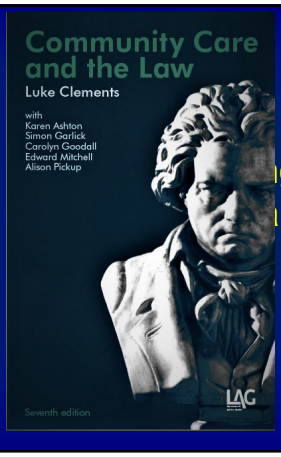
Understanding the limits of social care

Luke Clements
www.lukeclements.com

1



g the limits of
l care

Luke Clements
www.lukeclements.com

2

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

3

Session 2

- The National Framework (continued)
- The Checklist and Fast-Track Assessments
- The Decision Support Tool

Brief review:

- The Local authority / ICB dispute process
- s117 MHA 1983 & Continuing Care
- Jointly funded packages;
- Direct Payments
- Other resources

4

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*';**

5

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;

6

Legal Duties

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

7

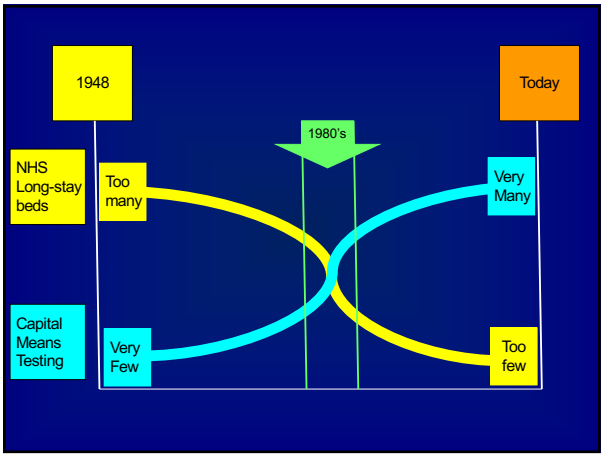
Legal limit of social care

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

8



9

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

10

Leeds Ombudsman case 1994

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

11

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

12

Law and Guidance

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

13

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

14

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:

15

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

16

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

17

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.

18

Wigan Patient 2003

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

19

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.

20

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.

21

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

22

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)

23

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"

24

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.

25

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).

26

Funded nursing care (FNC)

s49 Health & Social Care Act 2001
Now s22 Care Act 2014
£235.88pw (higher rate is £325.50)

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

27

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

28

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

29

The headlines – Key Messages

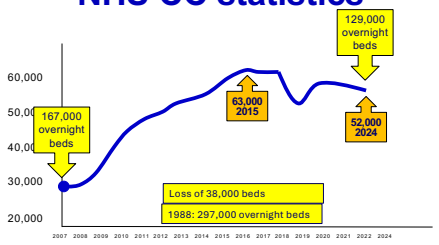
DH Department of Health

- 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

30

NHS CC statistics



31

2022 Framework Core Values

64 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.

32

2022 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.

33

2022 Framework Core Values

66 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.

34

Primary Health Need (PHN)

2022 Framework PG3 (& paras 55 – 62)

Four characteristics of need – namely 'nature', 'intensity', 'complexity', 'unpredictability' – 'may help determine whether the 'quality' or 'quantity' of care required is beyond the limit of a local authority's responsibilities, as outlined in the *Coughlan* case

Each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual's needs'

35

Primary Health Need (PHN)

2022 Framework PG3 (& paras 55 – 62)

Four characteristics of need – namely 'nature', 'intensity', 'complexity', 'unpredictability' – 'may help determine whether the 'quality' or 'quantity' of care required is beyond the limit of a local authority's responsibilities, as outlined in the *Coughlan* case

Each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual's needs'

36

Primary Health need

2022 Framework PG 3 'Nature'

Nature' ~ the characteristics of both the individual's needs and the interventions required to meet those needs.

- How does the individual / the practitioner describe the needs (rather than the medical condition leading to them)?
- What adjectives do they use?
- The impact of the need on overall health/well-being?
- What types of interventions are required to meet the need?
- Is there particular knowledge/skill/training required to anticipate and address the need?
- Could anyone do it without specific training?
- Is condition deteriorating/improving?
- What would happen if the needs were not met?

37

Primary Health need

2022 Framework PG 3 intensity

'Intensity' is about the quantity, severity & continuity of needs.

- How severe is this need?
- How often is each intervention required?
- For how long is each intervention required?
- How many carers/care workers are required at any one time to meet the needs?
- Does the care relate to needs over several domains?

38

Primary Health need

2022 Framework PG 3 Complexity

Complexity' is about the level of skill/knowledge required to address an individual need or the range of needs and the interface between two or more needs.

- How difficult is it to manage the need(s)?
- How problematic is it to alleviate the needs and symptoms?
- Are the needs interrelated?
- Do they impact on each other to make the needs even more difficult to address?
- How much knowledge is required to address the need(s)?
- How much skill is required to address the need(s)?
- How does the individual's response to their condition make it more difficult to provide appropriate support?

39

Primary Health need

2022 Framework PG 3 Unpredictability

'Unpredictability' is about the degree to which needs fluctuate and thereby create challenges in managing them.

- Is the individual or those who support him/her able to anticipate when the need(s) might arise?
- Does the level of need often change and does the level of support often have to change at short notice?
- Is the condition unstable?
- What happens if the need isn't addressed?
- How significant are the consequences?
- To what extent is professional knowledge/skill required to respond spontaneously and appropriately?
- What level of monitoring/review is required?

40

Primary Health need

2022 Framework PG 3 Unpredictability

3.6 'Unpredictability' is about the degree to which needs fluctuate and thereby create challenges in managing them. It should be noted that the identification of unpredictable needs does not, of itself, make the needs 'predictable' (i.e. 'predictably unpredictable') and they should therefore be considered as part of this key indicator.

being "predictably unpredictable" should never be used as a reason not to give NHS Continuing Healthcare.

DoH *A National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care in England Response to Consultation* (2007) (p.13)

41

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

42

People living in the community

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

Court approved an extract from the 2012 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). …

43

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)

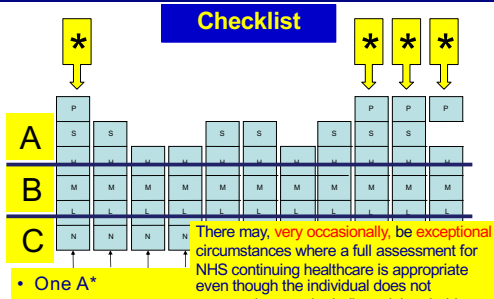
44

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)

45

Checklist

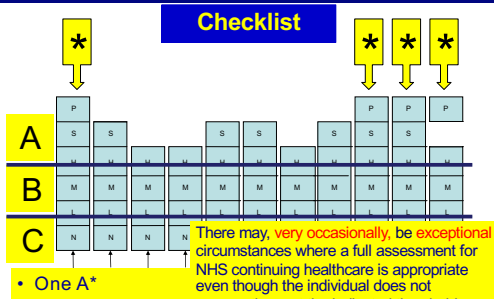


- One A*
- Two A's
- One A + four B's
- Five B's

There may, very occasionally, be exceptional circumstances where a full assessment for NHS continuing healthcare is appropriate even though the individual does not apparently meet the indicated threshold. 2022 Framework para 114.

46

Checklist



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

There may, very occasionally, be exceptional circumstances where a full assessment for NHS continuing healthcare is appropriate even though the individual does not apparently meet the indicated threshold. 2022 Framework para 114.

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

47

Checklist

- 'Any individual who 'crosses' the Checklist threshold but is ultimately deemed not to be eligible for NHS Continuing Healthcare is still likely to have their care jointly funded/provided by the [local authority] and [ICB]'.

ADASS & LGA, Commentary and advice for local authorities on the national framework for NHS continuing healthcare, 2007 p5

48

Fast track Pathway tool

- A ICB must decide that a person is eligible for NHS CC upon receipt of a FTPT completed by a clinician stating reasons for (his or her) decision
    - The 2012 Regulations (reg 21(9))

49

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.

50

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

51

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)

52

Fast track Pathway tool

- No individual identified through the Fast Track Pathway Tool who is eligible for NHS CHC should have this funding removed without their eligibility being re-considered through the completion of a DST by a MDT, including this MDT making a recommendation on eligibility for NHS CHC'
- (para 268)

53

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).

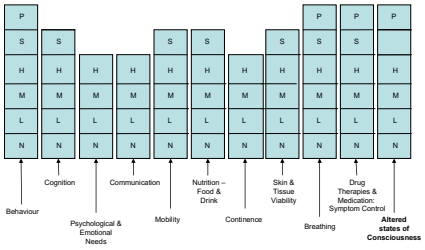
54

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

55



56

[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

57

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

58

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

59

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.

60

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

61

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

62

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).
.

63

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.

64

5. Mobility

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

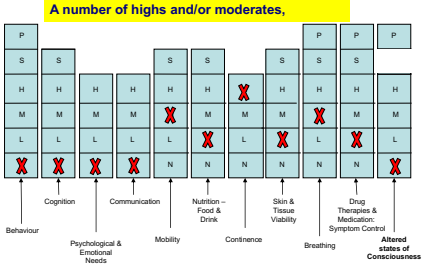
Moderate
Not able to consistently weight bear.
OR
Completely unable to weight bear but is able to assist or cooperate with transfers and/or repositioning.
OR
In one position (bed or chair) for the majority of time but is able to cooperate and assist carers or care workers.

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.

65

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

66

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.

67

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

68

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.

69

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.

70

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.

71

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.

72

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

73

Who decides?

Who decides what?

NHS CC

- The panel decides – ie primarily an NHS decision;

The limits of social care

- The local authority decides.

74

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 National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996

75

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

76

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

77

Dispute causing severe harm

A disabled person suffered significant harm (pressure sores / broken back) due to a LAs withdrawal of care in a dispute with the ICB over responsibility.

The SW requested night-time care but rejected by the panel - saying it was for the ICB to fund. During this dispute, neither service met her needs.

Maladministration

57. ... Miss X was left without the support she needed due to disputes between the Council and the NHS.

Complaint 23 202 786 Croydon LBC (2025) para 52

78

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

When a person is eligible for NHS CHC 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)

79

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

s13YB(7) NHS A 2006
Inserted by s13 Health and Care Act 2022

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

80

S117 MHA 1983 and NHS CHC

81

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 is a joint duty of the ICB and the LA;

The s117 support must be free of charge

.

82

s117 Mental Health Act 1983

Patients entitled to s117 will only be eligible for NHS CHC funding (ie from the NHS CHC budget):
- if a distinct health care need arises;
- ie a stroke; a serious physical injury etc

83

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 *Coughan* limit, the ICB should fund their care - ie 100% NHS funding – from their s117 budget.

84

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].

85

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

86

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/

Alzheimer's Disease Society – at

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

Luke Clements website (lecture 5) – at

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

87