**IN THE MATTER OF THE CARE ACT 2014**
**AND IN THE MATTER OF THE ADMINISTRATION OF MEDICATION**

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**ADVICE**

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1. I am asked to advise Knowsley Council as to the powers and duties of a local social services authority with regards to assisting service users with medication and as to the relative responsibilities in this regard of Clinical Commissioning Groups ("CCGs") and local authorities ("LAs").

2. I make clear at the outset of this advice my view that – unfortunately - the relevant legislation does not provide a straightforward or simple answer to the questions posed in my instructions (still less the answer that has been suggested (quasi-formally) to the Council by the Department of Health ("DH")).

**The statutory framework: the Care Act 2014**

3. The relevant provisions of the Care Act and associated regulations and guidance are set out in the following paragraphs[1].

[1] LAs will also have a responsibility to provide services under s. 117 of the Mental Health Act 1983 to service users falling with s. 117(1). The position in relation to s. 117 is relatively straightforward. Assistance with medication (whether prompting or administration or any other form of assistance) plainly falls within the definition of after-care service. S. 117(2) imposes a joint duty on the relevant LA and CCG to provide or commission after-care services. The only relevant limitation upon the LA's duty is that introduced by s. 117B, which provides (in terms similar to section 22 of the Care Act) that s. 117 does not authorise or require a LA to provide or arrange for the provision of nursing care by a registered nurse, *"nursing care by a registered nurse"* meaning a service provided by a registered nurse involving the provision of care or the planning, supervision or delegation of the provision of care, other than a service which, having regard to its nature and the circumstances in which it is provided, does not need to be provided by a registered nurse.

4. *Well-being* Section 1(1) of the Care Act imposes a general duty on a local authority, in exercising a function under Part 1 of the Act in the case of an individual, to promote that individual's well-being. Well-being is defined in section 1(2) as relating to any of the factors set out in section 1(2) which include personal dignity, physical and mental health and emotional well-being and control by the individual over day-to-day life. Section 1(3) provides that, in exercising a function under Part 1, the local authority must have regard to a range of matters which include, insofar as material, the importance of preventing or delaying the development of needs for care and support or for support and the importance of reducing needs of either kind that already exist.

5. The statutory guidance, at para 1.7, explains that promoting well-being involves actively seeking improvements in the aspects of well-being when carrying out a care and support function in relation to an individual, and that whenever a LA carries out any care and support functions it must act to promote well-being and should consider all of the aspects in looking at how to meet a person's needs. Paras 1.18 and 1.19 emphasise that the concept of independent living is a core part of the well-being principle and that supporting people to live as independently as possible for as long as possible is a guiding principle of the Care Act.

6. *Prevention* Section 2 of the Act (headed *Preventing needs for care and support*) requires a local authority to provide or arrange for the provision of services, facilities or resources, or take other steps, which it considers will (inter alia) reduce the needs for care and support of adults in its area or contribute towards preventing or delaying the development by adults in its area of needs for care and support. The statutory guidance, at para 2.1, states that it is critical to the Care Act that the care and support system works actively to promote well-being and independence and does not just wait to respond when people reach a crisis point. It emphasises the importance of early intervention and (at para 2.18) the need to look at a person's life holistically.

7. *Integration with health* Section 3 requires a local authority to exercise its functions under Part 1 with a view to ensuring the integration of care and support provision with health provision and health-related provision where it would promote well-being, contribute to the prevention or delay of development of needs for care and support or improve the quality of care and support, including the outcomes achieved by provision.

8. *Assessment and eligibility determination* Under section 9 of the Care Act 2014, where it appears that an adult may have needs for care and support, a LA has a duty to assess whether the adult does have such needs and if so, determine what those needs are. Section 9(4) provides that a needs assessment must include an assessment of the impact of the adult's needs for care and support on the matters specified in section 1(2) i.e. including physical and mental health. Having undertaken a needs assessment, under section 13 of the Act, if the LA is satisfied that the adult has needs for care and support it must then determine whether any of the needs meet the national eligibility criteria.

9. The eligibility threshold for adults with care and support needs is set out in the Care and Support (Eligibility Criteria) Regulations 2015 (the "Eligibility Regulations").

10. Regulation 2 of the Eligibility Regulations provides that an adult's needs meet the eligibility criteria if (a) the adult's needs arise from or are related to a physical or mental impairment or illness; (b) as a result of the adult's needs the adult is unable to achieve two or more of the specified outcomes; and (c) as a consequence of being unable to achieve these outcomes there is, or there is likely to be, a significant impact on the adult's wellbeing.

11. The specified outcomes are listed in regulation 2(2) and are as follows: a) managing and maintaining nutrition; b) maintaining personal hygiene; c) managing toilet needs; d) being appropriately clothed; e) maintaining a habitable home environment; f) being able to make use of the home safely; g) developing and maintaining family or other personal relationships; h) accessing and engaging in work, training, education or volunteering; i) making use of necessary facilities or services in the local community including public transport and recreational facilities or services; j) carrying out any caring responsibilities the adult has for a child. Para 6.106 of the statutory guidance provides (limited) examples of how LAs should consider the outcomes: e.g. the LA should consider the adult's access to food and drink and ability to prepare and consume food and drink; the adult's ability to wash themselves and launder their clothes; their ability to access and use a toilet and manage their toilet needs; their ability to dress themselves and to be appropriately addressed; and their ability to move around the home safely.

12. "Being unable" to achieve an outcome includes any of the following circumstances (see the guidance at para 6.105):

- where the adult is unable to achieve the outcome without assistance or prompting;
- where the adult is able to achieve the outcome without assistance but doing so causes significant pain, distress or anxiety;
- where the adult is able to achieve the outcome without assistance but doing so endangers or is likely to endanger the health or safety of the adult or of others;
- where the adult is able to achieve the outcome without assistance but takes significantly longer than would normally be expected.

13. Para 6.108 explains that where the adult is unable to achieve more than one of the outcomes, the LA does not need to consider the impact of each individually but should consider whether the cumulative effect of being unable to achieve those outcomes is one of a significant impact on well-being.

14. Para 6.14 of the guidance explains that whenever an individual expresses a need or any challenges and difficulties they face because of their condition(s) the LA should ensure that it has established the impact on the individual's day to day life. Para 6.6 points out that during the assessment LAs can identify needs that could be reduced or where escalation could be delayed and help people improve their wellbeing by providing specific preventive services.

15. *Service provision* Section 18 obliges a local authority, having made a determination under section 13, to meet the adult's needs for care and support which meet the eligibility criteria.

16. *Discretion to provide services* Section 19 gives local authorities a residual power to meet an adult's needs for care and support, where it is not required to meet them under section 18. This ability to exercise powers to meet non-eligible needs is emphasised in para 10.28 of the guidance. Para 10.29 requires a LA, if it decides not to use its powers to

meet other needs, to give a written explanation for its decision, with information and advice being provided as to how the person can reduce or delay their needs in future.

17. *Exception for provision of health services* Section 22(1) prohibits a local authority from meeting needs under sections 18 to 20 by provision or arranging for the provision of a service or facility that is required to be provided under the National Health Service Act 2006 unless (a) doing so would be merely incidental or ancillary to doing something else to meet needs under those sections and (b) the service or facility in question would be of a nature that the local authority could be expected to provide. These provisions essentially enact the quantity and quality tests introduced by the Court of Appeal's judgment in (Coughlan) v North and East Devon Health Authority [2001] QB 213. Section 22(3) prohibits a local authority from providing or arranging for the provision of nursing care by a registered nurse (defined in section 22(8) as *"the provision by a registered nurse of a service involving the provision of care, or the planning, supervision or delegation of the provision of care, other than a service which, having regard to its nature and the circumstances in which it is provided, does not need to be provided by a registered nurse"*), thus replicating the provisions of section 49(1) of the Health and Social Care Act 2001.

18. Under section 22(4) a local authority may arrange for the provision of accommodation together with the provision of nursing care by a registered nurse if it has obtained consent to do so from the local CCG or the case is urgent and the arrangements are only temporary.

19. The guidance summarises the effect of section 22 by explaining that the LA may provide or arrange healthcare services where they fall within section 22(1), but cannot arrange services that are the responsibility of the NHS (see para 6.81). Para 15.32 of the guidance gives as the two most "obvious" examples of healthcare that are clearly the responsibility of the NHS care provided by registered nurses and services the NHS must provide because the individual is eligible for CHC. There is no reference in this part of the guidance to medication or any suggestion that assistance with medication falls *per se* within the category of a service that cannot be provided because it is the responsibility of the NHS.

20. Para 23.9 explains that the new eligibility threshold replaced the existing guidance (*Prioritising need*) and introduces a threshold that is *"intended to allow for the same level of access to care and support to be maintained in the vast majority of circumstances and local areas."* It would appear, therefore, that it was not intended that the new eligibility arrangements would substantially alter LAs' responsibilities to provide services.

21. The guidance does not explicitly address medication save in para 4.101, where it says: "*Local authorities should ensure that where they arrange services, the assessed needs of a person with eligible care and support needs is translated into effective, appropriate commissioned services that are adequately resourced and meet the wellbeing principle of the Act. For example, short home-care visits of 15 minutes or less are not appropriate for people who need support with intimate care needs, though such visits may be appropriate for checking someone has returned home safely from visiting a day centre, or whether medication has been taken (but not the administration of medicine) or where they are requested as a matter of personal choice".* It is right to note, however, that this paragraph appears in a part of the guidance which deals with market shaping and commissioning arrangements with providers and offers no rationale for any distinction between checking and administration, and I do not think much weight can be placed upon it.

**Powers and duties of CCGs**

22. Insofar as the responsibilities of a CCG are concerned:

a. Section 2 of the National Health Service Act 2006 provides that a clinical commissioning group may do anything which is calculated to facilitate, or is conducive or incidental to, the discharge of any function conferred on the CCG by the Act.

b. Section 3 imposes duties on CCGs to provide, amongst other matters, medical and nursing services, such other services or facilities for the prevention of illness, the care of persons suffering from illness and the after-care of persons who have suffered from illness as the CCG considers are appropriate as part of the health service, and such other services or facilities as are required for the

diagnosis and treatment of illness – **but** this is a general, target duty, qualified by the fact that the duty is to make such provision *"to such extent as [the CCG] considers necessary to meet the reasonable requirements of the persons for whom it has responsibility"*.

c. Section 3A of the 2006 Act empowers a CCG to arrange for the provision of such services or facilities as it considers appropriate for the purposes of the health service that relate to securing improvement in the physical and mental health of the persons for whom it has responsibility, or in the prevention, diagnosis and treatment of illness in those persons for whom it is responsible.

23. Thus the 2006 Act confers a broad discretion on CCGs as to what services to provide, rather than a specific duty arising in individual cases. Plainly, however, where a patient is eligible for continuing health care, the provision of services (including assistance with medication, whether by way of prompting or administration) will be the sole responsibility of the CCG. Likewise the provision of nursing care by a registered nurse (other than care that does not need to be provided by a registered nurse) will be the sole responsibility of the CCG.

**Material from the Department of Health**

24. The issues on which I am asked to advise have arisen in consequence of advice received from a Policy Lead at the Department of Health ("DH") who has advised as follows (via the Care Act Implementation Lead for the North West) (underlining added for emphasis):

> *"If a person has a need for assistance with administrating medication this is considered a health need and is not to be taken into account as part of the eligibility criteria for care and support. In addition to the point made that it would be unfair to charge the person for something they should get from the NHS for free, there was also concern from LAs that they would not be insured if something went wrong when giving the medication. <u>We therefore deliberately did not include this as one of the eligibility criteria to make this distinction clear</u>."*

25. I am told that the Policy Lead went on to say that:

*"In some cases where a person has been assessed as having eligible needs, the LA and NHS might come to an agreement that the LA when meeting other needs could 'prompt' the person to take their medication if this is needed, but this does not go as far as helping with administration of the medication."*

26. In response to further enquiry, the Policy Lead, addressing the situation where an individual requires only a prompt with medication, stated that:

*"...in such a circumstance the person wouldn't meet the national eligibility criteria as s/he wouldn't meet the second test in the Regs [the Eligibility Regulations] of being unable to carry out two or more of the listed outcomes. If the LA decided that they wanted to meet this need it could use Section 19 of the Care Act which gives LAs the power to meet needs or even Section 2 of the Act if they felt it was preventing needs from worsening."*

27. I am instructed that the DH has said that it intends to provide formal guidance on the issue, but that thus far this has not been forthcoming and there is no indication when it may be. I agree with those instructing me that the draft of a note that is being worked on by the DH is, in any event, unlikely to take matters very much further.

28. I note that the DH *has* in April 2016 issued guidance entitled *Administration of medicines in care homes (with nursing) for older people by care assistants* ( https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/518298/Medicines_in_care_homes_A.pdf). This guidance states, amongst other matters, that:

*"This guidance has been prepared to make clear that care workers such as care assistants are not prohibited from administering medicines to residents."*

*"Is it legal for a care assistant to administer medicines in care homes (with nursing)?*

*Yes. The law does not prevent care assistants from administering medicines in care homes (with or without nursing)."*

*"So, a care assistant can administer medicines?*

*Yes, but any staff employed by the care home and responsible for the management and administration of medicines must be suitably trained and competent and the care home manager and staff should keep this regularly under review."*

The guidance outlines the training, policies and procedures that should be in place to enable care assistants to administer medicines in care homes. It addresses the position of residents who lack capacity, as well as the role of a registered nurse in care homes with nursing. In answer to a question as to what kind of medicines can a care assistant administer, the guidance explains that:

> "*Care workers should only administer medicines that they have been trained to give and this will generally include assisting people in: taking tablets, capsules, oral mixtures, applying a cream/ointment, inserting drops to ears, nose or eyes; and administering inhaled medicines …*
>
> *The administration of medicines by invasive or specialised techniques, or the administration of controlled drugs, will normally involve an RN, however, suitably trained and competent senior support staff may administer certain medicines when it has been deemed in the best interest of the resident."*

Whilst this guidance is not addressing the precise issue that I am asked to consider, I observe that (save in self-funded cases) placement in a care home without nursing will usually be commissioned by a LA; that placement in a care home with nursing may still be commissioned by local authority (save insofar as the services of the registered nurse are concerned: see R (Forge Care Homes Ltd) v Cardiff and Vale University Health Board [2016] EWCA Civ 26); and that this guidance contradicts (or at least undermines and certainly does not support) the views expressed by the DH Policy Lead to the Council.

29. In my view, the Council's briefing note dated 28 October 2015, which refers to *"recent guidance issued by the Department of Health on medication visits"*, overstates the significance of the advice provided by the DH Policy Lead to the Council, and the Council's review of its legal and policy position in reliance upon these quasi-formal communications from the DH (which are not equivalent to the issue of guidance) was premature.

**Discussion**

30. I address first the suggestion made by the DH Policy Lead that a need for assistance with administrating medication "is not to be taken into account as part of the eligibility criteria

for care and support" and was deliberately omitted from the list of outcomes. I cannot comment on whether, from the DH's perspective, medication was "deliberately omitted" from express inclusion within the Eligibility Regulations – although I have been unable to find any published DH documentation or Hansard material that supports this suggestion. However, it is incorrect, in my view, to assert that a need for assistance with medication "is not to be taken into account" by a LA in making its eligibility determination. A need for assistance with medication rarely arises in the abstract and it would be wrong to interpret the Eligibility Regulations in a mechanistic or rigid fashion, having regard in particular to the provisions of the guidance that I have set out above.

31. When assessing needs for care and support, the LA should be considering the effect of an inability (having regard to the broad approach in the guidance to the concept of "being unable" – see paragraph 12 above) to take medication without assistance (whether prompting or administration or some other form of assistance) on the identified outcomes. For example, pain relief medication (or medication given to reduce tremors or to treat epilepsy) may impact directly upon a person's ability to clothe, dress, wash or feed herself. Medication relating to continence or topical preparations for pressure ulcers could also directly impact upon one or more of the listed outcomes. Medication prescribed for symptoms of a mental disorder may, if not taken, result in the individual being unable to achieve one or more of the listed outcomes. It is wrong, therefore, to suggest that a duty to provide assistance with medication can *never* arise.

32. Insofar as the powers of a LA are concerned, and in the absence of any formal guidance from DH to the contrary, the correct position, in my opinion, is as follows:

    a. Firstly, the provision of assistance with medication can in principle form part of the duty under section 18 of the Care Act. Whether it does in any given case will depend upon the individual assessment, as set out above.

    b. Secondly, assistance with medication can plainly be provided pursuant to the LA's discretionary powers under sections 2 and 19 of the Act (and there could be cases where the effect on the individual, in well-being terms, of a failure to provide such assistance is so significant that a LA would be expected to exercise its power to provide the required assistance).

c. Thirdly, there are limitations upon a LA's power to provide assistance with medication, but those limitations arise from the provisions of section 22, the application of the quantity/quality test and the prohibition upon the provision of nursing care by a registered nurse.

d. Fourthly, considering section 22, I do not think that it can be said that prompting, assisting or administering medication necessarily or invariably falls outside the Council's responsibilities as a social care provider. A need for medication is common and many people who are prescribed medication take it by themselves, or with the assistance of family members, without any need for professional or trained or specialist assistance. I do not think that assistance with (or even administering) medication is invariably or generally a service of a nature which a local social services authority should not or could not be expected to provide. Nor is there a clear line that can be drawn, in terms of social care and health care responsibilities, between prompting and administration.

e. Fifthly, there will, however, be cases (involving, for example complex medication needs or invasive techniques or where reactions to particular medication require skilled observation or the administration of controlled drugs[2]) where a LA would be prohibited from providing or arranging for the provision of the service by virtue of section 22, and where the provision of assistance would be the responsibility of the CCG.

33. It follows that the approach taken by the Council does not, in my opinion, correctly reflect the provisions of the Care Act 2014, as set out above, although I recognise, of course, that the different view expressed by DH (albeit not in any formal issued guidance) and the counter-arguments identified by the DH.

34. I have not addressed the issue of reimbursement or some of the specific questions posed in my instructions because – on my analysis – those issues do not arise. However, I am very happy to do so or to discuss any of these issues further by telephone or in conference or by

[2] These are intended as examples and not as an exhaustive list.

way of further written advice if that would assist once those instructing me have had the opportunity to consider this advice.

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39 Essex Chambers
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