

The battle for justice

With the imminent publication of the Government's revised framework on continuing healthcare, Richard Bartholomew, chair of a strategic health authority appeals panel, sets out why recent legal verdicts should pave the way for far greater access to funding than any potential new statutory guidance

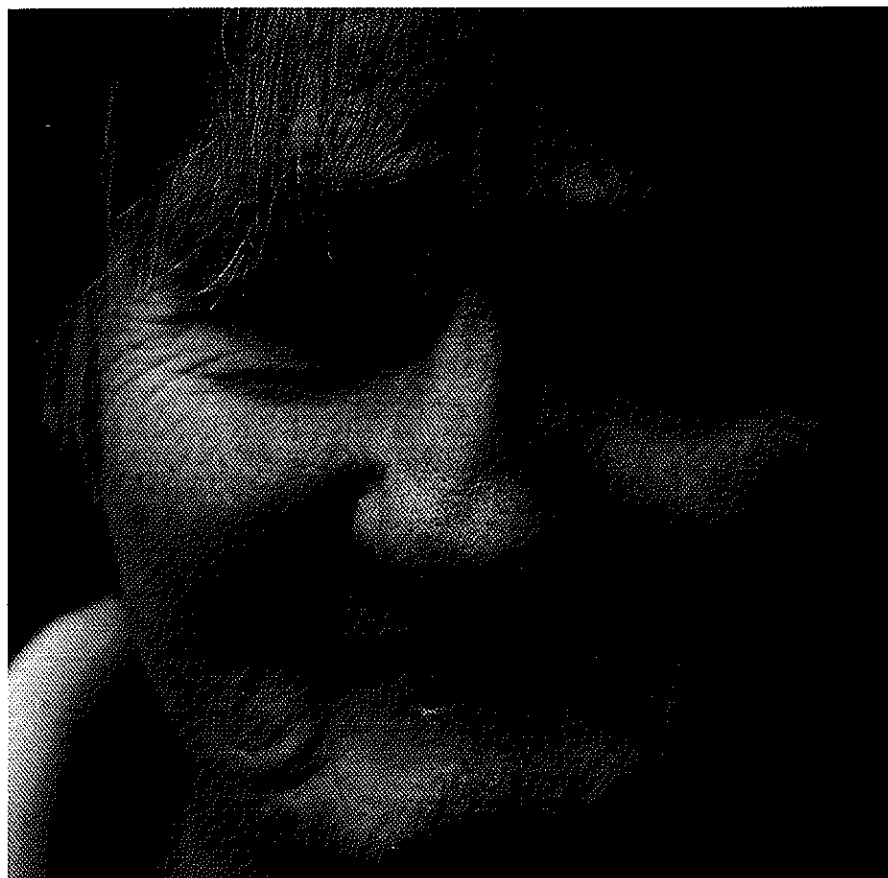
For ten years continuing health care (CHC) has been an intricate mystery to those on the outside of the health service, as well as to a great many of us who work within it, with so much apparently offered to people in poor health and with extensive care needs, but so little actually delivered to them.

After a series of landmark rulings the early signs are that some welcome relief is on the way for the many people who ought to be in receipt of CHC. In 1999 the Coughlan judgement of the Court of Appeal (see p19) introduced the notion that 'the primary need for health care' should be the crucial factor as to whether a person should receive 100% NHS funding of their care, regardless of whether or not they were living in a nursing home. The Court of Appeal, however, failed to define this term so that obtaining CHC remains elusive for patients and those sympathetic practitioners trying to help them secure NHS funding.

Crucial

In January 2006, a further crucial legal decision gave considerable new impetus to the debate. The High Court ruled in the case of Mrs Maureen Grogan (see p19) that she had been wrongly assessed, in that her local strategic health authority (SHA) had mis-applied the CHC eligibility criteria.

In the course of this judgement some other interesting things emerged. Firstly, the judge noted that there was a much clearer role for local authorities than had previously been thought, underlining that local authorities do not possess a 'mop-up' duty to fund anyone that the NHS decides not to fund, providing that they have had a financial assessment. Rather, he reversed the emphasis and made the point that a local authority had to make a clear judgement about the legality of funding individuals, under the powers given to them by Section 21 of the National Assistance Act 1948 (NAA), which only allows it to fund residential care for a person aged 18 or more 'who by reasons of age, disability or any other circumstance is in need of care



and attention which is not otherwise available to them'. Crucially the Act goes on to say that local authorities are not authorised to take on responsibilities of the NHS.

What does this mean? It means that we must surely be hearing the death-knell for those joint funding arrangements whereby the costs of care have been split between health and social care as a means of 'sharing the burden', since local authorities have been reminded by this judgement that they do not have the power to assume the financial responsibilities of the NHS. This is likely to affect many historical arrangements for people with learning disabilities, and enduring mental illness. It should also mean that local authorities are now under pressure to develop much clearer commissioning criteria, so that they

know exactly what types of care they are able to commission, without acting ultra-vires of their legal responsibilities.

There will doubtless be those who question why this is so important but for many social care professionals the reasons are all too clear. Those who do not receive CHC when they should do are being deprived of their right to the free care of the NHS, and left instead to pay for their care assistance, something that is both unlawful and a denial of their human rights.

Early experience from the post-Grogan appeals process seems to indicate that a clearer view is emerging of this 'primary need for health care'. For example, take the case of a patient known only as Mrs X, whose appeal had rattled around the system for three years. The final appeal hearing,

Grogan Judgement, High Court 2006

- Quashed the strategic health authority's (SHA) decision that Mrs Grogan did not qualify for continuing health care (CHC).
- Required the SHA to re-assess Mrs Grogan's needs for CHC bearing in mind whether the care she required could be lawfully financed by a local authority.
- This re-assessment for CHC was not to be obscured by trying to make a premature decision as to whether Mrs Grogan qualified for free nursing care under the RNCC assessment.

before her case would have had to go to the Ombudsman, demonstrated with much clarity that all her healthcare issues, including the 'small' ones, needed to be taken into account in a totting-up process that gave a holistic view of her needs. So, while the fact that she was partially-sighted did not, of itself, qualify her for CHC, the ability to re-enforce her case by emphasising that she was also confused and immobile started to demonstrate what the courts have termed 'a primary need for health care'.

The appeal panel took the situation to mean that if Mrs X was without her carers for a relatively short period (imagine that a flu pandemic had prevented any of her carers from visiting her) – say 24-48 hours – the assessments to hand suggested that she wouldn't even be able to get to the kitchen for a drink of water from a tap, let alone to get food for herself. To determine this, it was necessary to put together all the needs that she had, without artificially distinguishing between health and social care, and calculate the likely outcome or risk if these needs were not met.

If it is about anything at all, the need for primary health care is about survival, and avoiding having your health irretrievably impaired. In this light it is evident that many people who are currently funding their own care, wherever they live, or having it partly funded by adult social care, should actually be funded by the NHS, and that they should not be charged for this care.

The issue for local authorities is to rise to



Richard Bartholomew, pictured with his wife Liz

the challenge of being clearer about what Section 21 actually allows them to purchase, and to be able to apply this to individuals whose needs it has assessed. They have to be resolute about following through on this, even if it seems that they are threatening any cosiness that may have developed in joint working with the NHS at a local level. Local authorities also need to be aware that they will not only be under the closer scrutiny of service user and advocacy groups, in terms of individual complaints to the Ombudsman and/or the courts, but also that if they do not get their act together they will lay themselves open to complaints to the District Auditor about making ultra-vires payments, with the consequent possibility of surcharges – a scenario that should surely concentrate minds.

Intriguingly, it may well mean that local authorities need to commit resources to ensuring that service users have the support of advocacy services to help them take on the appeal process.

New framework

Will the picture that I have illustrated be changed at all by the imminent publication of the Government's draft *National Framework on Continuing Healthcare Funding*, following the consultation that has taken place over the summer? I fear that the answer is 'no' as the guidelines seemed to be drafted in a way to distance them from the laws that I have been describing.

A briefing document on the NHS proposals, drawn up by social care lawyer Luke Clements for the BBC's *Panorama*

Coughlan Judgement, Court of Appeal 1999

- Local authorities may not finance a person's care where the quantity OR the quality of that care exceeds their legal duties under Section 21 of the National Assistance Act.
- If a person has needs in excess of what local authorities could lawfully fund they are by definition deemed to be eligible for continuing health care.
- It is not a qualifying condition for a CHC-eligible person to be living in a nursing home, they could even be living in their own home.

investigations into CHC funding anomalies, uses a new decision support tool to demonstrate that the new guidelines would exclude four test-case patients, including Miss Coughlan, from CHC funding.

This, of course, is pretty damning stuff as the Department of Health has claimed since 1999 that all CHC guidelines need to be 'Coughlan-compliant', yet it appears to be raising the bar to an unlawfully high level to exclude patients from entitlement. Clements takes the view that the new guidelines are unlikely to lead to the identification of more patients eligible for CHC, nor will they lead to a quickening up of the process.

In my view, professionals helping patients to receive a CHC assessment should be explicit in their written referrals to the CHC assessors about the reasons for the referral and the perceived risks and reasons for the referral, since this can only help the assessors to make considered judgements that meet the particular individual's circumstances.

It is also important that anyone with a borderline-to-strong case for CHC should be assisted to persevere with the appeals and review process, which, in England, consists of one stage at primary care trust level and a subsequent strategic health authority stage, before moving on to the Health Service Ombudsman. In my own experience very few younger people with enduring mental illness, learning or physical disabilities, are appearing on my appeal lists. My fear is that this is a direct result of the sad reality that these people are not even getting a look in when it comes to basic CHC funding.

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