Health check

How to improve your chances of securing NHS continuing healthcare funding, by *Cate Searle*

NHS continuing healthcare means a package of continuing care arranged and funded solely by the NHS. 'Continuing care' means care provided over an extended period of time to a person aged 18 or over to meet physical or mental health needs which have arisen as a result of disability, accident or illness.

If an individual is assessed as being eligible for NHS continuing healthcare funding, then the NHS will have responsibility to pay for the entire package of care, including functions which may normally be regarded as 'social care functions'.

The setting where the individual receives care is irrelevant to their eligibility for NHS continuing healthcare funding. The individual may be in a care home or nursing home setting, or may be in their own home.

National framework

Before 30 September 2007, eligibility for continuing NHS healthcare funding (sometimes known as fully funded NHS care) was established using criteria set by the local strategic health authority (SHA). The national framework has been in force since 1 October 2007, replacing the local eligibility criteria with one national single set of eligibility criteria and a standard process for assessing eligibility, reviewing cases and resolving disputes. The national framework was most recently revised in July 2009, and practice guidance most recently issued in March 2010.

Unfortunately, in my experience, despite the fact that the new framework has been in place for over four years, individuals who need long-term care, their families, representatives and legal advisers, are often given incorrect or misleading information which can result in them deciding not to explore eligibility for NHS continuing healthcare funding.

"Three out of four elderly people who should receive NHS-funded care have had to pay their own fees"

Age UK research suggests that three out of four elderly people who should receive NHS funded care have had to pay their own fees. Incorrect information may come from hospital or social services staff, NHS continuing healthcare teams, nursing and care home staff and also from websites. There are many common examples and unhelpful misconceptions that the elderly client adviser may encounter (see box).

One of the stated aims of the national framework was to remove the huge local variations resulting in a postcode lottery in who did and did not receive

Watch your step

Some common misconceptions that the elderly client adviser may encounter in relation to NHS continuing healthcare funding

- There's no point applying: you only get funding if you are terminally ill
- Don't waste your energy challenging the decision: continuing healthcare funding is only given to people who have dementia
- You can't get funding unless you are in a nursing home
- Healthcare costs must be met by the patient if they can afford to pay through savings, insurance or the sale of assets
- Your relative will not get funding because they do not need qualified nurses to look after them
- Your relative does not qualify because the carers are managing his/her needs well

funding for their health care needs across the country. The Department of Health (DoH) hoped to establish a fairer and more consistent system for determining whether an individual's care should be funded by the NHS.

The same basic principles that predated the framework still apply: the individual must have needs that are not merely incidental to the provision of residential accommodation or which are not of a nature that social services could be expected to provide for.

ITN recently featured a piece that argued that the postcode lottery remains and, in my experience, dealing with cases across England and Wales, this is certainly true. I can have two clients with very similar needs; one who is readily agreed for NHS funding, and another who has a significant battle to establish eligibility, having to overcome the local review process and then the independent review process to secure a fair result.

Back dated

It is possible to make, not only a current claim for NHS CHC funding, but also to bring a retrospective claim to recover care fees for someone who has been in care for some years, or for the estate of someone who is no longer alive. At present, if certain grounds are met, retrospective cases can go back to 1 April 2004.

It was inevitable that the DoH would take steps to 'close the floodgates' and shorten the date for any retrospective claim – I have been expecting them to introduce a new 'cut-off' point for some time now. The DoH has thus recently announced that the new cut-off point for any claims that cover the period 1 April 2004 to 31 March 2011 must be registered with the NHS by 30 September 2012.

I am concerned that the new cut-off date and deadline will make the process of assisting families in pursuing legitimate NHS appeals even more frustrating for the family and the adviser than it is at present. In many parts of the country, CHC teams are already operating under a heavy backlog and some retrospective assessments and reviews can take two years to get through the system.

It does not seem that the DoH plans to provide additional resources to enable the NHS to deal with the extra work. At the same time, a sense of panic may lead to the system getting further clogged up with claims that do not have merit.

Elderly client advisers need to take prompt action to look through all of their cases to identify whether there is a potential claim for a refund of care fees. They need to pay particular attention to those cases where they act or acted as a deputy or attorney, and arguably those where they are dealing with probate in relation to someone who had significant care needs. A failure to identify potential cases could lead to the family taking action against the adviser, rather than against the NHS.

However, they also need to be mindful about not starting what can be a very lengthy, costly and emotionally exhausting process for the family if the case lacks merit. An elderly client adviser who does not have expertise in this area of practice may want to seek an opinion from a more experienced NHS continuing healthcare adviser in at least some of their cases.

Moving forward

There are some important practical tips for advisers handling such cases.

Stick to the point. It may seem trite to say 'throw out the irrelevant arguments that your client insists on emphasising', however, the argument that your client or their relative should qualify for fully funded care as a matter of principle, simply because nobody should have to pay for care in their old age ("and they don't have to in Scotland"), will get your client nowhere.

> **"A sense of panic may lead to the system getting further clogged up with claims that don't have merit"**

Manage expectations. As importantly, it is vital to manage your client's expectations in this type of work from the outset, particularly when passionate feelings of injustice can be stoked by newspaper articles and websites that focus on the moral issues.

Empathise. Looking at assessment documentation, medical notes and records can be daunting for a client. In many cases, your client may be anxious or distressed because their relative has had a health crisis and requires care as a result. Your client may be trying to juggle the role of caring for their relative with managing their finances, liaising with social services and finding a suitable placement for their relative, and may find it difficult to step back and consider what is and what is not a primary health need. The very fact that there is no clear definition of a primary health need – even with the introduction of the new national framework – does not make your client's position any more manageable.

Think of the end result. Always consider and discuss with your client whether a successful appeal and a positive funding decision may be counter-productive – for example, will the local NHS insist that the funded individual has to move to an alternative care setting? Will the private care provider refuse to accept the lower weekly rate typically offered by the NHS and social services?

Be prepared. Make sure that your client brings as much relevant documentation as possible to the interview – as a minimum you need the checklist assessment and the DST, the panel decision letter and any minutes and rationale.

Ask your client to do some homework before they come in, and to make a note of their own opinion about their relative's needs in each domain on the DST, backing this up with as many examples and anecdotes as possible.

Don't give up. If you are going to correspond with the NHS on behalf of your client, make sure that you obtain a copy of any EPA, deputy order or LPA, but do not let the absence of a power of attorney prevent you lodging an appeal. If necessary, resort to the Mental Capacity Act 2005 and the principles of best interest decision making to insist that the NHS must accept that your client has 'proper standing' to appeal and to see relevant documentation.

Explore all available options. If the NHS decides that your client does not qualify for fully funded care, and social services suggest to the relatives that the client's home needs to be sold to pay their fees, always check whether there are any other rules under which the value of the family home should be ignored by social services in the financial assessment – for instance, if the house is occupied by a partner or by other dependent relatives. Social services has discretion to ignore the value of an individual's home in assessing their ability to pay for care, but they will not exercise it unless asked to do so.

Alternatively, consider whether a deferred payment agreement with social services may be appropriate – this allows your client to delay the sale of their home and a charge (similar to a mortgage) is set against the property. When the property is sold, social services recover the cost of your client's care fees from the sale proceeds. Always check that your client is getting all of the benefits to which they are entitled as a self-funding resident. ■

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