NHS Continuing Care: the draft Care Act regulations & guidance.

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Over the last 18 months great efforts have been made to ensure that the provisions of the Care Act 2014 did not undermine the NHS Continuing Healthcare boundary.[2] If the draft guidance and regulations to the Act (issued for consultation in June) are adopted in their current form – then this work will have been in vain.

It is possible that the many references in the draft documents to local authorities fulfilling what are currently NHS responsibilities are innocent misunderstandings. In a normal world, these could be resolved without undue difficulty. However the indecent haste with which the Care Act is being implemented, makes this much more of a challenge.[3]

The positive steps so far

The Select Committee[4] that scrutinised the draft Bill recommended that the wording (or what is now section 22) be amended to ensure that the current boundary between local authority responsibilities and those of the NHS (the so called 'NHS Continuing Healthcare' boundary as defined in the *Couglan* Court of Appeal judgment[5]) remained unchanged. The boundary is of immense importance – given that one of the UK's greatest and most admired achievements is the creation of a health care service that is free at the point of need. The Cinderella social care service, in contrast, is means tested. If health obligations are shunted into the social services' siding we undermine the NHS and start charging people for these services – with all the attendant impact this has on health and socio-economic inequalities.

The Government's response to the Select Committee's concerns was positive and the re-phrasing of section 22 appeared to achieve the aim of sustaining the current health / social care boundary. To put the matter beyond doubt the Minister (responding to a probing amendment by Paul Burstow MP) gave an assurance that:[6]

> The provisions in section 22 are not intended to change the current boundary—let me place that clearly on the record—and we do not believe that they will have that result. The limits on the responsibility by reference, as now, to what should be provided by the NHS remain the same'.

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[2] The legal boundary between the responsibility of the NHS & social services to fund an individual's care needs: as defined in *R v. North and East Devon health authority ex p Coughlan* [2000] 2 WLR 622.

[3] In July 2014 the Public Accounts Committee questioned whether the implementation timetable was 'feasible': House of Commons Committee of Public Accounts *Adult social care in England* HC 518 (Stationery Office 2014) p.7.

[4] Joint Committee on the Draft Care and Support Bill, 'Draft Care and Support Bill' Stationery Office (2013) HL Paper 143 HC 822 page 88.

[5] *R v. North and East Devon health authority ex p Coughlan* [2000] 2 WLR 622.

[6] House of Commons Public Act Committee Report 16 January 2014 (Hansard p.205/208).

This helpful statement is materially undermined by provisions in the draft guidance and regulations.

The need for vigilance

The need for vigilance on this question arises out of the incremental changes that have been taking place in relation to the provision of health and social services.

Public expenditure on social services has been falling for almost a decade – despite the dramatic increase in the numbers of disabled people and older people living in the community.[7] Today 30% fewer people get support from social services than did 20 years ago.

Simultaneously we have experienced a period of significant deinstitutionalisation with major reductions to the number of NHS beds. It is not only the large Mental Hospitals and Mental Handicap Hospitals that have closed. 35 years ago half of all General Hospital patients were 'long stay' (largely geriatric) patients. Today, most General Hospitals have no 'long stay' patients and very many people with severe conditions are now being cared for in the community: people with profound physical, mental and sensory impairments; people with PEG feeding tubes; people with morphine shunts; people with tracheostomies; people receiving dialysis and so on.

The transfer of ill and of disabled people into community living settings is of course something to be celebrated. The problem is that the process of institutional closure has not resulted in an equivalent transfer to the community of NHS resources. The last 10 years have seen a significant reduction in NHS primary care funding, with the impact felt in all sectors: transport, community nursing and GPs for example. The proportion of NHS expenditure spent on general practice is the lowest on record[8] and the Royal College of Nurses predict that on current trends District Nurses will become extinct during the next decade.[9]

The result is that carers are fulfilling functions that in the recent past were undertaken by healthcare professionals – and increasingly disabled, elderly and ill people (and their carers) are being told that these functions (because they are taking place in the community) are social services functions.

The current law is however clear: healthcare needs are the primary responsibility of the NHS. Where a healthcare need is delivered is irrelevant as is the person who delivers it:[10] 'nursing care' is not synonymous with

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[7] Jose-Luis Fernandez et al *Changes in the Patterns of Social Care Provision in England: 2005/6 to 2012/13* p.25 at www.pssru.ac.uk/archive/pdf/dp2867.pdf accessed 11th July 2014.

[8] M Baker et al *Put patients first* **(**Royal College of General Practitioners 2013) at www.napp.org.uk/Put%20Patients%20First%20Campaign%20Brief.pdf accessed 11th July 2014

[9] The number of qualified District Nurses fell by 23% between 1996 and 2006 see Queen's Nursing Institute *District nurse is becoming an endangered species* Press Release 26 March 2010 and see also Denis Campbell *District nurses are facing 'extinction* The Guardian 17 June 2014 p15.

[10] Department of Health *National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care November 2012 (Revised)* (DH 2012) para 56.

‘something done by a nurse’.[11] Community nurses are a dying breed – and the fact that the NHS has chosen not to invest in community health services does not mean that at law, the NHS’s obligations should be reinterpreted.

In practice, however, many elderly, ill and disabled people suffer the consequences and either rely on informal carers or have to pay for these supports / healthcare travel costs. In some cases social services have provided help – notwithstanding that the law places the responsibility on the health service. The cost shunting and social services funding reductions have meant, not only that people living in the community care have to pay for these healthcare supports – but also that social services have (to put it bluntly) gone bust.

It is against this social policy context, that the provisions in the draft guidance and regulations need to be considered.

The problem provisions

Accessing medical services

Travelling to an NHS facility is, one would assume, a health related activity – just as travelling to a school is an educational activity and travelling to a social services day centre is a social services activity. As efficiency and cost savings have resulted in NHS facilities becoming more centralised, NHS bodies have not developed their community transport support services. This has caused particular problems for (among others) carers and people with sensory impairments. Instead of requiring the NHS to address this problem, the regulations shunt responsibility to social services[12] – which means that: (a) for this service all patients will now be means tested; (b) the vast majority will have to pay; and (c) scarce social services resources will be used to subsidise yet another function that – under the current law – should be discharged by the NHS.

Help with medication

25 years ago nurses delivered a whole range of support services for elderly and ill people living in the community, including (for example) helping people bathe. Today, with the drastic reductions to community nursing and the increased healthcare needs of people living in their own homes, these needs are being met by others – particularly (where they are available) by their family carers.

At law, the administration of prescription medication is a health function: one that stems directly from a doctor’s decision. Given the concomitant need for the administration to be in accordance with that decision and for contra indications / adverse reactions to be closely monitored, the function remains throughout a health function. Whilst it may not be essential that every aspect be undertaken by a health service employee (provided that appropriate

[11] Of the 9 principal meanings identified by the Shorter OED of the verb ‘to nurse’ (and 21 variations) the noun ‘nurse’ is used only twice: in the context of a ‘wet-nurse’ and ‘to perform the duties of a sick nurse’.
[12] The [draft] Care and Support (Eligibility Criteria) Regulations 2014 Regulation 2(2)(d).

training, guidance and back up support is available) it is difficult to see how this can become a social services function for which social care charges can be levied.

Paragraph 4.88 of the draft guidance however makes it clear that it is a social services function to arrange (and therefore charge) for 'home-care visits of 15 minutes or less ... for services like checking whether medicine has been taken'.

Training carers in healthcare tasks

Increasingly, as noted above, people with significant health care needs are being discharged home and their carers are having to take responsibility for their (sometimes complex) healthcare support needs. Often the carer will need training in how to perform these tasks: tasks that hitherto would have been discharged in hospitals by nurses. Whatever the rights and wrongs of the dearth of community nurses – one would be hard pressed to suggest that the training of family carers in relation to such healthcare tasks is anything other than an NHS responsibility. However paragraph 2.2 of the (draft) statutory guidance states that social services have responsibility for (among other things) training carers 'to feel confident performing basic health care tasks' – and of course the Act enables social services to charge the carer and/or the disabled person for this training.

Creating ambiguity about NHS Continuing Healthcare responsibilities

Equally problematical – although rather more technical – is the section in the guidance that appears under the subheading of 'NHS Continuing Healthcare' (paragraph 6.68). This states that although 'local authorities cannot arrange services that are the responsibility of the NHS (e.g. care provided by registered nurses and services that the NHS has to provide because the individual is eligible for NHS CHC)' they '*may provide or arrange healthcare services where they are simply incidental or ancillary to doing something else to meet needs for care and support*'. Whilst this is strictly correct – it is most certainly not correct in relation to people who are eligible for 'NHS Continuing Healthcare' funding. For such people social services cannot 'provide or arrange <u>any</u> services' (healthcare or social care). The presence of the above italicized statement in a section headed 'NHS Continuing Healthcare' can do nothing other create confusion and undermine the clear principles established in the *Coughlan* judgment.

If the statements analysed in this paper remain in the draft guidance and regulations – the result will be a further erosion of the NHS system and a further drain on a chronically underfunded social care system. The losers – the people that will have to pay for these changes – will be disabled people; elderly people; ill people; and their carers.