Luke Clements Training

NHS Responsibilities for Community Care in England

Luke Clements
www.lukeclements.com

Luke Clements Training

Key issues

1. **An area regulated by the law;**
2. **The law gives only a general 'steer' as to where the boundary lies;**
3. **Accordingly decisions of the court and Ombudsmen important - the '*benchmark cases*';**

Luke Clements Training

Legal regulation

Example

s275(1) NHS Act 2006 (interpretation)
"illness" includes mental disorder and any injury or disability requiring medical or dental treatment or nursing,

s1(2) Mental Health Act 1983
"mental disorder" means any disorder or disability of the mind;

Legal Duties

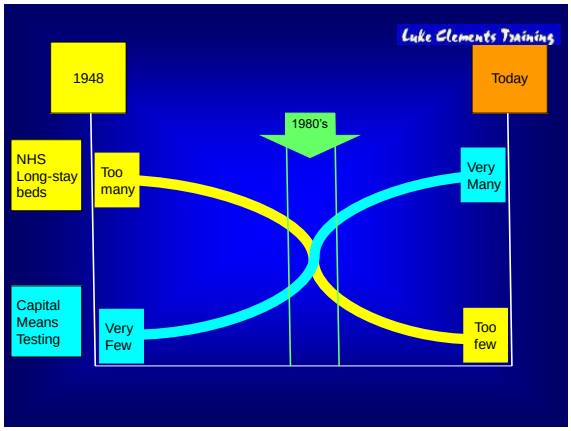
NAA 1948 Social Services	NHS Act 1946
Section 21/29 Duty to provide social care for elderly ill & disabled people	Sections 1 & 3 Duty to provide health care for ill people

Legal Duties

CA 2014 Social Services	NHS Act 2006
Section 18 Duty to provide social care for 'adults in need'	Sections 1 & 3 Duty to provide health care for ill people

s22 Care Act 2014

- **A LA may not meet needs under the CA 2014 if those needs are required to be met under the NHS Act – unless**
  - The provision falls within the *Coughlan* criteria *(discussed below)*



Luke Clements Training

Leeds Ombudsman case 1994

- **incontinent and unable to walk, communicate or feed himself: a kidney tumour, cataracts and occasional epileptic fits, for which he received drug treatment.**
- **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 needed for the rest of his life**

Luke Clements Training

Leeds Ombudsman case 1994

- **Stable**
- **Substantial low level nursing**
- **No need for specialist input**
- **Adequately cared for in ordinary nursing home**

Luke Clements Training

Leeds Ombudsman case 1994

Government Response

- **HA's to prepare CC statements**
- **If in the light of the guidance, some HA's are found to have reduced their capacity to secure continuing care too far – as clearly happened in the case dealt with by the Health Service Commissioner – then they will have to take action to close the gap**

NHS Guidance

Statutes eg NHS Act 2006	**Court cases** eg *Coughlan*
Regulations / directions	
Practice Guidance	

Luke Clements Training

Coughlan (1999)

- **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**

Coughlan (1999)

The distinction between those services which can and cannot be so provided is one of degree which in a borderline case will depend on a careful appraisal of the facts of the individual case. However, as a very general indication as to where the line is to be drawn, it can be said that if the nursing services are:

Coughlan (1999)

(1) merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide to the category of persons to whom section 21 refers and

Coughlan (1999)

(2) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide,

Then they can be provided (by SS).

IN THE SUPREME COURT OF JUDICATURE
COURT OF APPEAL (CIVIL DIVISION)
Royal Courts of Justice
Date: 16 July 1999

R. v .NORTH AND EAST DEVON HEALTH AUTHORITY

- Respondent

Ex parte PAMELA COUGHLAN

- Applicant

- **SECRETARY OF STATE FOR HEALTH**
- Intervener
- **and**
- **ROYAL COLLEGE OF NURSING**

118. …. . Miss Coughlan needed services of a wholly different category.

Luke Clements Training

2003 Ombudsman Report

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

Luke Clements Training

2003 Ombudsman Report

I do not underestimate the difficulty of setting fair, comprehensive and easily comprehensible criteria. …. But that is all the more reason for the Department to take a strong lead in the matter … One might have hoped that the comments made in the Coughlan case would have prompted the Department to tackle this issue. … [however] Authorities were left to take their own legal advice about their obligations to provide continuing NHS health care … The long awaited further guidance in June 2001 … gives no clearer definition than previously of when continuing NHS health care should be provided: if anything it is weaker … .

Such an opaque system cannot be fair.

Wigan Patient 2003

Luke Clements Training

- **Several strokes**
- **No speech or comprehension**
- **Unable to swallow**
- **PEG fed**

Wigan Patient 2003

Luke Clements Training

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. It seems clear to me that she, like Miss Coughlan, needed services of a wholly different kind.

Pointon 2004

Luke Clements Training

- Advanced dementia, (ie 'some of the severe behavioural problems, which had characterised his illness during its earlier stage, had now diminished');
- Behaviour still challenging;
- Unable to look after himself;
- His wife cared for him at home.

Pointon 2004

- Mrs Pointon 'giving highly personalised care with a high level of skill ... nursing care equal if not superior to that that Mr Pointon would receive in a dementia ward'
- Complaint upheld: assessors had focused on acute care' rather than assessing the 'psychological needs of patients with illnesses such as dementia' (para 39)
- Severe psychological problems and the special skills required to nurse someone with dementia

Luke Clements Training

R (T, D & B) v Haringey LBC (2005)

- Disabled child
- Tracheostomy (a tube in the throat) which needed, suctioning about three times a night.
- "It is quite common now for children who have tracheostomies to be discharged from hospital and cared for at home (para 5)
- Great Ormond Street Hospital provides training for parents in how to manage those requirements at home; the Claimant mother has been trained fully in those areas" (para 7)

Luke Clements Training

R (T, D & B) v Haringey LBC (2005)

Mother argued that the respite care should be funded by social services and not the NHS.

Mr Justice Ouseley (para 61) (citing *Coughlan*)

- the provisions of the Children Act are not to be regarded in general as reducing or replacing the important public obligations … set out in the 1977 NHS Act. I do not see that the impact there of section 21(8) of the NAA 1948 means that the principles enunciated were peculiar to that Act"

NHS Continuing Care & Young People

Children's services retain responsibility for safeguarding /associated social work functions:

- helping parents with the emotional problems of caring for disabled children;
- providing carer support services ie services delivered solely to the parents / siblings;
- giving information
- signposting.

Free nursing care

s49 Health & Social Care Act 2001
Now s22 Care Act 2014

Free nursing care

R (Grogan) v. Bexley NHS CT (2006)
Must consider eligibility for NHS CC
before any discussion about FNC

R (Grogan) v. Bexley NHS Care Trust (2006)

all nursing care (including RNCC) [must be] … merely (a) incidental or ancillary to the provision of the [social care] … and (b) of a nature which …. it could have been expected that [a LA] could … provide (para 66)

R (Grogan) v. Bexley NHS Care Trust (2006)

particularly when it is remembered that the focus of *Coughlan* was on nursing care and the decision of the Court of Appeal was that the care she needed was well outside the limits of what could be lawfully provided by a local authority …

Luke Clements Training

National Framework for NHS Continuing Care

October 2007 – revised July 2009

Updated 2012 (CCG's for PCTs)

Decision support Tool

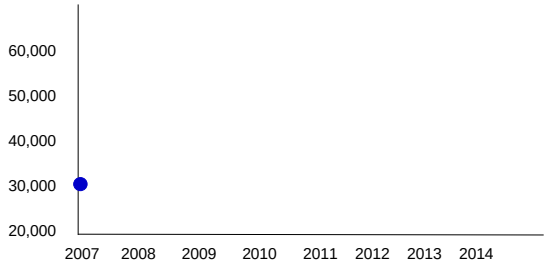
- **11 different care domains**

The headlines – Key Messages

- The Framework (for all adults) is a change in system that will require PCTs and LAs to think and act differently
- NHS Continuing Healthcare is part of a whole process of care pathways.
- Whatever someone's ongoing health and social care needs, they still need to be met but NHS Continuing Care should always be considered in the first place
- The Framework is the first step in making continuing care easier for the people who work in it and those who are being assessed for it
- We do expect there to be more people eligible for full funding

DoH Resource pack: Introduction Module 1: slide 7

NHS CC statistics



Luke Clements Training

2012 Framework

Core values

55 Eligibility for NHS CC is based on an individual's assessed health needs. The diagnosis of a particular disease or condition is not in itself a determinant of eligibility.

Luke Clements Training

2012 Framework

PG 38 ~ DST & learning disabilities?

38.1 The DST should be used for all adults who require assessment for NHS CHC, irrespective of their client group/diagnosis. ..

38.5 The question is not whether learning disability is a health need, but rather whether the individual concerned, whatever client group he or she may come from, has a 'pimary healthcare need'.

Luke Clements Training

2012 Framework Core Values

56 NHS CC may be provided … in any setting (including, but not limited to, a care home, hospice or the person's own home).

Eligibility … is therefore not determined or influenced by either the setting where the care is provided nor by the characteristics of the person who delivers the care.

Luke Clements Training

2012 Framework Core Values

56 … The decision-making rationale should not marginalise a need because it is successfully managed: well-managed needs are still needs. …

Luke Clements Training

2012 Framework Core Values

56 … Only where the successful management of a healthcare need has permanently reduced or removed an ongoing need will this have a bearing on NHS Continuing Healthcare eligibility.

Luke Clements Training

2012 Framework Core Values

58 The reasons given for a decision on eligibility should not be based on:

- the setting of care;
- the ability of the care provider to manage care;
- the use (or not) of NHS employed staff to provide care;
- the need for/presence of 'specialist staff' in care delivery;
- The fact that the need is well managed;
- the existence of other NHS-funded care;
- or any other input-related (rather than needs-related) rationale.

Stability and 'inputs'

Ombudsman in over-ruling a decision was particularly concerned about statements in DST domains that:

- M's needs had not recently changed'; and
- no health interventions being needed'

This is not the test. The test is whether someone has a primary health need, not what interventions they are receiving or who is providing them'.

Aneurin Bevan LHB (2013)

Luke Clements Training

2012 Framework Core Values

91 … Only in exceptional circumstances, and for clearly articulated reasons, should the multidisciplinary team's recommendation not be followed.

Luke Clements Training

2012 Framework Core Values

[exceptional] means exactly what it says on the tin, there must be something truly exceptional. If more than 1% of MDT recommendations are not being followed then something is wrong: exceptional circumstances means that there is something 'truly unusual'.

DoH Stakeholders meeting 1st July 2010

Luke Clements Training

2012 Framework Core Values

91 … A decision not to accept the recommendation should never be made by one person acting unilaterally..

Luke Clements Training

2012 Framework Core Values

93 … the final eligibility decision should be independent of budgetary constraints, and finance officers should not be part of a decision-making panel

Luke Clements Training

Panel requiring additional evidence

- Missing NHS evidence
  - *create a presumption; or*
  - *Early escalation of dispute process*
- Evidence of 'well managed' (establishing a negative)
- Evidence from family
- Evidence out of date
- Immaterial evidence (ie bureaucratic pointlessness)
- The Panel '*trying to avoid making a decision*' .

Welsh Ombudsman Report
Carmarthenshire LHB 2009 No. 200800779.

Luke Clements Training

Discretion not to convene a panel

the NHS body has the 'right to decide in any individual case not to convene' a panel but that it 'is expected that such a decision will be confined to those cases where' the individual 'falls well outside the eligibility criteria or where the case is very clearly not appropriate' for the panel to consider.

Annex 5 para 5.11 (2014 guidance)

Luke Clements Training

Discretion not to convene a panel

The Welsh Ombudsman considered a decision by a Panel not to hear a referral because 'no fresh evidence' had been submitted (even thought the MDT noted a 'high' in two domains and a 'moderate' in four domains).

The Ombudsman considered that the provision of 'fresh evidence 'was not the test'.

'the role of the panel is essentially to act as an independent check-balance on those cases where the appeal is not very clearly a 'lost cause' or where there are no persuasive reasons for deeming the appeal to be 'inappropriate'.

Cardiff & Vale University LHB 201400255/SB (2014)

Luke Clements Training

2012 Framework Core Values

167 Where a person qualifies for NHS continuing healthcare, the package to be provided is that which the PCT (CCG) assesses is appropriate for the individual's needs. Although the PCT(CCG) is not bound by the views of the LA on what services the individual requires, the LA's assessment s47 NHS & CC Act 1990 … will be important … .

What the NHS funds is up to it – within the limits of public law reasonableness *R (S) v Dudley PCT (2009)*

Luke Clements Training

Topping up & the NHS

2012 Framework (PG 99)

99.1 The funding provided by CCGs in NHS continuing healthcare packages should be sufficient to meet the needs identified in the care plan …

99.2 Unless it is possible to separately identify and deliver the NHS-funded elements of the service, it will not usually be permissible for individuals to pay for higher-cost services and/or accommodation (as distinct from purchasing additional services).

Topping up & the NHS

Luke Clements Training

2012 Framework (PG 99)

99.3 … [social services] 'Topping-up' is legally permissible … but is not permissible under NHS legislation. For this reason, there are some circumstances where a CCG may propose a move to different accommodation or a change in care provision.

99.8 Where separation of NHS and privately funded care arrangements is possible, the financial arrangements for the privately funded care is entirely a matter between the individual and the relevant provider …

People living in the community

Luke Clements Training

R (Whapples) v. Birmingham Crosscity CCG (2015)

Court approved PG 85 in Part 2 of 2012 Framework – that where people living in the community:

> the expectation … is that the CCG would remain financially responsible for all health and personal care services and associated social care services to support assessed health and social care needs and identified outcomes for that person, e.g. equipment provision (see PG 79), routine and incontinence laundry, daily domestic tasks such as food preparation, shopping, washing up, bed-making, support to access community facilities, etc. (including additional support needs for the individual whilst the carer has a break).

Checklist

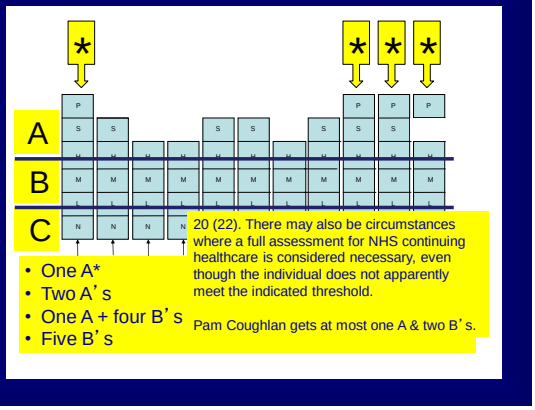
Luke Clements Training

The Checklist … designed to give a low threshold (para 10.2 Practice Guidance [PG]);

Health and social care practitioners can complete the Checklist. (para 6.3 PG);

The individual should be given a copy of the completed Checklist. (para 6.7 PG);

Not necessary to submit detailed evidence with completed Checklist. (para 6.9 PG).



Fast track Pathway tool

Luke Clements Training

(97 2012 Framework Guidance) Individuals with a rapidly deteriorating condition that may be entering a terminal phase may require 'fast tracking' for immediate provision of NHS continuing healthcare. … [Used by appropriate] clinicians … such as a consultants, registrars or GPs or registered nurses … .

99 FTPTs should be supported by a prognosis, if available. However, strict time limits that base eligibility on some specified expected length of life remaining should not be imposed … .

Fast track Pathway tool

Luke Clements Training

- The 2012 Regulations (reg 21) ~ a CCG must accept and action the FTPT;
- PCTs should not require any additional evidence to support eligibility (para 5.9 practice guidance);
- Only 'exceptionally' can such a FTPT be questioned by a PCT, and in such cases it should 'urgently ask the relevant clinician to clarify the nature of the person's needs and the reason for the use of the FTPT (para 5.9 practice guidance).

Luke Clements Training

Ordinary care homes

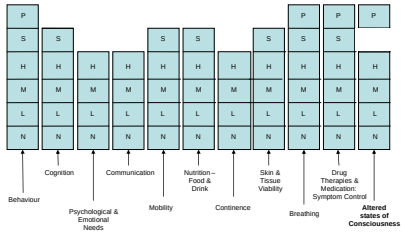
'there is nothing within the regulatory framework, which would prevent a person in receipt of NHS continuing healthcare remaining within a Care Home (Personal Care)'.

Department of Health (2008) Joint Statement re: NHS Continuing Healthcare Funding for End of Life Care within Care Homes 15 August 2008. London, DoH.

[DST] What it's NOT

- **An another assessment**
- **A decision MAKING tool**
- **Suitable for every individual's situation**
- **A substitute for professional judgement**

DoH Resource pack: Introduction Module 1: slide 19



Luke Clements Training

Decision Support Tool

31. A clear recommendation of eligibility to NHS Continuing Healthcare would be expected in each of the following cases:
1 Priority; or
2 Severe

If there is:
1 severe + needs in a number of other domains, or a number of highs and/or moderates,

1. Behaviour

Low
Some incidents of "challenging" behaviour. A risk assessment indicates that the behaviour does not pose a risk to self or others or a barrier to intervention. The person is compliant with all aspects of their care.

Moderate
"Challenging" behaviour that follows a predictable pattern. The risk assessment indicates a pattern of behaviour that can be managed by skilled carers or care workers who are able to maintain a level of behaviour that does not pose a risk to self or others. The person is nearly always compliant with care.

High
"Challenging" behaviour that poses a predictable risk to self or others. The risk assessment indicates that planned interventions are effective in minimising but not always eliminating risks. Compliance is variable but usually responsive to planned interventions

Severe
'Challenging' behaviour of severity and/or frequency that poses a significant risk to self and/or others. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.

Pointon?

Priority
"Challenging" behaviour of severity and/or frequency that presents an immediate and serious risk to self and/or others. The risks are so serious that they require an urgent and skilled response for safe care.

2. Cognition

Low
Cognitive impairment (for example difficulties in retrieving short-term memory) which requires some supervision, prompting or assistance with more complex activities of daily living, such as finance and medication, but awareness of basic risks that affect their safety is evident.
OR
Occasional difficulty with memory and decisions/choices requiring support, prompting or assistance. However, the individual has insight into their impairment.

Moderate
Cognitive impairment (which may include some memory issues) that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. Some awareness of needs and basic risks is evident. The individual is usually able to make choices appropriate to needs with assistance. However, the individual has limited ability even with supervision, prompting or assistance to make decisions about some aspects of their lives, which consequently puts them at some risk of harm, neglect or health deterioration.

High
Cognitive impairment that could include marked short-term memory issues and maybe disorientation in time and place. The individual has awareness of only a limited range of needs and basic risks. Although they may be able to make choices appropriate to need on a limited range of issues they are unable to do so on most issues, even with supervision, prompting or assistance. The individual finds it difficult even with supervision, prompting or assistance to make decisions about key aspects of their lives, which consequently puts them at high risk of harm, neglect or health deterioration.

Severe
Cognitive impairment that may for example include, in addition to any short-term memory issues, problems with long-term memory or severe disorientation to time, place or person. The individual is unable to assess basic risks even with supervision, prompting or assistance, and is dependent on others to anticipate even basic needs and to protect them from harm, neglect or health deterioration.

3. Psychological & Emotional Needs

Low
Mood disturbance, hallucinations or anxiety, periods of distress, which is having an impact on their health and/or wellbeing but responds to prompts and reassurance.

OR

Requires prompts to motivate self towards activity and to engage in care plan and/or daily activities.

Moderate
Mood disturbance , hallucinations or anxiety symptoms or periods of distress which do not readily respond to prompts and reassurance and have an increasing impact on the individual's health and/or wellbeing.

OR

Due to their psychological or emotional state the individual has withdrawn from most attempts to engage them in care planning, support and/or daily activities.

High
Mood disturbance , hallucinations or anxiety symptoms or periods of distress that have a severe impact on the individual's health and/or wellbeing.

OR

Due to their psychological or emotional state the individual has withdrawn from any attempts to engage them in care planning, support and/or daily activities

4. Communication

Low
Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or may need additional support either visually, through touch or with hearing.

Moderate
Communication about needs is difficult to understand or interpret, or the individual is sometimes unable to reliably communicate, even when assisted. Carers or care workers may be able to anticipate needs through non-verbal signs due to familiarity with the individual.

High
Unable to reliably communicate their needs at any time and in any way, even when all practicable steps to do so have been taken. The person has to have most of their needs anticipated because of their inability to communicate them.

Interaction of domains / needs

Luke Clements Training

A 2014 Welsh Ombudsman's report

- patient with Parkinson's Disease - symptoms included night time wakefulness, noisiness, restlessness, increased lethargy and increased physical rigidity.
- Over period of review these symptoms increased.
- Although individually minor he considered that they should have been properly recorded by the NHS body
- cumulatively they were significant and the NHS body had failed to consider 'how a need in one domain might intensify or complicate needs in another'.

Powys Teaching Health Board No. 201303895

5. Mobility

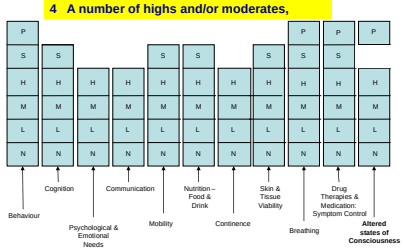
Low
Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.

Moderate
Not able to consistently weight bear.
OR
Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning.
OR
In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers.

High
Completely unable to weight bear and is unable to assist or cooperate with transfers and/or repositioning.
OR
Due to risk of physical harm or loss of muscle tone or pain on movement needs careful positioning and is unable to cooperate.
OR
At a high risk of falls (as evidenced in a falls risk assessment).
OR
Involuntary spasms or contractures placing themselves and carers or care workers at risk.

Severe
Completely immobile and/or clinical condition such that, in either case, on movement or transfer there is a high risk of serious physical harm and where the positioning is critical.

1 Priority; or
2 Severe; or
3 1 severe + needs in a number of other domains, or
4 A number of highs and/or moderates,



Miss Coughlan needed services of a wholly different category

6. Nutrition – Food and Drink

Moderate
Needs feeding to ensure adequate intake of food and takes a long time (half an hour or more), including liquidised feed.
OR
Unable to take any food and drink by mouth, but all nutritional requirements are being adequately maintained by artificial means for example via a non-problematic P.E.G.

High
Dysphagia requiring skilled intervention to ensure adequate nutrition/hydration and minimise the risk of choking and aspiration to maintain airway.
OR
Subcutaneous fluids that are managed by the individual or specifically trained carers or care workers.
OR
Nutritional status "at risk" and may be associated with unintended, significant weight loss.
OR
Significant weight loss or gain due to identified eating disorder.
OR
Problems relating to a feeding device (for example P.E.G.) that require skilled assessment and review.

Severe
Unable to take food and drink by mouth. All nutritional requirements taken by artificial means requiring ongoing skilled professional intervention or monitoring over a 24 hour period to ensure nutrition/hydration for example I.V. fluids.
OR
Unable to take food and drink by mouth, intervention inappropriate or impossible

7. Continence

Low
Continence care is routine on a day-to-day basis;

Incontinence of urine managed through for example medication, regular toileting, use of penile sheaths etc.
AND
Is able to maintain full control over bowel movements or has a stable stoma, or may have occasional faecal incontinence.

Moderate
Continence care is routine but requires monitoring to minimise risks, for example those associated with urinary catheters, double incontinence, chronic urinary tract infections and/or the management of constipation.

High
Continence care is problematic and requires timely and skilled intervention, beyond routine care (for example frequent bladder wash outs, manual evacuations, frequent re-catheterisation).
.

8. Skin (including tissue viability)

High
Pressure damage or open wound(s), pressure ulcer(s) with 'partial thickness skin loss involving epidermis and/or dermis', which is not responding to treatment
OR
Pressure damage or open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule', which is/are responding to treatment.
OR
Specialist dressing regime in place; responding to treatment.

Severe
Open wound(s), pressure ulcer(s) with 'full thickness skin loss involving damage or necrosis to subcutaneous tissue, but not extending to underlying bone, tendon or joint capsule' which are not responding to treatment and require a minimum of daily monitoring/reassessment.
OR
Open wound(s), pressure ulcer(s) with 'full thickness skin loss with extensive destruction and tissue necrosis extending to underlying bone tendon or joint capsule' or above

OR
Multiple wounds which are not responding to treatment.

9. Breathing

Moderate
Shortness of breath which may require the use of inhalers or a nebuliser and limit some daily living activities.
OR
Episodes of breathlessness that do not respond to management and limit some daily living activities.
OR
Requires any of the following:
• low level oxygen therapy (24%).
• room air ventilators via a facial or nasal mask.
• other therapeutic appliances to maintain airflow where individual can still spontaneously breathe e.g. CPAP (Continuous Positive Airways Pressure) to manage obstructive apnoea during sleep.
High
Is able to breathe independently through a tracheotomy that they can manage themselves, or with the support of carers or care workers.
OR
Breathlessness due to a condition which is not responding to treatment and limits all daily living activities.
Severe
Difficulty in breathing, even through a tracheotomy, which requires suction to maintain airway.
OR
Demonstrates severe breathing difficulties at rest, in spite of maximum medical therapy.
Or
A condition that requires management by a non-invasive device to both stimulate and maintain breathing (bilevel positive airway pressure, or non-invasive ventilation)
Priority
Unable to breathe independently, requires invasive mechanical ventilation.

10. Drug Therapies and Medication: Symptom Control

Moderate
Requires the administration of medication (by a registered nurse, carer or care worker) due to: Non-concordance or non-compliance, or type of medication (for example insulin), or route of medication (for example PEG).
OR –
Moderate pain which follows a predictable pattern; or other symptoms which are having a moderate effect on other domains or on the provision of care.

High
Requires administration and monitoring of medication regime by a registered nurse or care worker specifically trained for this task because there are disks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. However, with such monitoring the condition is usually non-problematic to manage.
OR - Moderate pain or other symptoms which is/are having a significant effect on other domains or on the provision of care.

Severe
Requires administration of medication regime by a registered nurse, carer or care worker specifically trained for this task, because there are risks associated with the potential fluctuation of the medical condition or mental state, or risks regarding the effectiveness of the medication or the potential nature or severity of side-effects. Even with such monitoring the condition is usually problematic to manage.
OR - severe recurrent or constant pain which is not responding to treatment
OR - Risk of non-concordance with medication, placing them at-risk of relapse.

Priority
Has a drug regime that requires daily monitoring by a registered nurse to ensure effective symptom and pain management associated with a rapidly changing and/or deteriorating condition.
OR
Unremitting and overwhelming pain despite all efforts to control pain effectively.

11. Altered States of Consciousness (ASC)

Low
History of ASC but effectively managed and there is a low risk of harm.

Moderate
Occasional (monthly or less frequently) episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.

High
Frequent episodes of ASC that require the supervision of a carer or care worker to minimise the risk of harm.
OR
Occasional ASCs that require skilled intervention to reduce the risk of harm.

Priority
Coma.
OR
ASC that occur on most days, do not respond to preventative treatment, and result in a severe risk of harm.

12. Blank Box

Other significant care needs to be taken into consideration.

There may be circumstances, on a case-by-case basis, where an individual may have particular needs which do not fall into the care domains described above. If explanatory notes added at the end of the domains are not sufficient to document all needs, it is the responsibility of the assessors to determine and record the extent and type of this need here. The severity of this need and its impact on the individual need to be weighted, in the judgement of the assessors, in a similar way to the other domains. This judgement should be based on the risks associated with the need and the skill needed to manage the need. This weighting also needs to be used in the final decision.

Who decides?

NHS CC

- The panel decides – ie primarily an NHS decision;

The limits of social care

- The local authority decides.

Who decides?

If patient disagrees

- Seeks review by CCG & then appeals to 'NHS England' & Ombudsman

If local authority or NHS disagrees

- they must invoke their dispute procedures (PG para 10.4) eg
- Reg 22 2012 Regulations

Funding during a dispute

Neither the NHS nor an LA should unilaterally withdraw from an existing funding arrangement …

If agreement between the LA and NHS cannot be reached on the proposed change, the local disputes procedure should be invoked, and current funding and care management responsibilities should remain in place until the dispute has been resolved.

para 143 2012 Framework

Luke Clements Training

Reviews and appeals

Between 2009-10 and 2010-11 there was a 9% rise in appeals against NHS CC refusals in England and an increase in the success rate of these from 33% - 40%

Community Care 27 Oct 2011 p4

Luke Clements Training

S117 Mental Health Act 1983

Patients detained under:

- s3 MHA 1983 or
- MHA 1983's criminal provisions.

On discharge entitled to s117 MHA 1983 after care services

1. Free
2. Joint NHS / SS

S117 Mental Health Act 1983

Patients entitled to s117 unlikely to be eligible for NHS CC

- unless distinct non-mental health care need

But s117 patients can be taken to 'panel' - to answer the question:

- "but for entitlement to s117 would this person have been deemed eligible for NHS CC?"

If 'Yes' then NHS should fund 100% of the MHA 1983 costs

Carers

section 10 Care Act 2014

- Social services have a duty to undertake carers assessments of people even if the person for whom they care is eligible for NHS CC funding and

Section 20 Care Act 2014

- A duty to meet carer's eligible needs

BUT NB

- Respite / short break care is not a carers service

Carer eligible vs adult non-eligible

section 20

(7) A LA may meet … a carer's needs for support in a way which involves the provision of care and support to the adult needing care, even if the LA would not be required to meet the adult's needs … .

Care & support plans

Replacement care & NHS continuing healthcare?

What if the replacement care (identified in carer's assessment) is for an adult in receipt of NHS CC funding?

- NHS would be responsible for this.
- What if it failed / refused to provide this?

Social services could make a section 7 CA 2014 request

Where LA requests co-operation of a 'relevant partner' in relation to an 'individual with needs' or a carer, a carer of a child or a young carer, then it must comply with the request unless it would:

(a) be incompatible with its duties, or

(b) have an adverse effect on the exercise of its functions

Learning disabilities & NHS CC

- illness ~ s275(1) NHS Act 2006 includes 'mental disorder' within the meaning of the MHA 1983.

SS Work & Pensions v. Slavin (2011)

- 30 yr old severe LD (Fragile X Syndrome);
- residential care home (not a nursing home);
- Challenging behaviour requiring continuous supervision 1:1 and sometimes 2:1;
- Staff trained to meet the needs of residents but did not have any medical or nursing qualifications;
- C of A held his LD meant fell within s.275(1) & that:
  his healthcare needs qualify him for an NHS-funded residential placement at a care home where he is provided with the specialist care he requires by reason of his illness' (para 52).

Joint funding

If there is an upper limit to social care packages – is it lawful for a the NHS / SS to enter into a joint funding arrangement for someone considered to be at (or near) this upper limit?

The Court of Appeal in *Coughlan* held that it was:

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. TheLA cannot meet the costs of services which are not its responsibility because of the terms of section 21 (8) of the 1948 Act.

NHS & Direct Payments

s12A NHS Act 2006

- Empowers CCGs to make DPs to patients
- Pilots 2010 – 2013
- April 2014

  everyone in receipt of NHS continuing care to 'have the right to ask' for a personal health budget, including a direct payment

NHS & Direct Payments

s12A NHS Act 2006

- Empowers CCGs to make DPs to patients
- Pilots 2010 – 2013
- April 2014
  - everyone in receipt of NHS continuing care to 'have the right to ask' for a personal health budget, including a direct payment
- October 2014 ~ became a duty
- National Health Service (Direct Payments) Regulations 2013

NHS & Direct Payments