

# **NHS Responsibilities for Community Care**

**Luke Clements**

# Key issues

1. The limits of social care – s21(8) NAA 1948;
2. A history of defective guidance;
3. Guidance is subordinate to the law (eg court judgments); and
4. The importance of the benchmark cases;

# **Legal Duties**

## **NAA 1948 Social Services**

### **Section 21**

**Duty to provide  
accommodation for  
elderly ill & disabled  
people**

## **NHS Act 1946**

### **Sections 1 & 3**

**Duty to provide  
Accommodation for  
ill people**

## s21(8) National Assistance Act 1948

*Nothing in this section shall authorise or require a local authority to make any provision authorised or required to be made (whether by that or by any other authority) by or under any enactment not contained in this Part of this Act, or authorised or required to be provided under the National Health Service Act 2006.*

## s21(8) National Assistance Act 1948

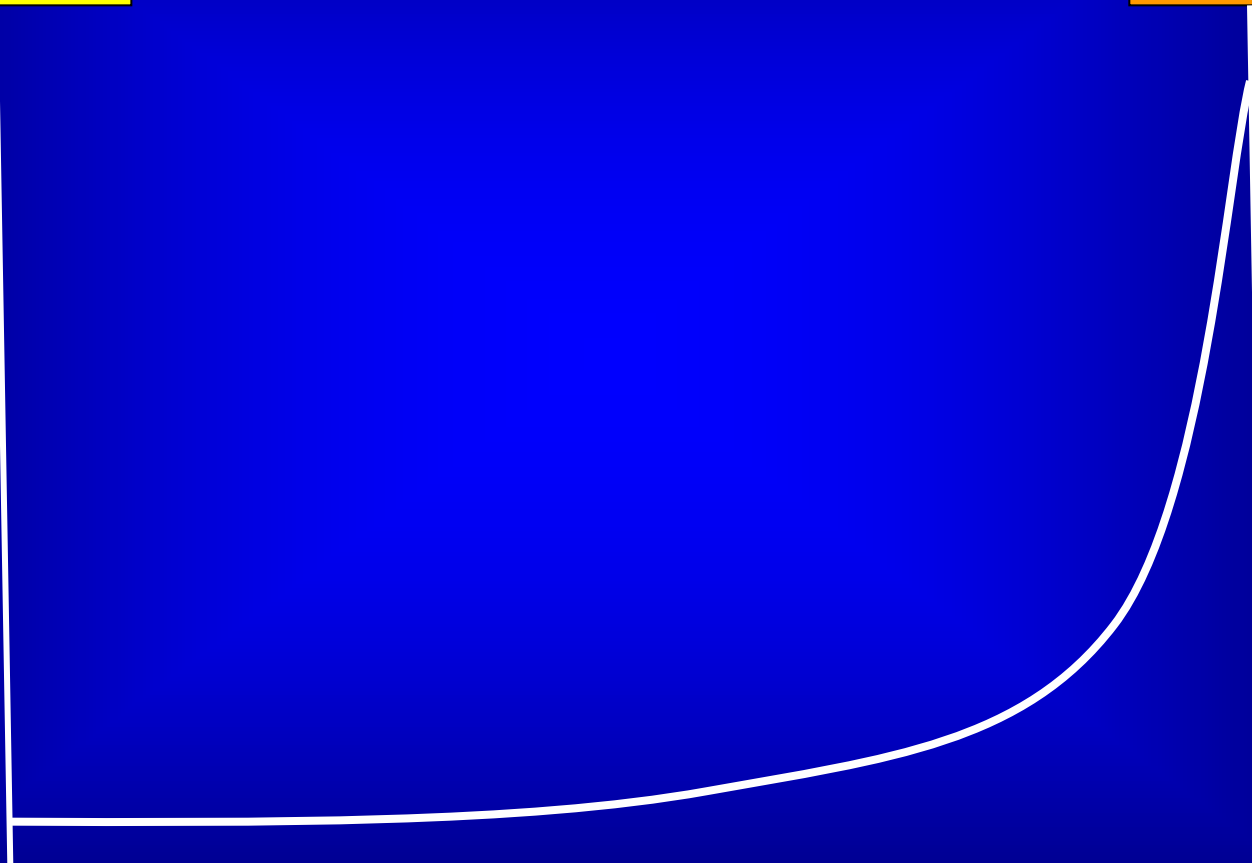
- Where a service could be provided by the NHS or social services then it must be provided by the NHS
- **NHS is the dominant service**
- It is unlawful for a local authority to provide services that could be provided by the NHS

1.9.79

1.4.93

£2.3 billion

£10 million



# Legal Duties

## Social Services

National Assistance Act 1948

► Specific duty

## NHS

NHS Act 2006

► Target duty

# *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

- **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

# ***NHS Guidance v. the Law***

**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 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).

# **Coughlan judgement (1999)**

- **Unlawful for social services to fund unless:**

- 1. Nursing merely ancillary or incidental to social care AND**
- 2. Not complex or specialist**

**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.

# 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

# ***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’ );
- Behaviour still challenging;
- Unable to look after himself;
- His wife cared for him at home.

# *Pointon* 2004

- Severe psychological problems and the special skills required to nurse someone with dementia

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

- Disabled child with complex medical conditions which required – a tracheostomy (a tube in the throat) which needed, suctioning about three times a night.
- Proceedings taken to argue that the respite care (to allow mother to have a break) should be funded by social services and not the NHS – ie that the child was not entitled to NHS CC.



**Free nursing care**

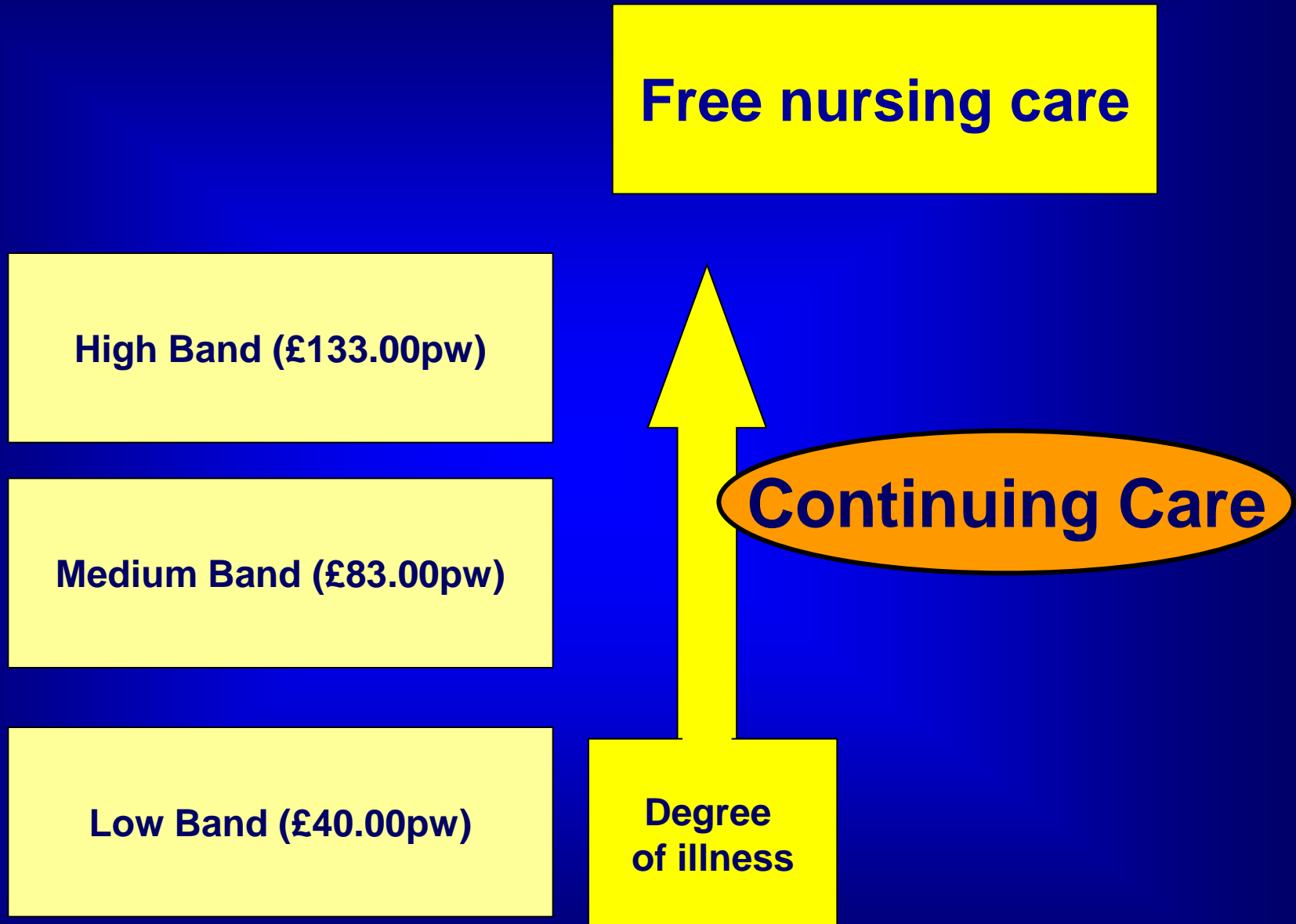
**High Band (£133.00pw)**

**Medium Band (£83.00pw)**

**Low Band (£40.00pw)**

**Continuing Care**

**Degree  
of illness**



# High Rate

high needs for registered nursing care  
[with] complex needs that require  
frequent mechanical, technical and/or  
therapeutic interventions

[and] need frequent intervention and re-  
assessment by a registered nurse  
throughout a 24 hour period,  
and their physical/mental health state  
will be unstable and/or unpredictable.

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

that as a matter of fact registered nursing care falling within the high band (and perhaps the medium bands) falls outside that limit set by *Coughlan*, 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 ...

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

suggests that over 20,000 people in England are being inappropriately charged for their nursing home accommodation. This means that in each English social services authority area on average at least 125 self funding or local authority funded residents should in fact be funded by the NHS – ie inappropriate expenditure in the region of £2½ million per annum

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**Continuing Health Care  
NHS Guidance**

**notwithstanding the legislative potential for  
there being a gap ...  
the policy is that there is to be no such gap ...**

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**Limits of social services  
Power to fund  
S21(8) NAA 1948**

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**Continuing Health Care  
NHS Guidance**

**This bar  
is moveable  
as created  
by guidance**

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**Limits of social services  
Power to fund  
S21(8) NAA 1948**

**This bar  
is fixed by  
Parliament**

# **National Framework for NHS Continuing Care**

**October 2007 – revised July 2009**

**England only (Wales ≡ August 2010)**

**Decision support Tool**

- **11 different care domains**

# Regulatory Impact assessment

Department of Health 2007

- almost 31,000 people were receiving NHS Continuing Healthcare on 31 March 2007 (para 31)
- Modelling suggests that up to 5,500 more people are likely to qualify for NHS Continuing Healthcare under the new Framework. (para 32)
- Based on existing data about the costs of care, we have estimated the overall cost to the NHS in the first full year as £219 million.



# NHS Continuing Healthcare - numbers

Regulatory Impact assessment stated that

- 31,000 receiving NHS CC ~ 31 March 2007
- Expect 5,500 more people to qualify p.a.

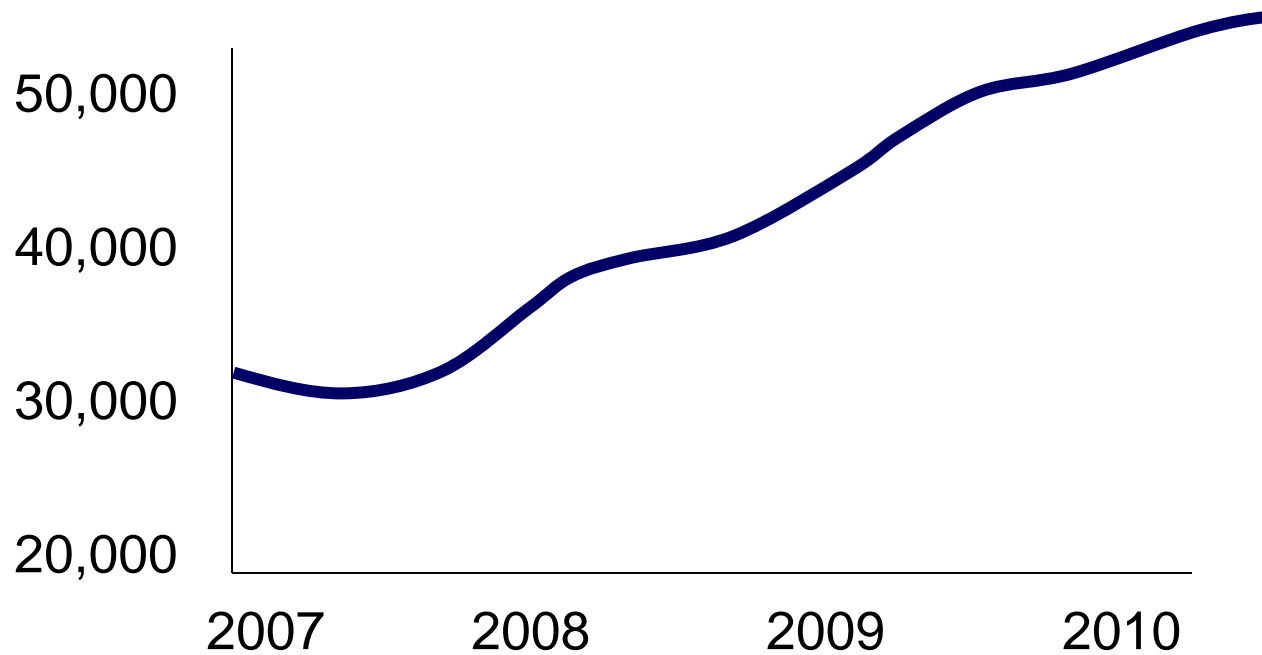
## Evidence

3<sup>rd</sup> quarter 2007/08 – 29,092

4<sup>th</sup> quarter 2009/10 – 50,424

4<sup>th</sup> quarter 2010/11 – 53,264

# NHS CC statistics



# 2009 Framework

## Core values

**46** 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.

# 2009 Framework Core Values

**47** NHS CC may be provided by PCTs 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.

# 2009 Framework Core Values

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

# 2009 Framework Core Values

**47...** 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.

# 2009 Framework Core Values

**49** 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.

# 2009 Framework Core Values

79. PCTs should be aware of cases which have indicated circumstances where a finding of eligibility for NHS Continuing Healthcare should have been made, and where the same outcome would be expected if the same facts were being considered in an assessment for NHS Continuing Healthcare under the National Framework (e.g. *Coughlan*, and those in the Health Service Ombudsman's report NHS funding for long term care of older and disabled people). However, they should be wary of trying to extrapolate generalisations about eligibility for NHS Continuing Healthcare from the limited information they may have about those cases. There is no substitute for a careful and detailed assessment of the needs of the individual whose eligibility is in question.



# 2009 Framework Core Values

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

# 2009 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 1<sup>st</sup> July 2010

# 2009 Framework Core Values

80. ... A decision to overturn the recommendation should never be made by one person acting unilaterally..

# 2009 Framework Core Values

82. ... Because the final eligibility decision should be independent of budgetary constraints, finance officers should not be part of a decision-making panel.

# Panel requiring additional evidence

## Panels returning DST for more evidence:

- Missing NHS evidence
  - *create a presumption; or*
  - *Early escalation of dispute process*
- Evidence of 'well managed' (establishing a negative)
- Evidence that will not be material (ie bureaucratic pointlessness)
- The Panel '*appeared to be trying to avoid making a decision*' .

# 2009 Framework Core Values

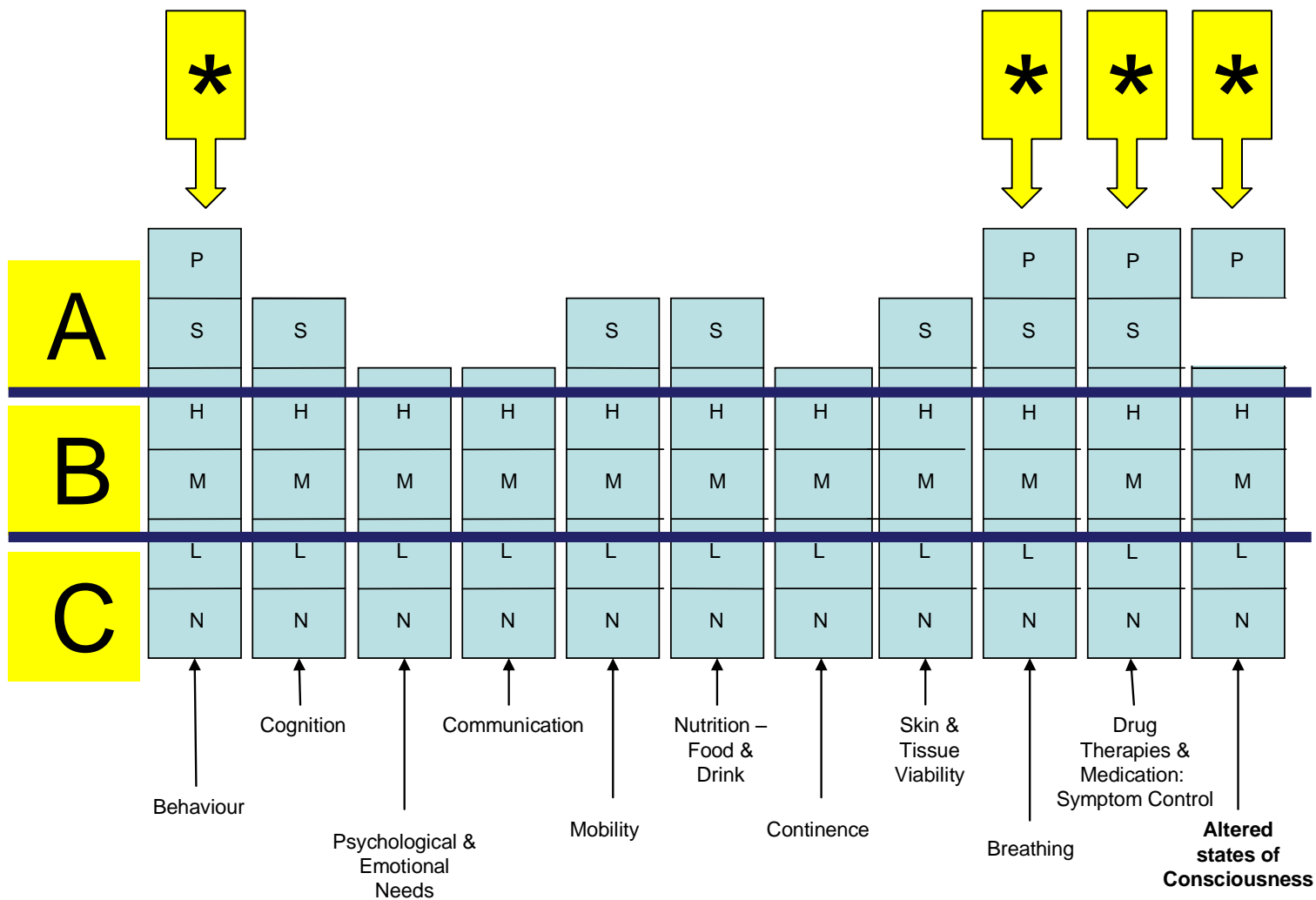
**100.** ... Where a person qualifies for NHS continuing healthcare, the package to be provided is that which the PCT assesses is appropriate for the individual's needs. Although the PCT is not bound by the views of the LA on what services the individual requires, the LA's assessment s47 NHS & CC Act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

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

# Checklist

## Simplified version of DST

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





# Checklist

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

20. There may also be circumstances where a full assessment for NHS continuing healthcare is considered necessary, even though the individual does not apparently meet the indicated threshold.

# Checklist

20. There may also be circumstances where a full assessment for NHS continuing healthcare is considered necessary, even though the individual does not apparently meet the indicated threshold.

Pam Coughlan gets at most one A and two B's;

# Checklist

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

- For individuals with a rapidly deteriorating condition, which may be entering a terminal phase, require fast tracking for immediate provision of NHS continuing health care
- Used by a senior clinician such as a ward sister, consultant or GP to outline the reason for the fast tracking decision.
- Justification for the use of the tool can be supported with a prognosis, but 'strict time limits that base eligibility on some specified expected length of life remaining should not be imposed'

# Fast track Pathway tool

- The 2009 Directions ~ a PCT must accept and action the FTPT immediately where it has been properly completed;
- 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).

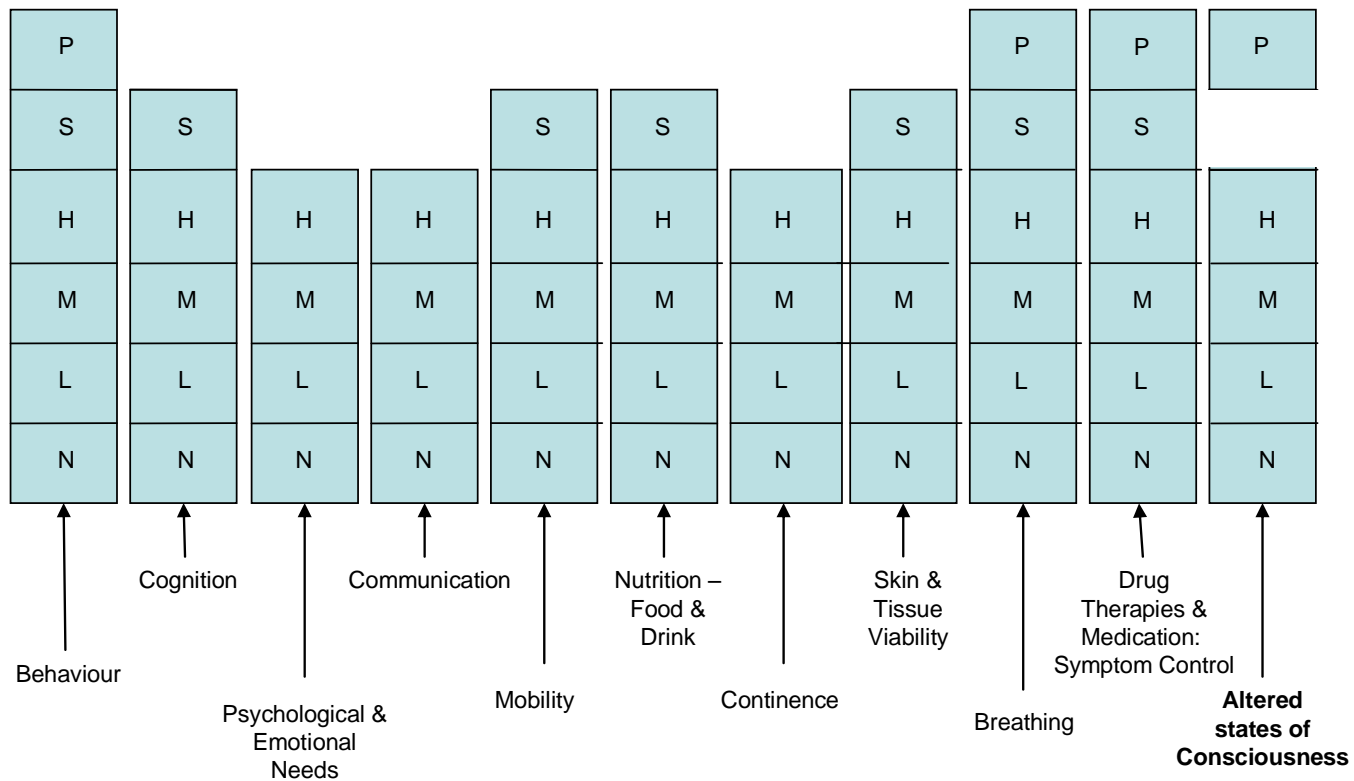
## Fast track Pathway tool

- If LAs believe that clinicians routinely and inappropriately refusing to use FTPT or
- PCTs believe that clinicians routinely and inappropriately signing off FTPTs; or
- PCTs routinely and inappropriately rejecting FTPTs
- This would need to be challenged by evidence - ie a structural and coordinated challenge (where records of past refusals / grants etc collated)

# [DST] What it's NOT



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





# Decision Support Tool

**22.** if there is difficulty in placing their 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

# Decision Support Tool

**32. 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 of behaviour that can be managed by maintain a level of behaviour that does not pose 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**

### Priority

“Challenging” behaviour of severity and/or frequency that poses a serious risk to self and/or others. The risks are so serious that they require a prompt and skilled response for safe care.

**Pointon**

**Severe Psychological problems**

**EMI**

**[Well  
Managed]**

### 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

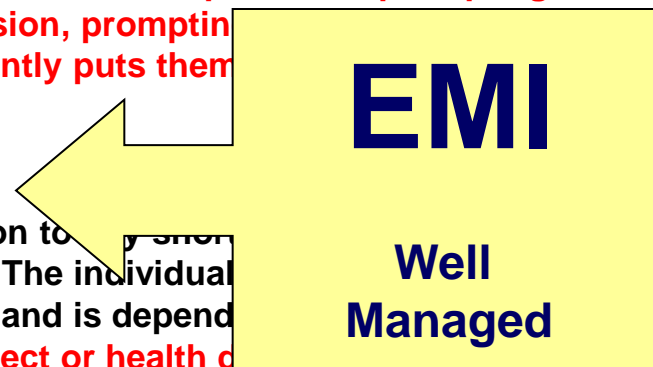
Cognitive impairment **(which may include some memory issues)** that requires some supervision, prompting and/or assistance with basic care needs and daily living activities. **Some** awareness of needs and basic risks is evident. The individual is **usually** able to make choices appropriate to needs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

### Severe

Cognitive impairment that may include, in addition to **short-term memory issues**, with long-term memory or severe disorientation. The individual **is unable to make choices appropriate to needs with assistance, even with supervision, prompting or assistance, and is dependent on others for help with 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

Withdrawn from social situations and demonstrates difficulty in engaging in care plan and/or daily activities.

#### High

Mood disturbance and/or anxiety, which has a severe impact on the individual's health and/or wellbeing.

OR

Withdrawn from any attempts to engage them in support, care planning and/or daily activities.

What of people with extreme OCD or with debilitating mental illnesses etc??

Include These details in Box 12??

## 4. Communication

### Low

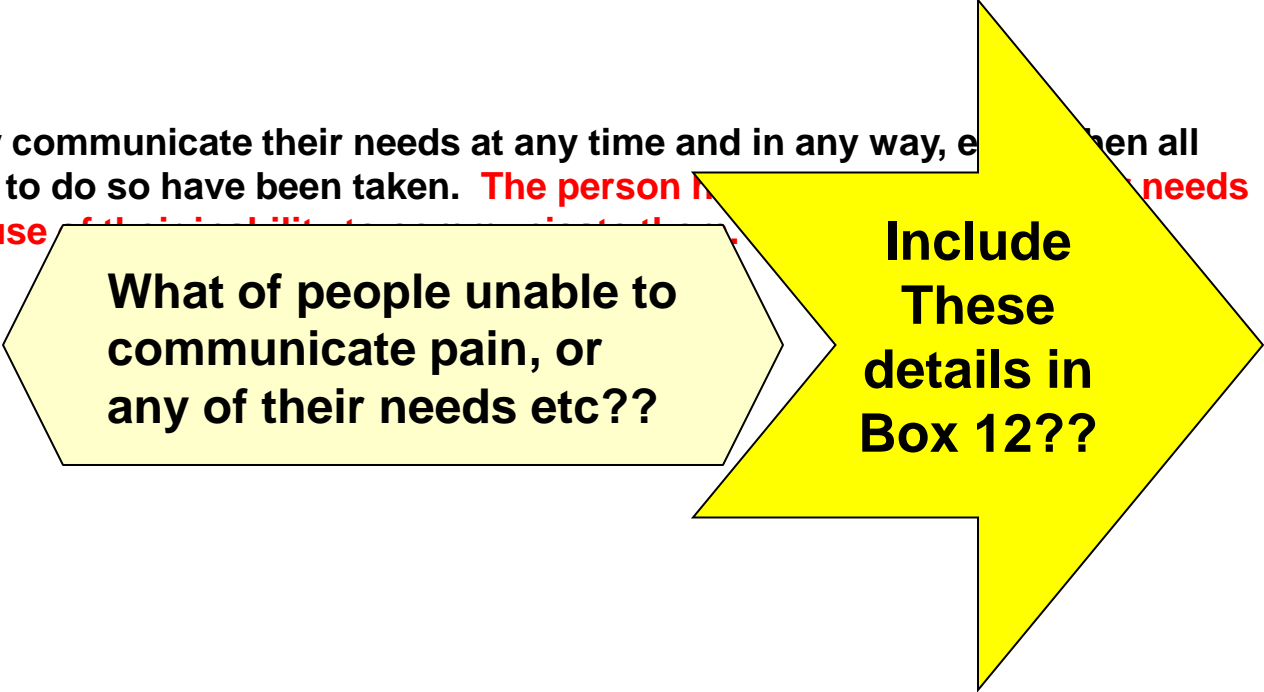
Needs assistance to communicate their needs. Special effort may be needed to ensure accurate interpretation of needs or may need additional support either visually, through touch or with hearing.

### 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 needs anticipated because of their inability to communicate.**



What of people unable to communicate pain, or any of their needs etc??

Include  
These  
details in  
Box 12??

## 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 the day, requiring assistance from carers or care workers.

**Coughlan**  
Tetraplegic

### 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.

## 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 minimise the risk of choking and aspiration to

OR

Subcutaneous fluids that are managed by the individual workers.

OR

Nutritional status “at risk” and may be associated with

OR

**Significant weight loss or gain due to identified eating**

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

**Wigan Patient**

PEG fed

**Fed through tube  
into stomach a  
‘social need’ ?**



# Phase shift

**Priority**

**NHS  
Continuing  
Care**

**Severe**

**High**

**Moderate**

## 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.**

**What if combined with  
pressure ulcers / tissue  
loss?**

**Include  
These  
details in  
Box 12??**

## 8. Skin (including tissue viability)

### Moderate

[largely unchanged from 2007 guidance – but [very] slightly less demanding]

### 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.

**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 air.

**OR**

**CPAP (Continuous Positive Airways Pressure).**



## **Haringey Children**

### **Tracheostomies**

**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.**

**Priority**

**Unable to breathe independently, requires invasive mechanical ventilation.**

## 10. Drug Therapies and Medication: Symptom Control

### Moderate

Requires the administration of medication due to:

- Non-concordance or non-compliance,
- Type of medication (for example insulin), or
- Route of medication (for example PEG, liquid medication).

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 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 **severe** risk of relapse.

### Priority

Has a drug regime that requires 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.



Difference?

## 11. Altered States of Consciousness (ASC)

### Low

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

### Moderate

Occasional episodes of **ASC unconsciousness** that require the supervision of a carer or care worker to minimise the risk of harm.

### High

**Frequent episodes of ASC** that require ~~skilled intervention~~ **to the supervision of a carer or care worker to minimise** the risk of harm.

**OR**

**Occasional ASCs that require skilled intervention to the supervision of a carer or care worker to minimise the risk of harm.**

**Brittle Diabetes ?  
Constant epileptic fits ?**

### 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?

## Who decides what?

NHS CC

- The panel decides – ie primarily an NHS decision (*St Helens v Manchester*);

The limits of social care

- The local authority decides.



# Who decides?

## *St Helens v Manchester (2008)*

- The PCT decided because it had followed a highly structured statutory process in compliance with the relevant directions (the Continuing Care (National Health Service Responsibilities) Directions 2004)

# Who decides?

If patient disagrees

- Seeks review & then appeals to SHA & Ombudsman

If local authority or NHS disagrees

- they must invoke their dispute procedures (PG para 10.4) eg
- **Direction 3(4) NHS Continuing Healthcare (Responsibilities) Directions 2009**

# Funding during a dispute

Neither the NHS nor an LA should unilaterally withdraw from an existing funding arrangement without a joint assessment of the individual, and without first consulting one another and the individual about the proposed change of arrangement. Alternative funding arrangements should first be agreed and put into effect. Any proposed change should be put in writing to the individual by the organisation that is proposing to make such a change. If agreement cannot be reached on the proposed change, the local disputes procedure should be invoked, and current funding arrangements should remain in place until the dispute has been resolved.

**para 143 2009 Framework**

# 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
3. Mental health needs not covered by NHS CC

# **S117 Mental Health Act 1983**

- Anomalous that the NHS can have less responsibility for a patient who has been forcibly detained than for one who has not.

**BUT**

- As a joint duty, in such cases NHS could fund 100% of costs.
- NHS & SS must have an interagency agreement to deal with this.

Unlikely to attract any litigation

# Carers

## Department of Health Advice:

- Social services have a duty to undertake carers assessments of people entitled to NHS CC funding and
- A power to provide carer's services

BUT NB

- Respite / short break care is not a carers service

# Children' s NHS Continuing care

- In *R (T, D & B) v Haringey LBC* (2005) Ouseley J considered adult regime applied with equal force to children;
- Arguable that CA 1989 provides greater obligations on NHS as it is silent concerning nursing (cf NAA 1948 s261A);
- Frequently tripartite funding
- Another major transition problem for children as move into adulthood;
- Unlikely to attract any litigation

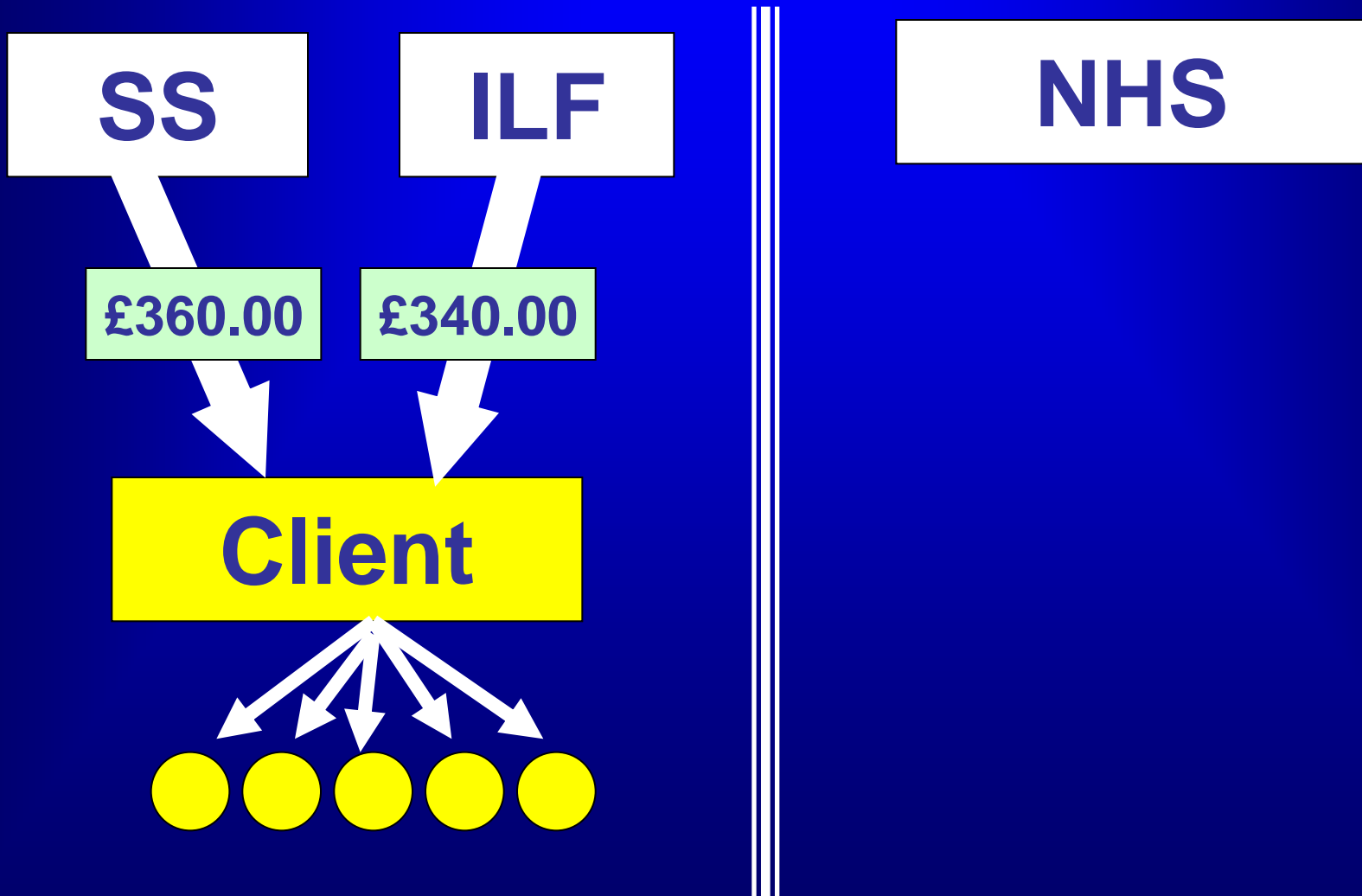


# Learning disabilities and NHS CC

History ~ HSG (92)43 / LAC (92)17:

- ❑ illness ~ s275(1) NHS Act 2006 / s206(1) NHS (W) Act 2006 includes 'mental disorder' within the meaning of the MHA 1983
- ❑ Pointon ~ managing challenging behaviour.
- ❑ many people with learning difficulties traditionally cared for in long-stay hospitals are predominantly in need of social care;
- ❑ In order to support ... people who might in earlier times have been cared for in long-stay hospitals, health finance may be spent on SS rather than on health services.

# NHS & Direct Payments



# NHS & Direct Payments

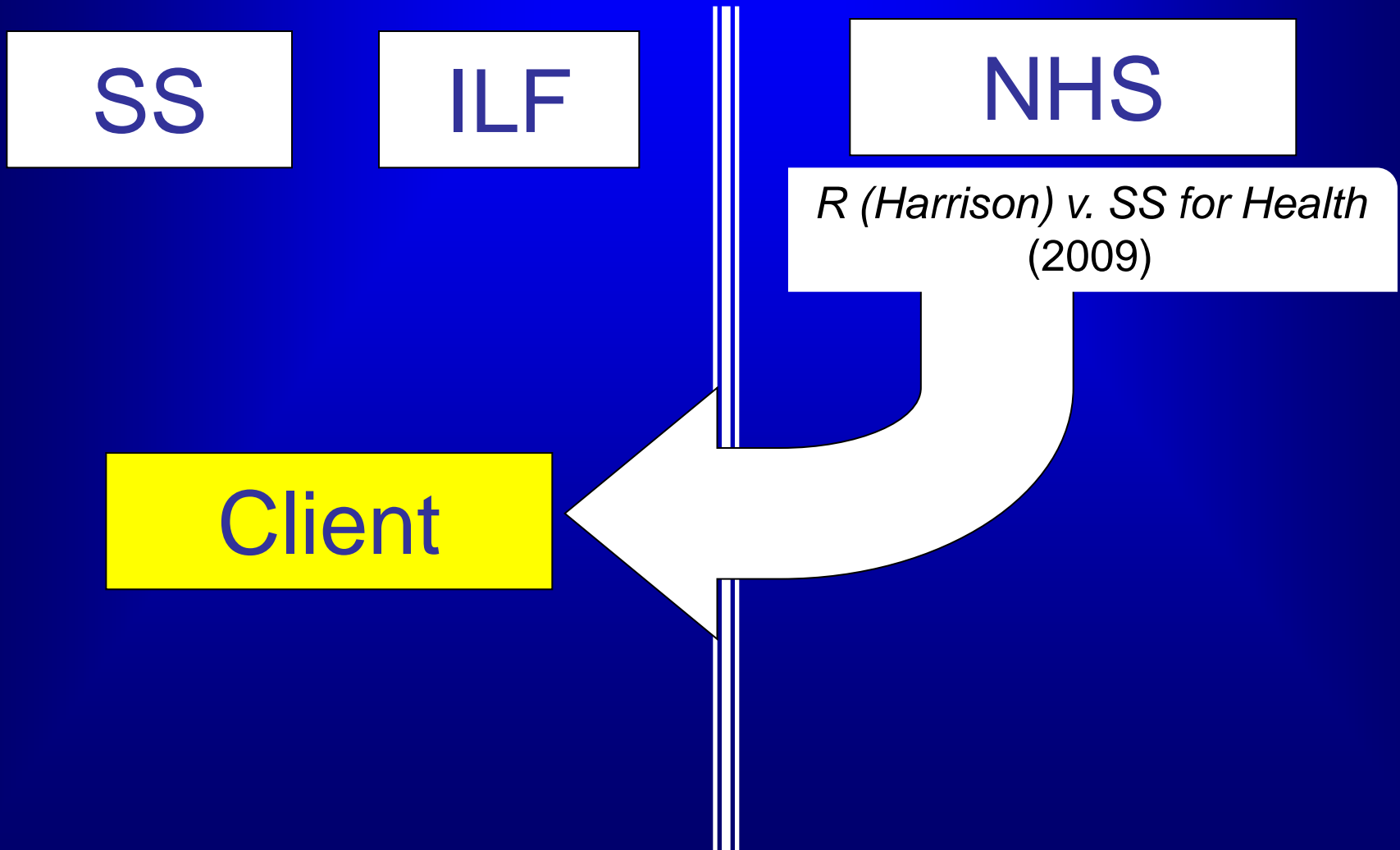
**SS**

**ILF**

**NHS**

**Client**

# NHS & Direct Payments



# NHS & Direct Payments

SS

ILF

NHS

Client

*Health Act 2009*

All PCTs can provide PB's

June 2010 – 2012 DP pilots

Doncaster PCT

E & Coastal Kent PCT

Central London (3 PCTs)

Islington PCT

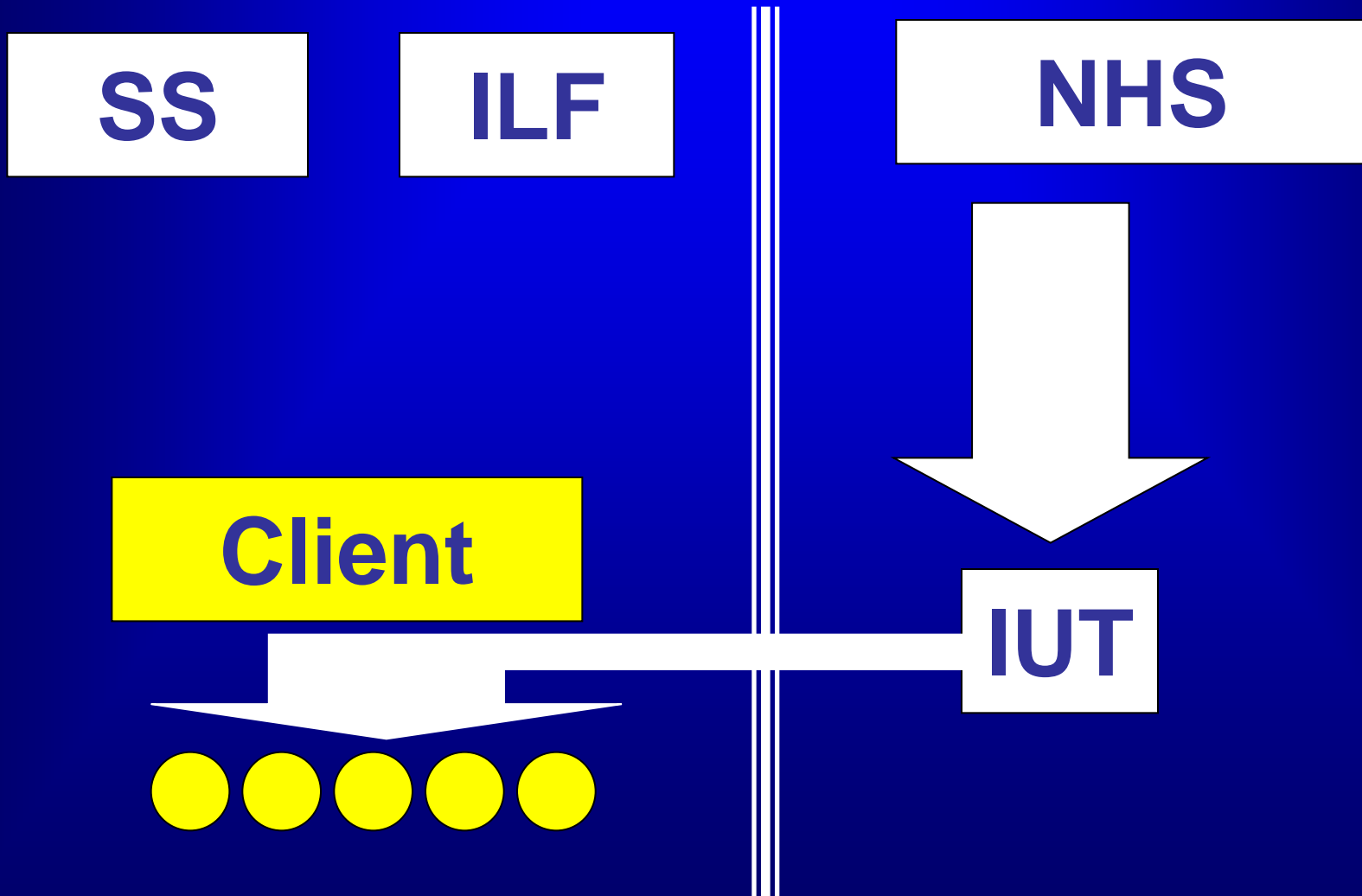
Merseyside (3 PCTs)

Oxford PCT

Somerset PCT

West Sussex PCT

# NHS & Direct Payments



The diagram is set against a solid blue background. At the top center, a yellow rectangular box contains the text 's256 NHS Act 2006' and 's194 NHS(W) Act 2006'. Below this box, there are two white rectangular boxes: 'SS' on the left and 'NHS' on the right. A large, yellow, curved arrow originates from the 'SS' box and points towards the 'NHS' box. Below the 'SS' and 'NHS' boxes, there is a yellow rectangular box labeled 'Client'.

s256 NHS Act 2006  
s194 NHS(W) Act 2006

**SS**

**NHS**

**Client**