IN THE COURT OF APPEAL (CIVIL DIVISION)

ON APPEAL FROM THE HIGH COURT OF JUSTICE

QUEEN'S BENCH DIVISION

ADMINISTRATIVE COURT

(The Honourable Mrs Justice Ellenbogen)

BETWEEN:

The QUEEN
(on the application of
PHILIP MATHIAS)

Appellant

-v-

SECRETARY OF STATE FOR HEALTH AND SOCIAL CARE
and
NHS ENGLAND

Respondents

APPELLANT'S SKELETON ARGUMENT

Essential Advance Reading (2 hrs):

i. Claimant's Grounds dated Jan.'21
ii. The NHS Continuing Healthcare Scandal: Rear Admiral Philip Mathias, Jan.'21
iii. 2nd Witness statement of Philip Mathias
iv. Witness statement of Melanie Parsons dated 27 May '21
v. Transcript of judgment of Ellenbogen J.

Introduction

1. The Appellant, Rear Admiral Philip Mathias (retired), brings to the court a matter of very considerable public importance, namely the failure of the

Respondents to ensure that lawful decisions are made with respect to funding the healthcare of many of the most vulnerable and ill members of society. In short Rear Admiral Mathias has identified, on the basis of his own experience and thorough research, systemic failings on the part of the NHS in the making of Continuing Healthcare (CHC) funding decisions which cause distress and hardship to many thousands of families across the country. As he says in his evidence, his reason for bringing these proceedings "*is to represent the many thousands of old, very ill and vulnerable people who have been, and continue to be, unlawfully denied (CHC) funding, often with devastating emotional and financial consequences*"[1].

2. Despite the care with which Rear Admiral Mathias has presented his case the High Court has refused him permission to commence judicial review proceedings on multiple grounds. To have refused permission on the grounds, inter alia, that he does not have a sufficient interest in the matter and that his case is not arguable is truly astonishing. For the reasons outlined below the Court of Appeal is invited to rectify the position by granting permission pursuant to CPR 52.8(5) and retaining the hearing of the substantive application to itself (CPR 52.8(6)).

Summary of Issues.

3. Legal background: the relevant law, including the statutory provisions and guidance is set out in the Claimant's Grounds at paras [13] – [33]. The following points are emphasised:

    a. NHS Continuing Healthcare funding is to fund the care needs of people who have a primary health need as opposed to social care needs which a social services authority could be expected to provide;

    b. In meeting an individual's needs for care and support, a social services authority may not provide healthcare services which are the

[1] 2nd witness statement of Philip Mathias dated 1 June '21 at para [2].

responsibility of the NHS and would therefore be beyond its legal limits to provide;

c. If a person living in the community (including a person living in a nursing home) has a primary health need they are as entitled to free healthcare as a person receiving in-patient care in an NHS hospital. If the eligibility criteria are met CHC is not discretionary or subject to affordability;

d. By regulation 21(5) of the 2012 Regulations[2] a 'relevant body' (which is either a Clinical Commissioning Group, CCG, or NHS England[3]) must, when carrying an assessment of eligibility for CHC, ensure that:

> *(a) a multi-disciplinary team—*
>
> *(i) undertakes an assessment of needs, or has undertaken an assessment of needs, that is an accurate reflection of that person's needs at the date of the assessment of eligibility for NHS Continuing Healthcare, and*
>
> *(ii) uses that assessment of needs to complete the Decision Support Tool for NHS Continuing Healthcare issued by the Secretary of State and dated 1st March 2018; and*
>
> *(b) the relevant body makes a decision as to whether that person has a primary health need in accordance with paragraph (7), using the completed Decision Support Tool to inform that decision.*

e. It is therefore important to recognise that an assessment by a multidisciplinary team informs the Decision Support Tool (DST) which in turn informs the CCG (or NHS England) decision whether a person is eligible for CHC funding.

---

[2] The National Health Service Commissioning Board and Clinical Commissioning Grounds (Responsibilities and Standing Rules) Regulations 2012
[3] See regulation 2 of the 2012 Regulations

f. Relevant parts of the DST are set out in the Claimant's Grounds at paras [19] – [20]. It will be seen from the table at para [19] of the Grounds (para [20] of the DST) that the eligibility assessment covers 12 domains with scores of between 'no need' ('N'), and 'priority need, ('P'). It will be seen however that only in 4 of the domains can a person be scored as having a priority need. In 5 of the domains a person can be scored no higher than severe and in 3 of the domains the maximum score is high.[4]

g. Para [31] of the DST says that a clear recommendation for CHC funding would be expected where a person is assessed as having either one priority need score or two or more incidences of severe needs.

h. The 12th domain covers 'other significant care needs' and can attract, at most, a severe level of need.

4. Rear Admiral Mathias' Research Paper: As Rear Admiral Mathias explains in his 1st witness statement, after his protracted 2-year battle with Wiltshire CCG to obtain CHC funding for his late mother (which concluded the day before she died in September 2018) he conducted extensive research into CHC decision-making nationwide. As he says at para [7] of his 1st witness statement, "*the evidence indicated that many thousands of old, very ill and vulnerable people were being unlawfully denied significant sums (often six figures) of CHC funding, with devastating emotional and financial consequences, with some being unlawfully forced to sell their homes*".

5. He then wrote to the CEO of NHS England, the Secretary of State and the Prime Minister's Chief of Staff whose responses Rear Admiral Mathias describes as "woefully inadequate".[5] Rear Admiral Mathias subsequently

[4] See table from DST replicated in Claimant's Grounds at para [19].
[5] Rear Admiral Mathias' communications with the Metropolitan Police and the Equality and Human Rights Commission proved equally fruitless.

published a paper in August 2020 entitled '*The NHS Continuing Healthcare Scandal'*. This paper was subsequently updated in January 2021 in a paper entitled "*Evidence that CHC eligibility numbers have significantly reduced since 2015 and that there are huge and unexplained variations in CCG CHC eligibility award rates across the country – the Postcode Lottery*'."

6. As the title of the latter document reveals, Rear Admiral Mathias was concerned with two particular issues:

    a. **Overall CHC eligibility numbers have significantly reduced since 2015**. Using a range of NHS open-source data, the evidence revealed that numbers of people deemed eligible for 'standard' CHC (as opposed to 'fast track' CHC which is for people with rapidly deteriorating conditions who may be entering a terminal phase) has declined since 2015 by about a quarter when numbers had been increasing. The position is, as Sir Norman Lamb (former Minister for Care) told the Public Accounts Committee in November 2017, that "*demand is rising significantly across the country, yet the number of people eligible is going down*". An NHS England report in January 2018 stated, "*an ageing population and an increasing number of people living with multiple co-morbidities means that CHC is a priority for the populations that CCGs serve*". As Rear Admiral Mathias shows, this decline in eligibility rates has taken place at a time of declining NHS bed numbers which suggests that more elderly and ill people are being cared for in the community many of whom would reasonably be expected to be eligible for CHC funding;

    b. **Huge and Unexplained Variation in CCG CHC Award Rates**. Drawing on evidence given to the Public Accounts Committee, the 2017 report of the National Audit Office and NHS data, Rear Admiral Mathias shows that there is a variation of up to 25-fold between the rates at which CCGs award CHC funding. As he says, the figures show that a person living in Luton is 14 times less likely to receive CHC funding than a person in Salford. As the NAO report found, these

variations in eligibility rates "*cannot be fully explained by local demographics*". The PAC report is unequivocal and states, *"the funding system is failing people with continuing healthcare needs and there is an unacceptable variation in the number of people assessed as eligible. NHS England is not adequately carrying out its responsibility to ensure CCGs are complying with the legal requirement to provide CHC to those who are eligible. There is a huge variation between CCGs in access to CHC funding"*.

7. It was against this background that Rear Admiral Mathias issued judicial review proceedings on 26 January '21. His claim raises two grounds.

8. **Ground 1** is concerned with the DST. There are two limbs to this ground. Firstly, decisions are routinely not informed adequately or at all by multi-disciplinary assessments and the practical effect of the use of the DST is that it is inevitably used as a 'tick-box exercise' to determine whether a person is eligible for CHC funding[6]. In this regard see the 2016 report of the CHC Alliance which says, at page 12, that "*despite explicit guidance to the contrary, there is evidence that assessors use the DST tool mechanistically, and do not apply their professional judgment*." The routine failure to carry out multidisciplinary assessments prior to the completion of the DST as required by law and the flawed use of the DST as being determinative of CHC decisions is clarified by the witness statements sought to be adduced by Rear Admiral Mathias and summarised at Annex 1 to this document.

9. Secondly, the scoring of the various domains is not a rational means of determining whether a person has a primary health need and is therefore eligible for CHC funding. In this regard the court is invited to read paras [42] – [45] of the Claimant's Grounds as well as paras [19] – [20] of the witness statement of Melanie Parsons who has over 40 years' experience of working

[6] See evidence presented to the Public Accounts Committee, eg that of Valerie Thompson ("*the Assessment was carried out by ticking boxes. …"* and that of the Continuing Healthcare Alliance (paras 22-25, "*the assessment process is a shambles. ….*".

in this field and has attended '*many hundreds*' of CHC assessments. A person can have primary health needs (as defined by regulation 21(7) of the 2012 Regulations) across any of the domains which do not fall into the descriptors which lead to score of either 'severe' or 'priority' (see table reproduced at para [19] of Claimant's Grounds). The consequence of this is that a person could have needs that fall within the 'moderate' or 'high' scoring bands which are beyond those which '*social services could be expected to provide*' (per regulation 21(7) of the 2012 regulations). Under the DST policy and practice these needs would however effectively be ignored when deciding whether a person has a primary health need and therefore eligible for CHC funding. This could arise with respect to any of the DST domains. The irrationality of the scheme is particularly marked with respect to those domains which do not permit 'priority' or 'severe' scores. This irrationality is particularly acute for people with severe dementia who may also have serious continence, skin viability, communication and psychological needs, all of which may give rise to needs beyond those which social services could be expected to provide but none of which can attract a score of severe or priority need.

10. **Ground 2** is that both Defendants are responsible for systemic flaws with the process for assessing CHC eligibility which gives rise to an unacceptable risk of unlawfulness. The two substantive outcomes which the Claimant is particularly concerned with are those set out at paragraph 6 above, namely: (a) the significant reduction in CHC eligibility numbers since 2015 when they had previously been increasing, and (b) the "Postcode Lottery". Rear Admiral Mathias argues that these arise as a result of systemic procedural unfairness. This procedural unfairness includes the matters which are the subject of Ground 1, as well as other related procedural errors – for example, that CHC assessments are often completed without the proper input of the individuals and/or their families. The Appellant relies on a range of evidence in support of this ground, namely:

    a. Reports from the National Audit Office, House of Commons Public Accounts Committee (including evidence submitted to the Committee),

the Parliamentary and Health Service Ombudsman, and the CHC Alliance.

b. The Treasury's Response to the Public Accounts Committee's Report in which it agrees with the PAC's recommendations, (i) that "*the Department (of Health and Social Care) and NHS England should report back to the Committee by April 2018 on what action they have taken to improve the quality of assessment tools and training for staff carrying out assessments; and how it plans to monitor the impact of these changes on reducing variation between CCGs*"[7] and (ii) that "*NHS England needs to establish a consistent oversight process, using the new data available, to ensure eligibility decisions are made consistently both within and across CCGs, including by setting out what criteria they will use to identify and investigate outliers, and undertaking annual sample audit*"[8].[9]

c. The witness evidence of Rosalind Hughes, Melanie Parsons, Gary Evans, Robert Staley and Margaret Reed (see Annex 1 for a summary).

The Respondents

11. As explained at para [13] of the Claimant's Grounds, the NHS Act 2006 (as amended) provides that the Secretary of State has a duty to promote a comprehensive health service and be accountable to Parliament. The 2006 Act created the NHS Commissioning Board (generally known as NHS England) which has concurrent responsibility with the Secretary of State to promote a comprehensive health service and has "*the function of arranging for the provision of services*" in accordance with that duty (s.1H of the 2006 Act). Accordingly, the 2006 Act took away from the Secretary of State responsibility for 'on the ground' decision-making and vested that responsibility on NHS England.

---

[7] 'Government Response to the Committee of Public Accounts on the Twelfth to Nineteenth report from Session 2017-19', March 2019, p.15 at para 3.1.
[8] Ibid at p.16, para 4.1
[9] Despite this no effective corrective action has been taken by the Secretary of State or NHS England to address the concerns of the PAC.

12. S.1H(3) of the 2006 Act also provides that for the purpose of discharging its duties, NHS England:

> *(a) has the function of arranging for the provision of services for the purposes of the health service in England in accordance with this Act, and*
> *(b) must exercise the functions conferred on it by this Act in relation to clinical commissioning groups so as to secure that services are provided for those purposes in accordance with this Act.* (emphasis added)

13. Additionally, s.14Z21(2) of the 2006 Act provides that if NHS England is satisfied that a CCG is failing to discharge any of its functions "*it may direct the clinical commissioning group to discharge such of those functions, and in such manner and within such period or periods, as may be specified in the direction"*.

14. In this particular context the 'National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care' provides at para [22] that "*NHS England hold CCGs accountable and therefore engages with them to ensure that they discharge their functions. In carrying out this role, NHS England should be aware of the range of responsibilities that CCGs hold in relation to NHS Continuing Healthcare ….*".

15. In light of the above it is clear that NHS England has a duty to ensure that CCGs act lawfully and has the responsibility for arranging CHC services. It is also clear that the Secretary of State has a responsibility for the DST as it is issued in his name and it is also clear that he also has a concurrent oversight duty with NHS England due to his duty to promote a comprehensive health service. Plainly both the Secretary of State and NHS England have a duty to ensure that the health services they 'promote' and 'arrange' are done so lawfully.

16. It is for these reasons that the First Respondent (the Secretary of State) was the appropriate defendant with respect to the second limb of the Claimant's first ground and with respect to his second ground. The Second Respondent

(NHS England) was the appropriate defendant with respect to the first limb of the Claimant's first ground and with respect to the second ground.

The Decisions of the High Court

17. Permission was initially refused on the papers by Moulder J. following very extensive 'Summary Grounds' from both Respondents[10]. Moulder J accepted the Respondents arguments that the Appellant lacked standing, had not brought the claim promptly and that the claim was not arguable. Accordingly, she refused to grant permission and ordered the Appellant to pay the Respondents' costs to be summarily assessed.

18. The Appellant's renewed application for permission came before Ellenbogen J on 23 June '21. In her judgment given on 25 June '21 she also refused permission. She found:
    a) The Claimant did not have a 'sufficient interest' in the matter and accordingly lacked standing;
    b) There was no objectively good reason for the delay in bringing the claim;
    c) On the merits the claim was not reasonably arguable; and
    d) Although she granted permission for the Appellant to adduce his 2nd witness statement, despite the Respondents making no objection, she refused to admit the five other witness statements sought to be admitted by the Appellant on the basis that they were "*anecdotal and highly generic*";

19. Having therefore refused permission the judge dealt with costs. Despite the Appellant submitting that the Respondents' 'Summary Grounds' could not properly be described as 'summary' or that they were not "as concise as possible" and that "substantial expense has been impermissibly incurred" the judge ordered the Appellant to pay the First Respondent £9,404 and the Second Respondent £15,000. The judge went on to refuse an application for

[10] The edict that Summary Grounds should not exceed 30 pages now found in CPR 54PDA para 6.2(4) was introduced on 31 May 2021 after the Respondents filed their summary grounds. The amended provision does however say that Summary Grounds should be "*as concise as possible*".

the stay of the enforcement of this costs order pending determination of any application to the Court of Appeal.

20. The Order giving effect to the above was sealed on 30 June ’21 and is the subject of this appeal.

Grounds of Appeal

21. The Appellant advances three Grounds of Appeal which are concerned with (1) procedural issues, (2) substantive issues, and (3) costs.

Ground 1 (procedural issues)

22. Standing: the judge was wrong to find that the Appellant did not have ‘*sufficient interest*’ in the matter and adopted too illiberal an approach to this test. The Appellant, a concerned citizen who has established an informal campaign with its own team and web-site addressing CHC funding issues, plainly has standing. The judge was wrong to place overriding weight on the (misconceived) basis that there were “*better-placed challengers*”. In so doing she in effect applied a test of whether there were individuals with a ‘greater interest’, rather than whether the Claimant has ‘sufficient interest’. In any event, she was wrong to conclude that there were “*better-placed challengers*”: no such ‘challengers’ (individuals or bodies) have come forward and in any event it is wholly unrealistic to expect individuals battling to secure CHC funding for themselves or loved ones to bring a legal challenge of this kind. Such individuals would inevitably be concerned with care issues and any dispute with their CCG and would be barred from bringing a judicial review on the basis that the designated CHC eligibility appeals process offers a “suitable alternative remedy” and such individuals have not to date brought a claim for judicial review.

23. Delay: the judge was wrong to refuse to extend time for the Appellant to bring his claim. In particular, firstly, the judge was wrong not to have concluded that the Appellant’s efforts to address the issues raised in his claim by alternative means amounted to a good reason for delay. This finding was

contrary to the principle that judicial review is a "remedy of last resort": for example, as expressed by the Court of Appeal in *R (on the application of Burkett) v Hammersmith and Fulham LBC (No.1)* [2001] Env LR 684, at paragraph 14. Second, the judge entirely overlooked the wider public importance of the case, which provided good reason to extend time and at the very least should have weighed heavily in her judgment. Third, the judge wrongly concluded that possible third-party claims against CCGs arising out of delay posed a risk to good administration. The outcome of such claims will not be determined by the outcome of the Claimant's application for judicial review.

24. Evidence: the judge was also wrong to refuse to admit the witness statements of Melanie Parsons, Rosalind Hughes, Gary Evans, Margaret Ann Reed and Robert Staley, which she wrongly described as "*anecdotal and highly generic*". All five of these statements were highly relevant to the issues in the claim (see Annex 1 for summaries). They had been served on the Respondents three weeks before the hearing and were not objected to. Given their relevance and the lack of any prejudice to the Respondents, the judge erred in refusing the Appellant's application that these statements be admitted.

Ground 2 (substantive issues)

25. Decision Support Tool (DST)

    a. The judge did not address the Appellant's contention that CHC funding decisions are routinely made without the benefit of a multidisciplinary assessment of the needs of the individual as required by regulation, guidance and the common law. Instead, she found that the Second Respondent (against whom this limb of its first ground of review was focused) was not responsible for CHC decisions made by Clinical Commissioning Groups (CCGs), who are "statutorily separate". She was wrong to do so given the oversight function of the Second Respondent in respect of CCGs. The key statutory provisions in this

regard are sections 1H and 14Z21 of the NHS Act 2006 (see paragraphs 11-13 above). For an example of the Second Respondent exercising an oversight function, see paragraphs 45-46 of its Summary Grounds of Resistance (adoption of an *"assurance process"* and *"cluster analysis"* to investigate *"potentially unwarranted variation in CHC eligibility rates"*).

b. The Appellant gave examples of the irrationality of the DST scoring over the 'domains' and provided evidence from very experienced practitioners which supported his contentions. He further provided cogent and uncontroverted evidence that the twelfth domain, which is designed to catch cases that fall outside the parameters of the scores for the other eleven domains, is not used to support CHC funding. Accordingly, the judge was wrong to have found that *"the Claimant has provided no concrete examples that the DST itself gives rise, or would give rise, to irrational outcomes*". In this regard, it was artificial for the judge to distinguish between "design" of the DST and its "use". "Design" necessarily impacts "use"; whilst issues with the DST's "use" reveal issues with its "design".

26. Unacceptable Risk of Unlawful Decisions: the judge was wrong to have found that, in light of the clear evidence of huge and unexplained variation in CHC eligibility rates across the country and a significant decline in the number of people found to be eligible for CHC funding despite an increasingly elderly population suffering from comorbidities, it was not arguable that there are systemic failings in the system such as to give rise to an unacceptable risk of unlawfulness.

27. As stated above, in relation to the Second Respondent, the judge failed to recognise the oversight function of both Respondents under the NHS Act 2006 (the relevant statutory duty on the First Respondent primarily arises by virtue of section 1 of that act). In this regard, the judge also incorrectly relied on *R (Woolcock) v Secretary of State for Communities and Local Government*

[2018] 4 W.L.R., paragraph 99: the Defendants do not merely have *"the power"* to eradicate unfairness; but are under statutory duties to do so.

28. The judge was wrong to conclude that the evidence relied on by Rear Admiral Mathias was so deficient that this ground is unarguable; particularly in circumstances where no counter evidence has been provided by either Respondent. The Courts are required to adopt a realistic approach to the availability of evidence in systemic challenges: see, for example, *R (Howard League for Penal Reform) v Lord Chancellor (Equality and Human Rights Commission intervening)* [2017] EWCA Civ 244, paragraph 53.

29. The judge also erred in concluding that the Claimant had not identified issues giving rise to systemic unlawfulness. The Claimant submitted that reasons for a decline in eligibility and the "postcode lottery" were explained via the large volume of evidence relied on in support of his claim (see paragraph 10 above).

Ground 3 (costs)

30. The judge Ordered the Appellant to pay the Respondents' costs of preparing their Acknowledgment of Service and Summary Grounds in the sum of £9,404 and £15,000. She was wrong to do so as the Respondents' 'Summary Grounds' could not sensibly be described as '*summary*' or '*as concise as possible*', and '*substantial expense*' had therefore been impermissibly incurred: see Practice Note of Carnwath LJ in *R(Ewing) v Office of Deputy Prime Minister* [2005] EWCA Civ 1583; [2006] 1 WLR 1269.

31. In making this order, the judge erred in concluding that the reference to a 30-page limit at CPR Practice Direction 54A, paragraph 6.2(4), provided an indication of what is meant by "concise" Summary Grounds of Resistance.

32. Finally, as the judge refused permission, she did not have to deal with the Appellant's application for a cost capping order. Not only did the judge err in

not granting permission, she should also have granted such a cost capping order (see below).

Conclusion

33. For the reasons set out above this is a strongly arguable case for which permission should be granted. In addition, the significant public interest in ensuring that CHC decisions affecting thousands of the most vulnerable members of society are lawfully made is a further imperative for the grant of permission. The arguability of this case is of course highly relevant to the procedural issues that arise in the case and provides support for the contention that the judge below was wrong to make the procedural orders she made.

34. As the Appellant invites the Court to retain the hearing of the substantive judicial review to itself it is necessary to address the costs of such a hearing. The Appellant makes clear in his 1st witness statement at para [12] that he has nothing personally to gain from mounting this legal challenge and "*it is clearly in the public interest for this legal challenge to proceed but without (this) costs capping order, I would be forced to withdraw*". Although he has raised slightly over £100k in Crowdfunding he has no money remaining and indeed, as things stand would have to meet the costs order made by Ellenbogen J from his own pocket.

35. The Court will see from paras [61] – [74] of the Claimant's Grounds that the conditions for a cost capping order (CCO) found in s.88 of the Criminal Justice and Courts Act 2015 are met in this case. On reflection the Appellant is however content for the terms of a CCO to provide for there to be no costs liability on either party.

36. Accordingly, the Appellant asks the Court to make an order in the following terms:

i. Permission to apply for judicial review be granted;
ii. The Appellant has permission to rely on the witness statements of Melanie Parsons (dated 27 May '21), Rosalind Hughes (dated 26 May '21), Gary

Evans (dated 1 June ’21), Margaret Ann Reed (1 June ’21) and Robert Staley (1 June ’21);

iii. The hearing of the Appellant’s application for judicial review be reserved to the Court of Appeal, the matter to be listed in the Michaelmas 2021 term; and

iv. There be a cost capping order pursuant to s.88 of the Criminal Justice and Courts Act 2015 which provides for a nil liability for costs arising form these proceedings for all parties.

IAN WISE QC

WILL PERRY

Monckton Chambers

5 July 2021

ANNEX 1 – SUMMARY OF EVIDENCE FILED ON 1 JUNE 2021

Witness	Relevant experience	Summary of evidence
Melanie Parsons	Registered learning disability nurse with more than 40 years' experience of working in health and social care. First learnt about CHC funding issues around 1996 when employed by local authority social care services. Later worked as a CHC assessor for a Primary Care Trust. Set up a consultancy which offers advice on CHC issues 4 years ago. Also manages a Facebook page which acts as a resource for families seeking CHC advice, which has over 4,000 subscribers. Has seen *"countless"* decisions and attended *"many hundreds"* of assessments. (§§1-6)	- Flaws with the assessment process – e.g. assessors are untrained, failure to carry out an MDA, or insufficient evidence (§§4, 8, 10, 15-16, 18, 21). - Predetermination of assessment outcome (§§8-9, 12, 14, 22-23). - DST used mechanistically and/or determinatively (§§8-9). - DST structure/domains insufficient to capture patient needs – e.g. has never seen a number of 'high' and 'moderate' scores result in eligibility decision. Agrees with C's analysis of the domains at §§34-36 of his SFG. (§§11, 17-20, 22). - Discretion to depart from DST indicative scores only ever used where indicative scores suggests eligibility (§9). - CHC eligibility based on a *"postcode lottery"* (§13). - CHC funding has become more difficult to obtain than previously (§24). - Considers C is best placed to bring the claim (standing) (§§25-26).
Rosalind Hughes	Solicitor who advises clients from across the country on CHC issues. Started to specialise in CHC cases in 2015 and has run her own firm, which exclusively focuses on CHC funding, since 2016. Has experience of around 450 cases in the past 6 years. (§§1-3)	- Flaws with the assessment process – e.g. lack of input from family members, or DST completed solely on basis of existing care records (§§6-8, 9, 13 - Predetermination of assessment outcome – e.g. DST used to downplay care needs (§§5, 10). - DST used mechanistically and/or determinatively (§§4-6, 9, 14). - DST structure/domains insufficient to capture patient

		needs – e.g. for individuals with advanced dementia (§10-13). - Discretion to depart from DST indicative scores only ever used where indicative scores suggests eligibility (§6).
Gary Evans	Qualified nurse, with experience of CHC assessments from NHS employment. Now works as an independent CHC funding consultant. Has experience of around 30 decisions. (§§1-4, 9)	- Flaws with the assessment process – e.g. assessors are untrained, or lack of input from relevant specialists (§§5-6, 8-9). - Predetermination of assessment outcome (in particular by CCG assessors) (§§5, 10). - DST used mechanistically and/or determinatively (§§5, 7, 11). - DST structure/domains insufficient to capture patient needs (§§5, 7, 11).
Margaret Anne Reed	Worked as a nurse in the NHS for 17 years. Became aware of CHC eligibility and funding issues from long-running attempts to obtain CHC for her mother. Set up Paladin Advocates in 2008, a specialist service offering advice and assistance with CHC eligibility issues. Has acted for clients across the country for the past 13 years. (§§1-3)	- Flaws with the assessment process – e.g. lack of input from family members, or assessors insufficiently trained (§§5-6). - Predetermination of assessment outcome – e.g. use of leading questions by assessors to elicit desired response, or selective approach to evidence (§§3-4, 6-7). - DST used mechanistically and/or determinatively (§7). - Discretion to depart from DST indicative scores only ever used where indicative scores suggests eligibility (§7).
Robert Staley	Has provided advice and assistance regarding CHC since 2007 and has co-authored 4 guidebooks on long-term care costs. Has advised between 500 and 600 families about CHC eligibility in the past 4 years. (§§1-2)	- Flaws with the assessment process – e.g. failure to obtain sufficient evidence, lack of input from relevant specialists, or failure to adjourn proceedings where required (§§2-3). - Predetermination of assessment outcome (§§4-5). - DST used mechanistically and/or determinatively (§§4-5). - Discretion to depart from DST indicative scores only ever used

		where indicative scores suggests eligibility (§5).