

# Understanding the limits of social care

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## Session 1

- The legislative context:-
- The NHS Act 2006 & its interface with the Care Act 2014
- Continuing NHS Care duties
- The benchmark cases and 'getting to grips' with Coughlan
- The 'primary health care needs' vs the 'limits of social services power to fund'
- The 2022 National Framework

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## Session 2

- The National Framework (continued)
- The Checklist and Fast-Track Assessments
- The Decision Support Tool
- The Local authority / ICB dispute process
- Discharge to Assess issues
- Learning Disability & Continuing Care
- s117 MHA 1983 & Continuing Care
- Carers; jointly funded packages; and Direct Payments

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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';

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## 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;

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### Legal Duties

CA 2014

NHS Act 2006

Clash of Acts  
Both create duties elderly ill and disabled people

Social care v Nursing care

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## Legal limit of social care

There is a 'limit to social care' under the CA 2014, section 22.

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

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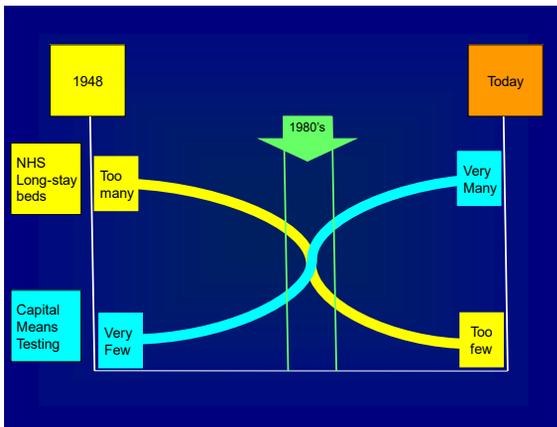
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## Leeds Ombudsman case 1994

- 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

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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

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### 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

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### Law and Guidance

#### Statutes

eg NHS Act 2006

#### Court cases

eg *Coughlan*

Regulations / directions

Practice Guidance

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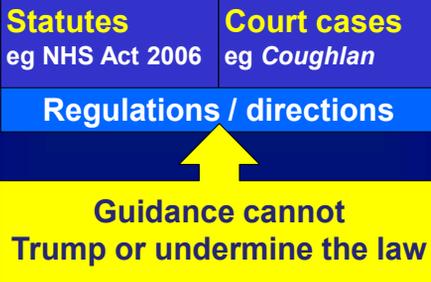
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## Law and Guidance



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## *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

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## *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:

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## 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

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## 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

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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.

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### **Wigan Patient 2003**

- **Several strokes**
- **No speech or comprehension**
- **Unable to swallow**
- **PEG fed** (percutaneous endoscopic gastrostomy)

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### **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.

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### **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.**

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### **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

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### **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)

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### **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"

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## 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.

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### *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).

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### Funded nursing care (FNC)

s49 Health & Social Care Act 2001  
Now s22 Care Act 2014  
£209.19pw (higher rate is £287.78)

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

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## **R (Forge Care Homes) v Cardiff & Vale UHB**

[FNC] was clearly intended to shift the boundary established by the *Coughlan* decision further in the direction of NHS funding.

Baroness Hale [2017] UKSC 56 para 26

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## **National Framework for NHS Continuing Care**

October 2007

Revised 2009, 2012, 2018 and 2022

Decision Support Tool (DST)

- 11 different care domains

Checklist

Fast-track Pathway Tool

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## **2022 Framework Core Values**

6 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.

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## 2018 Framework Core Values

64 ... 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.

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## 2018 Framework Core Values

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.

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## ICB assessment & care planning

Any assessment and decision making by a [ICB] 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 (see also PG 4 2022 Framework page 117).

South Tyneside MBC (16 018 767) 08 Jan 2018

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## 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 [ICB] 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). ...

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## Checklist

- The Checklist threshold ... has intentionally been set low ... ([para 114 2022 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 115 2022 framework](#))

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## Checklist

- Health or social care practitioners can complete the Checklist - so long as they have been trained in its use ([para 122 2022 framework](#));
- It is for each [ICB] & LA to identify and agree who can complete the tool ([para 123 2022 framework](#))

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### Fast track Pathway tool [2022 Framework]

**248** ... when the individual has a rapidly deteriorating condition and may be entering a terminal phase

**249** replaces the need for a Checklist and DST to be completed.

**250** 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

**244** [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.

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### Fast track Pathway tool [2022 Framework]

**251** 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

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### Fast track Pathway tool

- 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 253)
- **ICBs** 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 262)

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## Fast track Pathway tool

### NHS Ombudsman report

- In March 2017 a DST was completed for a care home resident and he was found to be ineligible for NHS CHC funding.
  - In July 2018 he was prescribed end of life medication and his GP completed and sent a fast-track tool to the NHS.
  - The NHS refused this stating that the resident did not have a rapidly deteriorating condition and that there 'had been no changes to his care needs since the last DST.
- The ombudsman held that this was maladministration, that:
- the fast-track document is a standalone assessment .... the previous DST was not relevant to [a patient's] eligibility for fast-track funding (para 17).

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## Fast track Pathway tool

- that it is the 'appropriate clinician' who determines that the individual has a primary health need and that the ICB 'must therefore decide that the individual is entitled to NHS continuing healthcare and should respond promptly and positively to ensure that the appropriate funding and care arrangements are in place without delay' (para 23)

P-001012 East Leicestershire and Rutland CCG ) 2020

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## [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

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## Decision Support Tool

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

- one priority;
- two severes.

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

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## DST & disputed domains

DST para **25**

... If there is difficulty in placing the individual's needs in one or other of the levels, the MDT should use professional judgement based on consideration of all the evidence to decide the most appropriate level. If, after considering all the relevant evidence, it proves difficult to decide or agree on the level, the MDT should choose the higher of the levels under consideration and record the evidence in relation to both the decision and any significant differences of opinion.

See also LGO report no 20 009 117 (Derbyshire CC) 2021 para 57

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### 1. 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 (bi-level positive airway pressure, or non-invasive ventilation)

Priority

Unable to breathe independently, requires invasive mechanical ventilation.

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**2. 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

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**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

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**3. 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).

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4. 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  
 OR  
 Multiple wounds which are not responding to treatment.

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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.

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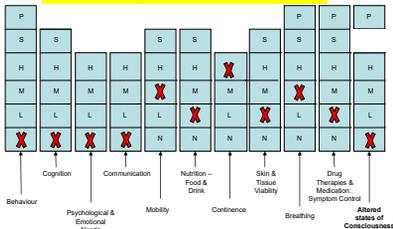
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1 Priority; or  
 2 Severe; or  
 1 severe + needs in a number of other domains, or  
 A number of highs and/or moderates,



Miss Coughlan needed services of a wholly different category

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6. 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.

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7. 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

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8. 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.

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9. 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.

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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.

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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.

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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

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**Who decides?**

Who decides what?

**NHS CC**

- The panel decides – ie primarily an NHS decision;

**The limits of social care**

- The local authority decides.

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**Who decides?**

**If patient disagrees**

- Seeks review by ICB & 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

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### 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 210 Framework

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### Dispute delayed care

It was agreed that a young adult with LD transitioning to adult services should move from her parents home into a residential placement.

The NHS and LA disagreed as to whether she was eligible for CHC and (pending this being resolved) their contributions to a care placement.

The ombudsman – in finding maladministration – held that this dispute prevented her placement from proceeding. The report cites extensively from the Framework Guidance.

Complaint 20 009 117 Derbyshire CC (2021) para 64

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### Co-operation

If a ICB fails to comply a local authority – the authority can request NHS England to ‘direct’ the ICBs to take appropriate action

s14Z21 NHS A 2006

Local authorities can require a ICB member (ie its CEO) to appear in front of a Health Scrutiny Panel

reg 27(1) Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013 SI 218

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## Discharge to Assess (D2A)

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## CHC and hospital discharge

### 2022 Framework para 101

... An assessment of longer-term or end of life care needs should take place once they have reached a point of recovery ... [as detailed in the hospital discharge guidance [11](#)].

This may include screening for NHS CHC, depending on the individual's circumstances and the point at which their longer-term needs are clearer. In the vast majority of cases this will be following discharge and after a period of recovery at home.

[11](#) Department of Health and Social Care Hospital discharge and community support guidance (1 July 2022).

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## CHC and hospital discharge

### 2022 Framework para 103

... ICBs should ensure that local protocols are developed ... These should set out each organisation's role and how responsibilities are to be exercised in relation to hospital discharge, including any arrangements for intermediate, reablement, rehabilitation or sub-acute care and arrangements for long-term care assessments including NHS CHC. ....

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## CHC and hospital discharge

### 2022 Framework para 104

For individuals leaving the acute hospital environment, it is best practice to screen for NHS CHC at the right time and in the right place for that individual. In the vast majority of cases this will be following discharge and after a period of recovery in a familiar setting or intermediate/rehabilitation placement. ....

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## CHC and hospital discharge

### 2022 Framework para 106

In order to ensure that unnecessary stays on acute wards are avoided, there should be consideration of whether the provision of further NHS-funded services is appropriate. This might include therapy and/or rehabilitation, if that could make a difference to the potential of the individual in the following few weeks or months. It might also include intermediate care or an interim package of support, preferably in an individual's own home. ... The interim services should continue until it has been decided whether or not the individual has a need for NHS CHC. ....

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## S117 MHA 1983 and NHS CHC

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### s117 Mental Health Act 1983

s117 arises when a patient detained under:

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

is discharged from their psychiatric ward

The duty is to provide free support and is a joint duty of the **ICB** and the LA.

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### s117 Mental Health Act 1983

Patients entitled to s117 will only be eligible for NHS CC

- if a distinct health care need arises;
- ie a stroke; a serious physical injury etc

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### s117 Mental Health Act 1983

- Even if no distinct (non-mental health) care need exists; and
- Even though there is no express 'limit to social care' under the MHA 1983;
- The *Haringey LBC* judgment (discussed above) makes it clear that there is a general principle that the *Coughlan* decision applies in all social services settings.
- So - if the person is above the *Coughlan* limit, the **ICB** will have to fund their case - ie 100% NHS funding – from their s117 budget.

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## 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 not 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

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## Carers

### 2022 Framework

**352** When a ICB 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.

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## Carers

**354** The ICB 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 ICB 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).

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## Carers

**354** Carers should have a single point of contact with the ICB to facilitate communication about any aspect of the care and support arrangements. ICBs should also work collaboratively with carers to agree contingency plans should the carer be unexpectedly unable to continue their caring role. This should include information on who to contact out of hours.

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## 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. The LA cannot meet the costs of services which are not its responsibility because of the terms of section [22 Care Act 2014].

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## NHS & Direct Payments

### s12A NHS Act 2006

- Places a duty on ICBs to make DPs to patients
- National Health Service (Direct Payments) Regulations 2013

### Guidance

Department of Health *Personal Health Budgets Guide: Budget setting for NHS Continuing Healthcare* (2012)

- A parallel regime to existing SS schemes

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## **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/](http://www.beaconchc.co.uk/)

**Age UK** – at

- <http://www.ageuk.org.uk/health-wellbeing/doctors-hospitals/nhs-continuing-healthcare-and-nhs-funded-nursing-care/>

**Alzheimer's Disease Society** – at

- [http://alzheimers.org.uk/site/scripts/documents\\_info.php?documentID=399](http://alzheimers.org.uk/site/scripts/documents_info.php?documentID=399)

**Luke Clements website (lecture 5)** – at

- <http://www.lukeclements.co.uk/lecture-series/>

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