineligible and would potentially have to fund all or part of their care from their own means.

We are concerned that the proposal to devolve responsibility to Primary Care Trusts (PCT) is unlikely to produce a national consistent approach to the provision of NHS Continuing Healthcare. The emphasis throughout the consultation documents is that professional judgement is paramount when assessing who is eligible which is unlikely to promote a consistent approach. Of particular concern is paragraph 19 of the Decision Support Tool which sets out when 'a primary health need may be indicated':

- Firstly it is clear that assessors may refer to the national Decision-Support Tool when determining eligibility for NHS Continuing Healthcare but they are not required to do so.[7]

[5] see for instance para 14 and the definition of intensity at Figure 1 page 9
[6] Para 33
[7] See also para 42 of the Consultation Document

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- Second, it is not specified how many ‘high’ and/or ‘moderate’ levels of need demonstrate a primary health need. This will presumably be left to clinical judgement.

We believe that this gives too much discretion to PCTs and is likely to result in regional variation in how a primary health need is determined. In light of court cases which have criticised the Department of Health for failing to adequately scrutinise the Continuing Care Statements issued by the Strategic Health Authorities[8] and the apparent failure of these authorities to properly police the day-to-day decision making by their local health bodies[9] it is unlikely that the new arrangements will address the inequalities and inconsistencies which have developed as a result of the current system.

We believe that the National Framework must be detailed, clear and prescriptive - and fully *Coughlan* compliant. The points scoring system used in the Decision-Support Tool should be abandoned and replaced by a full analysis of the terms ‘quality’ and ‘quantity’ in relation to the provision of care services (see response to question 9 below).

On balance, the policy responsibilities for NHS Continuing Healthcare should remain with the 10 Strategic Health Authorities rather than the 152 PCTs. However, national co-ordination with local representatives is needed to ensure consistency and fairness in applying any National Framework.

Q3 The National Framework sets out to assess individuals on the basis of their need for care, rather than their diagnosis, condition or where the care is provided, as the fairest way to determine eligibility for NHS funding. Does it achieve this or are there other factors which should be considered?

We generally agree with the needs-led approach adopted by the National Framework to determine eligibility for NHS funding. It is important however to restate that the assessment process must be linked back to the correct legal test of eligibility for NHS Continuing Healthcare – which is the ‘social care needs test’ identified in *Coughlan* (see response to question 1 above).

While we recognise the principle that the setting of a person’s care should not be determinative of eligibility for NHS Continuing Healthcare funding, using a common sense approach any person placed in a nursing home is likely to have needs that could not lawfully be met by social services since otherwise they could remain in their own home or a residential care home with periodic visits from, for example, a district nurse. We therefore suggest that a nursing home placement should create a presumption of eligibility for NHS Continuing Healthcare. This would simplify the process for determining NHS Continuing Healthcare eligibility and allow resources to be targeted on assessing people who are living in residential care or their own homes.

Q4 We assess whether an individual’s primary need is a health need with reference to four key indicators - nature, complexity, intensity and unpredictability. Do you think these are the correct indicators, or are there any omissions?

We are concerned that the reference to the ‘four key indicators’ to assess whether an

[8] For instance the Bexley NHS Care Trust statement which was the subject of proceedings in R(Grogan) v Bexley NHS Care Trust and others [2006] EWHC 44 (Admin).
[9] Evidenced by the high number of complaints before the NHS Ombudsman.

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individual has a primary health need is not inline with existing case law. In *Coughlan* the key criteria were simply the 'quantity' and 'quality' of the care provided (each of which has to be considered separately) and in order to assess whether *either* of these two factors had exceeded the section 21 National Assistance Act 1948 boundary, the Court provided the 'merely incidental or ancillary' test for quantity but only very general advice in relation to the quality of care. In terms of assessing the quality of care, the eleven generic 'Care Domains' in the Decision-Support Tool make up for this short-fall. We therefore suggest that in order that the process be as simple as possible, the guidance should direct assessors to the 'Care Domains' in the Decision-Support Tool without requiring preliminary consideration of the 'nature, complexity, intensity and unpredictability' indicators. We believe that they unnecessarily complicate and indeed confuse the process by adding an unnecessary intermediate hurdle.

The four key indicators are also elusive, overlapping and likely to confuse. It is difficult, for instance, to understand what consideration of the 'nature' of a condition adds – especially when the explanation directs attention back to the 'quality / quantity' division. The explanation provided in the Consultation Document suggests that 'nature' includes the type of intervention but then suggests that the 'intensity also includes the 'quality and quantity of the care provided'– which appears to be a duplication.[10]

We are also concerned that whereas all previous guidance has placed an 'or' between the four criteria, the Consultation Document frequently misses out the word 'or' – and at times the word 'and' appears in substitution.[11] This again suggests that patients will have to satisfy multiple criteria. Previous guidance issued by the Department of Health was critical of continuing care statements which, rather than being sensitive to the complexity *or* intensity *or* unpredictability of a person's needs, placed too much emphasis on the need for people to meet multiple criteria for NHS-funded care.[12]

Q5 Do you have any views on the statements used to describe the key indicators?

As previously stated we do not agree that the key indicators are the correct criteria for assessing eligibility for NHS Continuing Healthcare. The only 'indicators' which have been used by the courts are those of 'quantity' and 'quality' and it is these which should be used as the benchmark. We believe that the explanations provided of the key indicators sets the threshold for NHS Continuing Healthcare far higher than the Court of Appeal in *Coughlan*.

The statements used to describe the key indicators would require individuals to establish a very high level of health care need to qualify for NHS Continuing Healthcare. For example the Consultation Document suggests that a condition cannot be deemed 'unpredictable' or 'complex' unless it is extremely serious.[13] Similarly 'nature' is described as 'symptoms which are unstable, episodic, intractable, chronic, persistent, involuntary, etc.' and 'complexity' as symptoms which are 'severe, persistent or intractable'. These statements appear to establish a high threshold for NHS Continuing Healthcare, which is not inline with the *Coughlan* test that creates an altogether lower threshold and we believe it is highly likely that Ms Coughlan would qualify for NHS Continuing Healthcare funding under the new regime.[14]

It is also unclear why the statements used to describe the four indicators have been included in the Consultation Document and not in the Decision-Support Tool. We seek clarification on

[10] Figure 1 – page 9
[11] For example – para 50
[12] EL (96)8
[13] Figure 1 – page 9
[14] See appendix 1

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how the two would work together in practice.

Q6 Assessors will determine whether a primary health need is established by looking at the key indicators in terms of eleven generic 'care domains':

- **a. Behaviour**
- **b. Cognitive Impairment**
- **c. Communication**
- **d. Mobility**
- **e. Nutrition**
- **f. Continence**
- **g. Skin (including tissue viability)**
- **h. Breathing**
- **i. Drug Therapies and Medication**
- **j. Psychological/Emotional Needs**
- **k. Seizures/Altered States of Consciousness**

Bearing in mind that professional judgment is paramount and assessors can add to/overrule these on a case-by-case basis, are these the right core areas of need to assess?

We do not disagree that the eleven generic 'care domains' are the appropriate core areas of need for an assessment. The problem with the care domains approach is that it has the effect of obscuring the *Coughlan* 'quantity' category. Indeed we are concerned by the absence of detailed analysis of the quantity category in the National Framework (see response to question 4 above). The Court of Appeal in *Coughlan* placed equal emphasis on the quantity and quality categories, but the Decision-Support Tool very heavily concentrates upon the quality criterion. We believe it is crucial that this bias is redressed.

Q7 What are your views on the process shown in the Assessment Framework? What are the potential implementation issues?

We believe that a key implementation issue will be the need for re-education of health and social services staff. The entrenched view of many staff is likely to be that qualification for NHS Continuing Healthcare requires very severe ill health allied with an unstable condition - derived from a history of eligibility criteria which is too high and inaccurate Department of Health guidance.[15] Unless there is a very clear statement in the new Framework that this was wrong, that the new scheme is significantly different and that more people are likely to qualify, the existing mindset is likely to persist. Regrettably there is no such recognition in the proposed guidance or indeed in the Regulatory Impact Assessment (RIA) accompanying the Consultation Document. The RIA does not accept that the 2001 guidelines were defective: it merely states that 'the current situation has resulted in criticism, adverse media coverage and increases the potential for disputes'.[16]

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[15] For example, in relation to the 1999 guidance (issued following the Couglan judgement) the Health Service Commissioner noted in her Second Report for Session 2002-2003 *NHS funding for long term care*; Stationery Office. HC 399 (at para 21) 'My enquiries so far have revealed one letter (in case E.814/00-01) sent out from a regional office of the Department of Health to health authorities following the 1999 guidance, which could justifiably have been read as a mandate to do the bare minimum'.
[16] Para 23

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Q8 Do you agree with the concept of a national screening tool to help promote proportionate and appropriate assessments and to direct resources where they are most needed?

We are disappointed that the national screening tool has not been published for consultation. It is crucial that the Government clarifies what triggers an assessment for the provision of NHS Continuing Healthcare. We believe there must be a duty to assess which is triggered, not only on request, but also on an 'appearance of need' - i.e. in similar terms to the section 47(1) NHS and Community Care Act 1990 duty. In relation to patients awaiting hospital discharge, the assessment must be undertaken jointly by the relevant NHS and social services staff and the delayed discharge procedures should not be activated until these bodies have reached agreement or the arbitration / review procedure has concluded the question – e.g. if the patient or the social services authority have challenged an NHS non-entitlement assessment. In relation to people in care homes or in 'in the community' there must be:

a) a positive obligation on NHS, social services and care home staff to advise them of their rights;

b) a positive obligation to undertake NHS Continuing Healthcare assessments if 'it appears' to health or social services staff that the person may be entitled. In this context, we are disappointed by the lack of reference to the Single Assessment Process in the Consultation Document;

c) A positive obligation on social services staff to consider entitlement to NHS Continuing Healthcare when undertaking a community care or Children Act 1989 assessment.

The extent to which the NHS do inform patients of their entitlement to NHS Continuing Healthcare and undertake meaningful assessments of entitlement should be the subject of robust auditing by the Healthcare Commission – with dissuasive penalties being imposed on trusts that fail to properly discharge their obligations in this respect.

We are disappointed that the consultation documents fail to address or mention delays in assessments and refusals to assess. In particular we are concerned that pressure to discharge patients from hospital – due to increased demand for beds and the delayed discharge fining procedures - have led to patients are not being properly assessed for entitlement for NHS Continuing Healthcare. Although the NHS should not serve a discharge notice under section 2 of the Community Care (Delayed Discharge) Act 2003 until it is decided that a patient is not entitled to NHS Continuing Healthcare[17] – it is often either treated as a formality or the notice unlawfully states that no decision on entitlement has been made. We would welcome Government plans to end this practice.

Q9 We would welcome views on the concept of the national Decision-Support Tool to promote greater clarity and consistency in decision-making nationally.

We agree with the concept of a national Decision-Support Tool, but as previously stated we are concerned by the absence of detailed analysis of the 'quantity' category in the Decision-Support Tool (see response to question 4 above).

We are also concerned by the frequent use of undefined terms such as 'specialist' in the Decision-Support Tool. Government guidance has criticised NHS Continuing Healthcare

[17] The Delayed Discharge (Continuing Care) Directions 2003 dir 2.

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statements which placed an 'over-reliance on the needs of a patient for specialist medical supervision in determining eligibility for continuing in-patient care' and specifically referred to the fact that this was not considered by the NHS Ombudsman in the *Leeds* case as an acceptable basis for withdrawing NHS support[18]. In *Coughlan* the Court considered that in many cases the concept of 'specialist' was devoid of meaning, was unhelpful, 'elusive' and 'idiosyncratic'[19]. However, on at least 10 occasions the Decision-Support Tool uses the term 'specialist' as a description of the type of care that is required in order to access NHS Continuing Healthcare. For example:

- In order to be adjudged 'high' or 'priority' in the Behaviour Care Domain there is a requirement for specialist involvement. This, notwithstanding that it was not deemed essential in the *Pointon* determination.
- Under the Psychological/Emotional Needs Care Domain a high grading requires (amongst other things) specialist support and intervention
- Under the Seizures or Altered States of Consciousness Care Domain a high grading requires intervention of 'specially trained carer' or qualified nurse. Care done by nursing auxiliary is considered moderate.
- The table on the Behaviour Care Domain refers to specialist intervention.
- The Drug therapies and Medication Care Domain requires nurses/care workers specifically trained for a 'high' grading.
- Under the Nutrition – Food and Drink Care Domain there is reference to a 'skilled profession' but this is not defined.

We believe that any requirement for 'specialist' input should be removed from the Decision-Support Tool. Potentially it suggests that it is not the existence of a need but of formal acceptance by a specialist of a condition that is a precondition to eligibility. Such a requirement has the potential to erode the principle that diagnosis is not the determinant of eligibility for NHS Continuing Healthcare.

We are also concerned by the repeated use of the phrase 'professional judgment is paramount'. This appears twice in the Decision-Support Tool, once in the Consultation Document and twice in the Core Values and Principles Document. It is not however clear why the view of a professional should be determinative in the case of a patient entitled to NHS Continuing Healthcare on the 'quantity' ground – where the 'merely incidental or ancillary' legal threshold applies. The phrase 'professional' is also not defined and it is unclear for example whether it only means people who belong to a professional body and whether it includes social services professionals. We suggest it should be made clear that 'professional judgement' must include health and social services professionals to ensure that entitlement to NHS Continuing Care is a joint decision.

In order to promote greater clarity and consistency, we believe that the Decision-Support Tool should also provide detailed and clear examples from the bench mark case law and ombudsman cases - such as Ms. Couglan, the Leeds patient, the Wigan patient and Mr. Pointin - showing how and why they would qualify for NHS Continuing Healthcare under the new regime. In addition case studies should be provided involving people with mental health problems and learning disabilities.

[18] EL (96)8, para 16
[19] at paras 13 and 41

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Q10. Do you think that the care planning process is the best place to establish whether an individual requires care from a registered nurse? What are the alternative processes for determining eligibility for NHS-funded Nursing Care?

We agree that following a full assessment and a decision that the person is not eligible for NHS Continuing Healthcare, then the care planning process is the best place to establish whether an individual requires care from a registered nurse. It is also important that the National Framework avoids creating duplicate assessment systems and therefore this process should also be clearly linked to a community care assessment under section 47 of the NHS and Community Care Act 1990. We have already suggested that entitlement to NHS Continuing Care must be a joint decision between the NHS and social services, which would bring the two assessment systems together.

Question 11

What are your views on the principle of removing the banding system for payments of NHS-funded Nursing Care?

In principle we agree that the banding system for payments of NHS-funded Nursing Care should be removed. We are concerned however that the £97 rate set may not be high enough to cover all the costs of registered nurse care in care homes – and it is vitally important that local authorities, vulnerable adults and their families are not forced to cover any shortfall to pay the costs of nursing care. We therefore suggest that the single rate be set at £133 (the current high band rate) for all those who need registered nurse care and are not assessed as requiring fully funded care.

Q12 We would also welcome your views on the following supporting documents:

- **a. 'Core Values and Principles'**
- **b. Public Information Leaflet**
- **c. Consultation Presentation**
- **d. Partial Regulatory Impact Assessment**

We have no specific comments on the 'Core Values and Principles' document, the Public Information Leaflet and the Consultation Presentation.

We believe that the RIA must recognise that the threshold for the provision of NHS Continuing Healthcare has been set far too low in the past and that the introduction of a lawful test, which is fully *Coughlan* compliant, will inevitably mean that more people will qualify for fully funded care. In addition the RIA needs to consider the cost of restitution and compensation for service users and local authorities who, as a result of incorrect eligibility criteria, have paid for care that should have been provided for free.

Q13 If you would like to say anything else about the issues raised by the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care, please do so.

We are concerned that the 'Core Values and Principles' document states that the existing dispute resolution procedures will remain. Challenging an NHS Continuing Healthcare decision can be excessively complex and slow and does not provide a stage which is fully independent of the PCT. Any dispute resolution procedure at the local level must involve social services fully and as an equal party in any decision or review procedure. Currently,

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social services representatives on panels are too often easily overruled. This, combined with ineffective local dispute resolution procedures between Health and Social Services creates unnecessary difficulties. We believe that a new regime is needed which provides for a rapid and robust arbitration / binding review procedure. This scheme (or a parallel scheme) must also be available for NHS / social services disputes.

We believe that the National Framework must specifically address the particular needs of people who are likely to cause severe distress is those who appear to be likely to die in the near future. Considerable dissatisfaction has been expressed concerning the patchy nature of health body acceptance of responsibility for such patients[20] and the consultation papers do not provide any concrete mechanisms by which these problems will be overcome – such proving terminally ill patients with a dedicated and expedited procedure for assessment and review in the case of disagreements.

The Consultation Document specifically excludes direct payments and individual budgets from NHS healthcare.[21] However, we believe that this exclusion is causing unnecessary difficulties in healthcare settings. An individual who is assessed as eligible for NHS Continuing Healthcare, and was in receipt of direct payments, should be able to continue with their existing care regime where appropriate, including the direct payment of carers where NHS Continuing Healthcare is delivered at home.[22] The prohibition against direct payments by the NHS is unnecessarily disrupting existing care regimes – especially where care is delivered at home. The transition process, where responsibility for individuals passes from social care to NHS Continuing Care Healthcare, needs addressing in any Framework document.

[20] See for instance House of Commons Health Committee Fourth Report of Session 2003–04 on Palliative Care, Volume HC 454-I.
[21] Para 6
[22] See Gunter v South West Staffordshire Primary Care Trust [2005] EWHC 1894 (Admin)

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Appendix 1

The following has reproduced with the permission of Luke Clements who is a member of the Law Society's Mental Health and Disability Committee[23]*.*

The simplest test as to whether the new guidelines accord with the law – i.e. are *Coughlan* compliant – is to gauge whether in practice they will result in a significant lowering of the bar: whether they will remove the 'gap' identified by Charles J in *Grogan*, between the current (2001) guidelines which require patients to establish a very high level of health care need to qualify for *NHSCC*, and the *Coughlan* test that creates an altogether lower threshold. One can gauge whether the new guidelines pass this test by running the '*Coughlan* experiment' i.e. by asking whether Miss Coughlan (or indeed any of the other patients listed Table 2 at the end of this paper) would qualify for *NHSCC* under the new guidelines. These patients are a good sample since none of them are 'borderline' and some of them have been used as benchmarks by the NHS Ombudsman (for instance *Coughlan*[24]) and the Government (for instance the *Leeds* complaint[25]).

I have applied the Decision-Support Tool criteria to the four cases listed in Table 2 and the results are detailed in Table 1 below. I have discussed these results with a number of other lawyers with expertise in this field, whose only criticism has been that I may have been overgenerous in my assessments.

Table 1

	Priority	Severe	High	Medium	Low	None
The Leeds patient	0	2	1	3	1	4
Miss Coughlan	0	1	0	2	0	8
The Wigan patient	0	2	2	3	1	3
Mr Pointon	0	1	2	2	1	5

Paragraph 19 of the Decision-Support Tool advises that entitlement to *NHSCC* requires either:

- A **priority** level need in any one of the four domains which carry this level.
- A total of two incidences of identified **severe** level needs across all care domains.
- A number of domains with **high** and/or **moderate** level needs, which, in the judgment of the assessor, demonstrates an overall primary health need following the principles above.

The new guidelines therefore fail the *Coughlan* experiment – since Miss Coughlan does not qualify for *NHSCC* under the revised scheme. In this regard it is important to emphasise that her nursing care needs have been held to be 'well outside the limits of what could be lawfully provided by a local authority'[26]. Indeed none of the patient's qualify on the first ground of the Decision-Support Tool (para 19) since none get a 'Priority' score. The Wigan patient only

[23] Taken from An evaluation of the proposed National Framework Document for NHS Continuing Healthcare and NHS-Funded Nursing Care in England by Luke Clements

[24] See for instance the comments of the Health Service Commissioner in her 2003 report concerning Wigan and Bolton Health Authority and Bolton Hospitals NHS Trust Case No. E.420/00-01 [Second Report for Session 2002-2003 *NHS funding for long term care*; Stationery Office. HC 399.

[25] Department of Health Press Release of 4.11.94 and the Department of Health in its guidance EL (96)8 at para 16.

[26] *R (Grogan) v. Bexley NHS Care Trust and others* [2006] EWHC 44 (Admin) 25/01/2006 at para 61.

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just creeps into the second ground (two 'severe' needs): this is a case where the Health Service Commissioner held that (in effect) only a PCT that had taken leave of its senses could decide there was no entitlement to *NHSCC*[27].

Of course it could be said that there is nothing wrong with the descriptors of the various levels within the Care Domains in the Decision-Support Tool, but that the problem lies with my assessment. This in itself is no argument: if the descriptors are capable of being misunderstood by lawyers experienced in this field of law, they are no less likely to be misunderstood by practitioners in the field – especially practitioners inured in the previous regime where the bar to qualification was placed at an equally unrealistic level.

Table 2 Resume of patients involved in continuing care disputes

Leeds Ombudsman Report Case No E.62/93-94 January 1994
A man suffered a brain haemorrhage and was admitted to a neuro-surgical ward. … He received surgery but did not fully recover. After 20 months in hospital he was in a stable condition but still required full time nursing care. His condition had reached the stage where active treatment was no longer required but that he was still in need of substantial nursing care, which could not be provided at home and which would continue to be need for the rest of his life (para 22 of report)

The importance of this assessment was emphasised in NHS guidance EL (96)8 which (at para 16) criticised continuing care statements which placed an '*over-reliance on the needs of a patient for specialist medical supervision in determining eligibility for continuing in-patient care' and specifically referred to the fact that this was not considered by the ombudsman in the Leeds case as an acceptable basis for withdrawing NHS support*.'

R v North and East Devon Health Authority ex p Coughlan
Miss Coughlan was grievously injured in a road traffic accident in 1971. She is tetraplegic; doubly incontinent, requiring regular catheterisation; partially paralysed in the respiratory tract, with consequent difficulty in breathing; and subject not only to the attendant problems of immobility but to recurrent headaches caused by an associated neurological condition. (para 3 of judgment)

The court concluded at para 3
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 … . Here the needs of Miss Coughlan … were primarily health needs for which the Health Authority is as a matter of law responsible

Wigan and Bolton Health Authority and Bolton Hospitals NHS Trust Case No. E.420/00-01[28]
Mrs N had suffered several strokes, as a result of which she had no speech or comprehension and was unable to swallow, requiring feeding by PEG tube (a tube which allows feeding directly into the stomach). Mrs N was being treated as an in-patient in the

[27] The NHS Ombudsman stated in this case '*I cannot see that any authority could reasonably conclude*' – essentially a version of the test in *Associated Provincial Picture Houses v Wednesbury Corporation* [1948] 1 KB 223 (ie that no reasonable public body could have reached such a decision). In *R v SS Environment ex p Nottinghamshire CC* [1986] AC 240, HL at 247 the House of Lords suggested that the *Wednesbury* test was amenable to a more succinct expression, namely 'have taken leave of [its] senses'.
[28] From the NHS Ombudsman's Second Report for Session 2002-2003 *NHS funding for long term care*; Stationery Office. HC 399.

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Trust's stroke unit and was discharged to a nursing home (para 1 p 24)

Health Services Commissioner concluded (at para 30, p32)
I cannot see that any authority could reasonably conclude that her need for nursing care was merely incidental or ancillary to the provision of accommodation or of a nature one could expect Social Services to provide (paragraph 15). It seems clear to me that she, like Miss Coughlan, needed services of a wholly different kind.

Complaint against Cambridgeshire Health Authority & PCT (the 'Pointon' case)[29] Mr P is severely disabled with dementia and unable to look after himself. His wife cared for him at home . She took a break one week in five but had to pay more than £400 for the substitute care assistant, because the NHS would not pay, because Mrs P was not a qualified nurse (and could not therefore be offering nursing care). It was held that the fact that Mr P was receiving (what was in effect) nursing care from his wife, did not mean he could not qualify for continuing health care; that the health bodies had failed to take into account his severe psychological problems and the special skills it takes to nurse someone with dementia; that the assessment tools used by the NHS were skewed in favour of physical and acute care; the fact that MR P needed care at home – rather than in a nursing care home was not material to the question of continuing health care responsibility.

[29] Accessible on the NHS Ombudsman's web site at www.ombudsman.org.uk/hsc/document/pointon.pdf

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