NHS Responsibilities for Continuing Care Funding

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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*';**

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

CA 2014	NHS Act 2006
Clash of Acts Both create duties elderly ill and disabled people	
Social care	v Nursing care

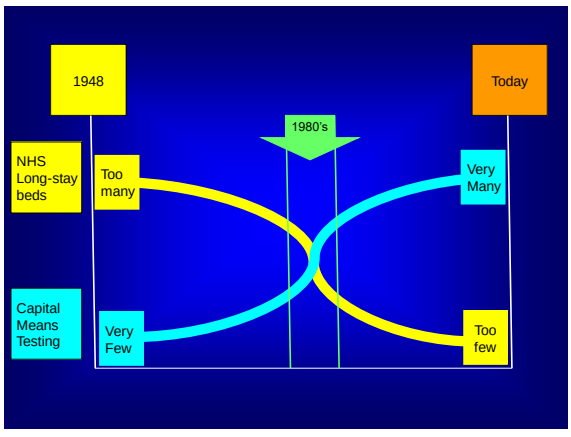
Legal limit of social care

There is a 'limit to social care' under the CA 2014.

If the person has needs above a certain level (the *Coughlan* criteria)

- It is unlawful for social services to fund their care
- All their health and social care needs have to be funded by the NHS

An identical legal limit existed under the National Assistance Act 1948 s21



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

Leeds Ombudsman case 1994

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Leeds Ombudsman case 1994

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

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**

Law and Guidance

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

Framework Guidance

Decision Support Tool

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 [social care] which a local authority is under a duty to provide [under the social care legislation] 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).

The Quantity / Quality test

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.

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

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

Wigan Patient 2003

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

- Advanced dementia, (ie 'some of the severe behavioural problems, which had characterised his illness during its earlier stage, had now diminished');
- 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

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)

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"

Children

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

- Although a broad interpretation of [the Children Act 1989] 'could cover what are essentially medical needs – but 'such an interpretation would turn the social services authority into a substitute or additional NHS for children.

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

- That would be … an impermissibly wide interpretation, creating obligations on a social services authority which are far too broad in the context of other statutory bodies and provisions covering the needs of [children]' (para 68).

Funded nursing care

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

Funded nursing care

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

National Framework for NHS Continuing Care

October 2007

Revised 2009, 2012 and 2018

Decision Support Tool (DST)

- 11 different care domains

Checklist

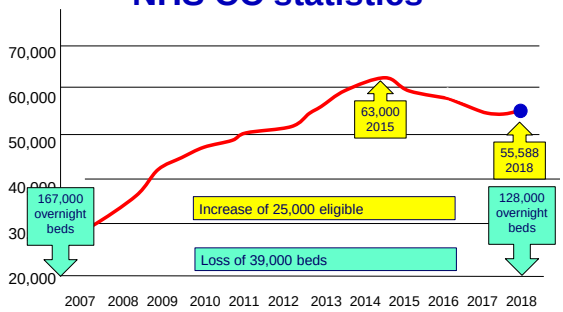
Fast-track Pathway Tool

The headlines – Key Messages

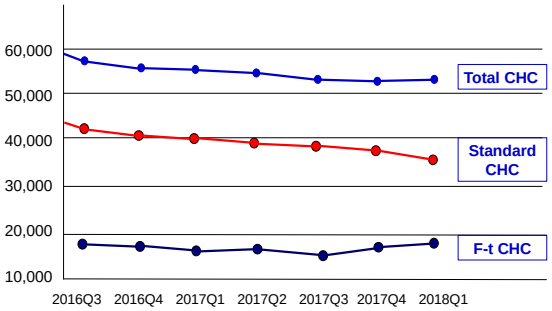
- The Framework (for all adults) is a change in system that will require PCTs and LAs to think and act differently
- NHS Continuing Healthcare is part of a whole process of care pathways.
- Whatever someone's ongoing health and social care needs, they still need to be met but NHS Continuing Care should 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



NHS CC statistics



2018 Framework Core Values

63 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.

2018 Framework Core Values

63 … The decision-making rationale should not marginalise a need because it is successfully managed: well-managed needs are still needs.
…
… Only where the successful management of a healthcare need has permanently reduced or removed an on-going need, such that the active management of a healthcare need is reduced or no longer required, will this have a bearing on NHS Continuing Healthcare eligibility.

2018 Framework Core Values

Evidence of well managed need:

- Not about 'incidents' its about the care regime;
- Care providers to keep records explaining what they are doing: why their care regime has avoided 'incidents'
- Hospitals saying no record of problems: attend the morning ward round / handover note what is said eg hear it is said … Fred had another terrible night – throwing his walking frame etc … [often not written in the log].

2018 Framework Core Values

Para **65**

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

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

2018 Framework Core Values

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

2018 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

2018 Framework Core Values

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

2018 Framework Core Values

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

Panel requiring additional evidence

- Missing NHS evidence
  - *Early escalation of dispute process*
- Evidence of 'well managed'
- 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.

Timescales

PG 28.2 This whole process should usually be completed within **28 calendar days**. This timescale is measured from the date the CCG receives the completed Checklist indicating the need for full consideration of eligibility (or receives a referral for full consideration in some other acceptable format) to the date that the eligibility decision is made. However, wherever practicable, the process should be completed in a shorter time than this.

Timescales

Where there is delay beyond this period the expectation is that LAs and individuals will be refunded their costs 'from day 29 of the period that starts on the date of receipt of a completed Checklist' unless the CCG has no responsibility for the delay

Annex E para 9 (page 160)

CCG assessment & care planning

Any assessment and decision making by a CCG concerning individual need must be 'person-centred: … placing the individual, their perception of their needs and preferred models of support at the heart' of the assessment and care-planning process (2018 Framework para 67).

South Tyneside MBC (16 018 767) 08 Jan 2018

2018 Framework Core Values

172 Where a person qualifies for NHS Continuing Healthcare, the package to be provided is that which the CCG assesses is appropriate to meet all of the individual's assessed health and associated care and support needs. …. Although the CCG is not bound by the views of the LA on what services the individual requires [the LA's assessment [of what the person needs] … will be important … .

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

Topping up & the NHS

180. NHS care is free at the point of delivery. The funding provided by CCGs in NHS Continuing Healthcare packages should be sufficient to meet the needs identified in the care plan. Therefore it is not permissible for individuals to be asked to make any payments towards meeting their assessed needs

Topping up & the NHS

283. [where a person becomes eligible for CHC and is already resident in a care home with fees higher than the CCG usually pays ie because funded by a LA and a 3rd party top up]. This 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.

Topping up & the NHS

284. In such situations, CCGs should consider if there are reasons why they should meet the full cost of the existing care package, notwithstanding that it is at a higher rate.

This could include that the frailty, mental health needs or other relevant needs of the individual mean that a move to other accommodation could involve significant risk to their health and well-being.

Topping up & the NHS

274. There should be as clear a separation as possible between NHS and private care. In [2009 guidance], 'separation' is described as usually requiring the privately-funded care to take place in a different location and at a different time to the NHS-funded care. However, many individuals eligible for CHC have limitations on their ability to leave their home due to their health needs. …

DoH *Guidance on NHS patients who wish to pay for additional private care* 2009

Topping up & the NHS

275. Based on the above principles, examples of additional private services which might be purchased separately include hairdressing, aromatherapy, beauty treatments and entertainment services

People living in the community

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

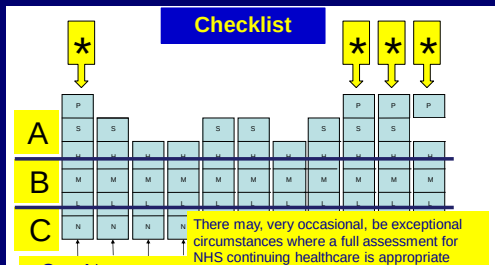
Court approved an extract from the 2012 Framework – (now at para 291 2018 Framework) - where people living in the community:

> the CCG is financially responsible for meeting all assessed health and associated social care needs. This could include: equipment provision …, routine and incontinence laundry, daily domestic tasks such as food preparation, shopping, washing up, bed-making and support to access community facilities, etc. (including additional support needs for the individual whilst the carer has a break). …

Checklist

- The Checklist threshold … has intentionally been set low … (para 85 2018 framework);
- Health or social care practitioners can complete the Checklist. (para 92 2018 framework);
- The individual should be given a copy of the Checklist. (para 100 2018 framework);
- Completion of the Checklist is intended to be relatively quick and straightforward. It is not necessary to provide detailed evidence along with the completed Checklist (para 86 2018 framework)

Checklist



- One A*
- Two A's
- One A + four B's
- Five B's

There may, very occasional, be exceptional circumstances where a full assessment for NHS continuing healthcare is appropriate even though the individual does not apparently meet the indicated threshold. 2018 Framework para 85.

Pam Coughlan likely to get one A & three B's.

Fast track Pathway tool [2018 Framework]

224 … when the individual has a rapidly deteriorating condition and may be entering a terminal phase
225 replaces the need for a Checklist and DST to be completed.
226 can be used in any setting. This includes where such support is required for individuals who are already in their own home or are in a care home and wish to remain there
220 [completed by] an appropriate clinician means … responsible for the diagnosis, treatment or care of the individual under the 2006 Act and a registered nurse or a registered medical practitioner.

Fast track Pathway tool [2008 Framework]

227 The completed FTPT should be supported by a prognosis, where available. However, strict time limits that base eligibility on a specified expected length of life remaining should not be imposed;

- 'rapidly deteriorating' should not be interpreted narrowly as only meaning an anticipated specific or short time frame of life remaining; and
- 'may be entering a terminal phase' is not intended to be restrictive to only those situations where death is imminent.

It is the responsibility of the appropriate clinician to make a decision based on whether the individual's needs meet the FTPT criteria.

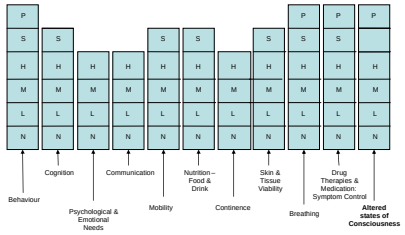
Fast track Pathway tool

- The 2012 Regulations (reg 21) ~ a CCG must accept and action the FTPT;
- an individual may currently be demonstrating few symptoms yet the nature of the condition is such that it is clear that rapid deterioration is to be expected in the near future (para 229)
- CCGs should have processes in place to enable … care packages to be commissioned quickly. Given the nature of the needs, this time period should not usually exceed 48 hours from receipt of the completed Fast Track Pathway Tool (para 238)

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

Decision Support Tool

31. A clear recommendation of eligibility for CHC would be expected:

- one priority;
- two severe's.

If however there is:

- One severe + needs in a number of other domains.
- A number of domains with high and/or moderate needs

this 'may' indicate a primary health need

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, others or property. The person is nearly always compliant with care.

High
"Challenging" behaviour that poses a predictable risk to self, others or property. 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, others or property. The risk assessment identifies that the behaviour(s) require(s) a prompt and skilled response that might be outside the range of planned interventions.

Priority
'Challenging' behaviour of severity and/or frequency and/or unpredictability that presents an immediate and serious risk to self, others or property. The risks are so serious that they require access to an immediate and skilled response at all times for safe care.

2. Cognition

Low
Cognitive impairment 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 consistently 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 marked 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 their 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 them in care planning, support 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 additional support may be needed 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

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

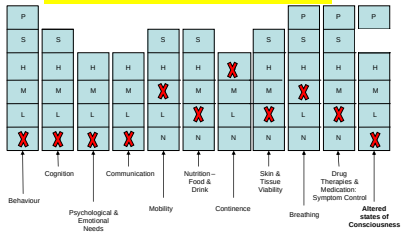
Low
Able to weight bear but needs some assistance and/or requires mobility equipment for daily living.

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 the individual or others 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
1 severe + needs in a number of other domains, or
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/constipation.

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 regular 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 necrosis extending to underlying bone,
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 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. 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 or cannot be adequately reflected in these domains. If the boxes within each domain that give space for explanatory notes are not sufficient to document all needs, it is the responsibility of the assessors to determine and record the extent and type of these needs here. The severity of this need and its impact on the individual need to be weighted, using the professional judgement of the assessors, in a similar way to the other domains. This weighting also needs to be used in the final decision. It is important that the agreed level is consistent with the levels set out in the other domains. The availability of this domain should not be used to inappropriately affect the overall decision on eligibility

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 90 Framework

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

When a person is eligible for NHS CC funding the burden of deciding whether they no longer qualify rests with the NHS.

In the absence' of any such assessment, the NHS "remains liable to arrange for those needs to be met and cannot lawfully pass responsibility for a patient to a local authority".

SS W&P v. Vale (CDLA/3161/2003 27/7/2005 (cited in *Grogan* at para 76)

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

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 will only be eligible for NHS CC
- if a distinct health care need arises or

s117 patients can be taken to 'panel' - to answer the question:
- "but for entitlement to s117 would this person have been eligible for NHS CC?"

If 'Yes' then then 100%NHS s117 funded
Especially if previously NHS CC eligible

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 CA 2014 support;

Section 20 Care Act 2014
- A duty to meet carer's eligible needs

BUT NB
- Respite / short break care is not a carers service

Carers

2018 Framework para 291

- CCGs remain responsible for (among other things) the 'support needs for the individual whilst the carer has a break'.

Carers

2018 Framework para 326

When a CCG is supporting a home-based package where the involvement of a family member or friend is an integral part of the care plan, it should agree with the carer the level of support they will provide.

It should also undertake an assessment of the carer's ability to continue to care, satisfying themselves that the responsibilities on the carer are appropriate and sustainable, and establish whether there is an 'appearance of need for support', which would mean that the carer should be referred for a carer's assessment … .

Carers

2018 Framework para 327

The CCG may need to provide additional support to care for the individual whilst the carer(s) has a break from his or her caring responsibilities and will need to assure carers of the availability of this support when required.

This could take the form of the CCG providing the cared-for person with additional services in their own home or providing the necessary support to enable them to spend a period of time away from home (e.g. a care home).

Carers

Replacement care & NHS continuing healthcare?

- What if NHS fails / refuses to provide this?

The LA could make a s7 CA 2014 request

Where LA requests co-operation 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

If the CCG fails to comply the LA could request NHS England to direct the CCGs (s14Z21 NHS A 2006).

Section 7 requests can be used for other reasons – ie a failure of the NHS to complete a Checklist or DST etc

Learning disabilities and 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).

Children

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

- although on a broad interpretation of s17(1) CA 1989 'to safeguard and promote the welfare of children … ' could cover what are essentially medical needs – but 'such an interpretation would turn the social services authority into a substitute or additional NHS for children.

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

- That would be … an impermissibly wide interpretation, creating obligations on a social services authority which are far too broad in the context of other statutory bodies and provisions covering the needs of children' (para 68).

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

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- Pilots 2010 – 2013
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  - 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 CC Guides

Information concerning entitlement to NHS CHC can be accessed at:

Beacon ~ an Age UK spin off social enterprise that offers a initial free consultation see www.beaconchc.co.uk/

Age UK – at

- http://www.ageuk.org.uk/health-wellbeing/doctors-hospitals/nhs-continuing-healthcare-and-nhs-funded-nursing-care/
- Spinal Injuries Association at
- www.spinal.co.uk/userfiles/images/uploaded/pdf/291-747356.pdf

Alzheimer's Disease Society – at

- http://alzheimers.org.uk/site/scripts/documents_info.php?documentID=399