Neutral Citation Number: [2019] EWHC 3411 (Admin)

Case No: CO/3916/2018

IN THE HIGH COURT OF JUSTICE
QUEEN'S BENCH DIVISION
ADMINISTRATIVE COURT

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 17/12/2019

Before :

UPPER TRIBUNAL JUDGE ALLEN
(sitting as a Judge of the High Court)

- -

Between :

R (on the application of David GOSSIP)	**Claimant**
- and -	
NHS SURREY DOWNS CLINICAL COMMISSIONING GROUP	**Defendant**

- -
- -

David Lock QC and **Julia Smyth** (instructed by **Haven Solicitors**) for the **Claimant**
Vikram Sachdeva QC and **Jack Anderson** (instructed by **Hill Dickinson Solicitors**) for the **Defendant**

Hearing dates: 30 August 2019 & 20 September 2019

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Approved Judgment

Upper Tribunal Judge Allen :

Introduction

1. The claimant with permission granted by Rowena Collins-Rice sitting as a Deputy High Court Judge applies for judicial review of the defendant's decision of 29 March 2017 that he is not eligible for NHS continuing healthcare.

2. This is a factually complex case. I will endeavour to set out the key facts by way of outline but, as will be seen, there are disagreements as to the detail in a number of respects.

3. The claimant suffered a severe spinal injury while playing rugby in February 1984. He suffers from tetraplegia with no active motor or sensory function in the trunk or lower limbs and with very limited function in his upper limbs. He has a neurogenic bowel and bladder which means he does not have active control over these functions due to his disablement. He is also prone to autonomic dysreflexia, which is an unpredictable and potentially life-threatening condition whereby there is a sudden rapid and uncontrolled increase in blood pressure. Autonomic dysreflexia can cause severe, sudden hypertension and if left untreated can lead to a stroke, epileptic fit or even death. The claimant also suffers from postural hypotension, severe spasticity and severely impaired respiratory function. He has described in some detail in his witness statement the nature and extent of his disablement. He does not suffer from any significant pain. He cannot stand or walk a step so he uses an electric wheelchair to move.

4. Quite remarkably, despite his very significant disabilities, the claimant qualified as a solicitor and has worked for the Crown Prosecution Service for nearly 30 years. He works on a day-to-day basis from home. He is employed to provide legal advice on behalf of the CPS to police forces about criminal justice issues which arise where suspects are first apprehended. He works a complex shift pattern and is required to have care support which is extremely flexible.

5. Since about 2013 he has employed a carer, Linda Hayward, who clearly provides him with a remarkable level of support. The cost of employing Ms Hayward for 42 hours a week is partly met by the Surrey County Council (the Council) and partly by the defendant (to which I shall refer hereafter as "the Clinical Commissioning Group" or "CCG"). The CCG pays for ten hours per week of Ms Hayward's time. It has funded the claimant in this way and to this level since it came into existence in 2013 and before then the ten hours was funded by the primary care trust. The claimant is not presently responsible for funding his own care, but he is concerned that when he retires he will have to contribute towards the cost of his care services from his income as social services may no longer be willing to fund the level of care.

6. In light of his concerns the claimant sought advice from the Spinal Injuries Association who advised that he should be wholly funded by the NHS under a scheme called NHS Continuing Healthcare (CHC). As explained in the claimant's skeleton, CHC is concerned with the boundary between (a) health and social care services that are wholly funded by the NHS; and (b) health and social care services which are either wholly or in part funded by a social services authority under the Care Act 2014 or by the individual himself. NHS services are services which are not means tested

and attract no charges for the patient. The commissioning body for such services is the CCG under the National Health Service Act 2006, in contrast to a local authority providing services under the Care Act 2014. In effect, where a patient is eligible for CHC, the CCG takes on responsibility for funding all "care" services, namely the complete health and social care package of services for a patient. CHC services are therefore provided to the patient as NHS services and are free of charge. As it is put in the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (November 2012 (Revised)) further considered below:

> 'Where a person has been assessed to have a "primary health need" they are eligible for NHS continuing healthcare. Deciding whether this is the case involves looking at the totality of the relevant needs. Where an individual has a primary health need and is therefore eligible for NHS continuing healthcare, the NHS is responsible for providing all of that individual's health and social care needs – including accommodation, if that is part of the overall need' (paragraph 33)

Local authorities are prevented by law from employing nurses to deliver social care services (section 22 of the Care Act 2014).

7. The CCG, having decided to undertake an assessment of the claimant's eligibility for CHC funding, completed a checklist, in accordance with Regulation 21(4) of The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 ("the 2012 Regulations") (set out in detail below) and in December 2014 the CCG appointed a multi-disciplinary team ("MDT") to conduct an assessment and complete the decision support tool ("DST") in accordance with Regulation 21(5)(b), and the DST was sent off to the CCG. The conclusion of the MDT was that there was evidence of a primary health need which it was recommended required CHC input to ensure that the claimant had a skilled individual to care for his specific needs and detect and act on potential complications. Subsequently (and it will be necessary to go into some detail into the circumstances surrounding this) it was said that there was evidence of a primary health need which the MDT felt met CHC eligibility as the complexity and intensity of the claimant's needs were of a nature that required a skilled carer to meet them.

8. Subsequently, a CCG panel meeting was held in October 2015 as a consequence of which it was decided there was required to be a new MDT DST and there was subsequently a panel meeting in March 2017. That panel reached the decision which is the one under challenge.

9. The claimant exercised his right to appeal to an NHS England Panel, but his appeal was dismissed in a decision set out in a letter dated 6 July 2018.

The Law

10. The relevant legal provisions are as follows:

"The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012

PART 6

Standing rules: NHS Continuing Healthcare and NHS funded nursing care

Duty of relevant bodies: assessment and provision of NHS Continuing Healthcare

21.—(1) In exercising its functions under or by virtue of sections 3, 3A or 3B of the 2006 Act, insofar as they relate to NHS Continuing Healthcare, a relevant body must comply with paragraphs (2) to (11).

(2) A relevant body must take reasonable steps to ensure that an assessment of eligibility for NHS Continuing Healthcare is carried out in respect of a person for which that body has responsibility in all cases where it appears to that body that—

(a) there may be a need for such care; or

(b) an individual who is receiving NHS Continuing Healthcare may no longer be eligible for such care.

(3) If an assessment for NHS Continuing Healthcare is required under paragraph (2)(a), the relevant body must ensure that it is carried out before any assessment pursuant to regulation 28(1) (persons who enter relevant premises or who develop a need for nursing care) is carried out.

(4) If a relevant body wishes to use an initial screening process to decide whether to undertake an assessment of a person's eligibility for NHS Continuing Healthcare it must—

(a) complete and use the NHS Continuing Healthcare Checklist issued by the Secretary of State and dated 28th November 2012 to inform that decision;

(b) inform that person (or someone lawfully acting on that person's behalf) in writing of the decision as to whether to carry out an assessment of that person's eligibility for NHS Continuing Healthcare; and

(c) make a record of that decision.

(5) When carrying out an assessment of eligibility for NHS Continuing Healthcare, a relevant body must 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 28th November 2012; 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.

(6) If a relevant body decides that a person has a primary health need in accordance with paragraph (5)(b), it must also decide that that person is eligible for NHS Continuing Healthcare.

(7) In deciding whether a person has a primary health need in accordance with paragraph (5)(b), a relevant body must consider whether the nursing or other health services required by that person are—

(a) where that person is, or is to be, accommodated in relevant premises, more than incidental or ancillary to the provision of accommodation which a social services authority is, or would be but for a person's means, under a duty to provide; or

(b) of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide,

and, if it decides that the nursing or other health services required do, when considered in their totality, fall within sub-paragraph (a) or (b), it must decide that that person has a primary health need.

(8) Paragraphs (2) to (6) do not apply where an appropriate clinician decides that—

(a) an individual has a primary health need arising from a rapidly deteriorating condition; and

(b) the condition may be entering a terminal phase,

and that clinician has completed a Fast Track Pathway Tool stating reasons for the decision.

(9) A relevant body must, upon receipt of a Fast Track Pathway tool completed in accordance with paragraph (8), decide that a person is eligible for NHS Continuing Healthcare.

(10) Where an assessment of eligibility for NHS Continuing Healthcare has been carried out, or a relevant body has received a Fast Track Pathway Tool completed in accordance with paragraph (8), the relevant body must—

> (a) notify the person assessed (or someone lawfully acting on that person's behalf), in writing, of the decision made about their eligibility for NHS Continuing Healthcare, the reasons for that decision and, where applicable, the matters referred to in paragraph (11); and
>
> (b) make a record of that decision.

(11) Where a relevant body has decided that a person is not eligible for NHS Continuing Healthcare, it must inform the person (or someone acting on that person's behalf) of the circumstances and manner in which that person may apply for a review of the decision if they are dissatisfied with—

> (a) the procedure followed by the relevant body in reaching that decision; or
>
> (b) the primary health need decision made in accordance with paragraph (5)(b).

(12) In carrying out its duties under this regulation, a relevant body must have regard to the National Framework.

(13) In this regulation-

'appropriate clinician' means a person who is—

> (a) responsible for the diagnosis, treatment or care of the person under the 2006 Act in respect of whom a Fast Track Pathway Tool is being completed, and
>
> (b) a registered nurse or a registered medical practitioner;

'healthcare profession' means a profession which is concerned (wholly or partly) with the physical or mental health of individuals (whether or not that person is regulated by, or by virtue of, any enactment);

'multi-disciplinary team' means a team consisting of at least—

(a) two professionals who are from different healthcare professions, or

(b) one professional who is from a healthcare profession and one person who is responsible for assessing persons for community care services under section 47 of the National Health Service and Community Care Act 1990.

Duty of relevant bodies: joint working with social services authorities

22.—(1) A relevant body must, insofar as is reasonably practicable—

(a) consult with the relevant social services authority before making a decision about a person's eligibility for NHS Continuing Healthcare, including any decision that a person receiving NHS Continuing Healthcare is no longer eligible to do so; and

(b) co-operate with the relevant social services authority in arranging for persons to participate in a multi-disciplinary team for the purpose of fulfilling its duty under regulation 21(5).

…"

11. It can be seen therefore that the defendant is subject to a number of obligations under Regulation 21.

12. It is clear that the CCG is a "relevant body" for the purposes of the 2012 Regulations. Under Regulation 21(1) the defendant as a relevant body is required to comply with paragraph (2) to (11). Thus the defendant has a duty to carry out an assessment of eligibility for NHS continuing healthcare where, as in this case, the defendant is aware that he may be eligible for CHC. Thereafter the relevant body must ensure that a multi-disciplinary team undertakes an assessment of needs that is an accurate reflection of the person's needs at the date of the assessment of eligibility for NHS continuing care, and must use that assessment of needs to complete the decision support tool for NHS continuing healthcare. The decision as to whether or not a person has a primary health need in accordance with paragraph (7) is to be done by using the completed DST to inform that decision. If it is decided that the person has a primary health need in accordance with paragraph 5(b) it must also be decided that the person is eligible for NHS continuing healthcare.

13. Paragraph (7) requires, in a case such as the instant one, that in deciding whether the person has a primary health need in accordance with paragraph 5(b) the relevant body must consider whether the nursing or other health services required by that person are of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide, and if it decides that the

nursing or other health services required do when considered in their totality fall within sub-paragraph (b), it must decide that the person has a primary health need.

14. Sub-paragraph (11) requires the relevant body where it is decided that a person is not eligible for NHS continuing healthcare to inform the person or someone acting on that person's behalf of the circumstances and manner in which that person may apply for a review of the decision if they are dissatisfied with either the procedure followed or the primary health need decision.

15. It is also relevant to note paragraph (12) which requires a relevant body in carrying out its duties under the Regulation to have regard to the National Framework.

16. There is also the point made at paragraph 27(v) of the defendant's skeleton that the Regulations are silent on the question of what procedure should be adopted in the event that the decision maker considers that the multi-disciplinary assessment and/or DST is inadequate and/or that there is other relevant information that should be considered before making a decision.

17. It is also relevant to note the point in the defendant's skeleton, picking up from what is said at paragraph 16.112 in *Lock and Gibbs*: "NHS Law and Practice", that the panel is required to take the DST into account in reaching a decision but is not bound to adopt the same conclusions as the MDT which compiled the DST. The defendant's skeleton also goes on to adopt the view in *Lock and Gibbs* that the National Framework and the Practice Guidance should not be read to suggest that the panel should only depart from the conclusions of the MDT in exceptional circumstances. The point is made that if it had been wished in the Regulations for decision making panels to be bound by the conclusions of the MDT as expressed in the DST in all but exceptional circumstances it could have said so, but it did not.

18. Regulation 23 makes provision for a person to seek a review by an independent review panel if dissatisfied with the decision as to whether they are eligible for CHC funding. Regulation 23 provides that where a person is dissatisfied with the procedure followed or the primary health need decision, then it may apply in writing to the Board for a review of that decision and following an application for a review the Board may refer the matter for a decision to a panel of members ("a review panel") and a relevant body must, unless it determines in accordance with paragraph (9) that there are exceptional reasons not to do so, implement the decision of the review panel as soon as reasonably practicable. In determining whether under paragraph (8) there are exceptional reasons, a relevant body must have regard to the National Framework ((9)).

19. The meaning of "when considered in their totality" under Regulation 21(7)(b) is addressed in the National Framework as in effect meaning whether the person has needs beyond those that a local authority could be expected to meet under social care.

20. The National Framework also provides that the time that should elapse between the checklist being received by the CCG and the funding decision should in most cases not exceed 28 days.

21. The National Framework guidance for NHS continuing healthcare and NHS funded nursing care and practical guidance for decision makers has been issued by the

Department of Health. Among other things this addresses the balance between local authority and NHS responsibilities with respect to continuing care, and there is a consideration of the decision of the Court of Appeal in *R v North and East Devon Health Authority ex parte Coughlan* [2001] QB 213, which establishes that if the nursing services are merely incidental or ancillary to the provision of the accommodation that a local authority is under a duty to provide, pursuant to section 21 of the National Assistance Act 1949, and of a nature that an authority whose primary responsibility is to provide social services can be expected to provide, then such7 nursing services can be provided under section 21 of the National Assistance Act 1948. It is also said, at paragraph 33, that the concept of a "primary health need" was developed by the Secretary of State in order to assist in deciding which treatment and other health services it is appropriate for the NHS to provide under the 2006 Act and to distinguish between those and the services that local authorities may provide under section 21 of the National Assistance Act 1948. Where a person has been assessed to have a "primary health need" they are eligible for NHS continuing healthcare. Deciding whether this is the case involves looking at the totality of the relevant needs. A decision of ineligibility for NHS continuing healthcare is only possible, under paragraph 34, where, taken as a whole, the nursing or other health services required by the individual:

i) are no more than incidental or ancillary to the provision of accommodation which local authority social services are, or would be but for a person's means, under a duty to provide; and

ii) are not of a nature beyond which a local authority whose primary responsibility it is to provide social services could be expected to provide.

22. It is clear from paragraph 60 that establishing that an individual's primary need is a health need requires a clear, reasoned decision based on evidence of needs from a comprehensive assessment.

23. It is also clear, from paragraph 3.6 of the Practice Guidance to the National Framework, that primary health need is not about the reason why someone requires care or support, nor is it based on their diagnosis; it is about their overall actual day-to-day care needs taken in their totality. It is, it is said, the level and type of needs themselves that have to be considered when determining eligibility for NHS continuing healthcare.

24. It is also relevant to note paragraph 28.1 of the Practice Guidance which, among other things, states that an assessment that simply gathers information will not provide the rationale for any consequent decision; an assessment which simply provides a judgement without the necessary information will not provide the evidence for any consequent decision. It is said that as a minimum a good quality multi-disciplinary assessment of an individual's health and social care needs will, inter alia, be person-centred, making sure that the individual and their representatives are fully involved, that their views and aspirations are reflected and that their abilities as well as their difficulties are considered: and also informed by information from those directly caring for the individual and holistic, looking at the range of their needs from different professional and personal viewpoints and considering how different needs interact, and evidence-based – providing objective evidence for any subjective

judgments made. Relevant sources of information include nursing assessment, care home/home support records and physiotherapy, under paragraph PG29.

25. It is clear from PG 33.1(g) that the recommendation when presented to the CCG should be accepted, except in exceptional circumstances, and these circumstances could for example include insufficient evidence to make a recommendation or incomplete domains. Under paragraph (h) it is said that if the CCG, exceptionally, does not accept the MDT recommendation (for example under PG 41 where the DST is not completed fully, or where there are significant gaps in evidence to support the recommendation, where there is an obvious mismatch between evidence provided and the recommendation or where the recommendation would result in either authority acting unlawfully), it should refer the DST back to the MDT identifying the issues to be addressed. Once this has been completed the DST should be re-presented to the CCG who should accept the recommendation (except in exceptional circumstances).

26. Of further relevance is paragraph 92 which makes it clear that the CCG may ask a multi-disciplinary team to carry out further work on a decision support tool if it is not completed fully or if there is a significant lack of consistency between the evidence recorded in the DST and the recommendation made. However, the CCG should not refer a case back, or decide not to accept a recommendation, simply because the MDT has made a recommendation that differs from the one that those who were involved in making the final decision would have made, based on the same evidence.

27. It is clear from the Regulations that health authorities have to have regard to the National Framework rather than being required to comply with it. This was clarified further in *R (Whapples) v Birmingham Crosscity Clinical Commissioning Group* [2015] EWCA Civ 435 where, inter alia, it was said: "It is common ground that the National Framework does not amount to a direction" (paragraph 24) and:

> "In discharging its functions the CCG was obliged to take the National Framework into account. The CCG is susceptible to challenge on *Wednesbury* principles for failing to consider the National Framework, or misconstruing or misapplying it: see *R v North Derbyshire Health Authority ex parte Fisher* (1997) 38 BMLR 76".

28. The CCG's website states, inter alia: "We follow national guidance and criteria in assessing your care needs and eligibility". There is also reference in paragraph 6.2 of the CCG's operational policy in which it is said that the National Framework for NHS continuing healthcare and NHS funded nursing care (revised, 2012) provides a consistent approach to establishing eligibility for NHS continuing healthcare. This is achieved through the use of the revised National Tools and Guidance developed to assist in making decisions about eligibility for continuing healthcare.

Factual Background

29. By way of preliminary, I need to say a little more about the factual background and the disputes in relation to that. The MDT set up in this case in 2015 consisted of Ms Kate Flynn, a nurse, and Ms Nicole Blackman, a social worker. The claimant attended for an MDT assessment with Ms Flynn and Ms Blackman on 22 April 2015 and a DST was drafted. This recommended that the claimant should be found to be

eligible for CHC funding. It is asserted on behalf of the defendant that the draft DST was not sent to the CCG at that stage and indeed that the first time it saw it was on 12 July 2019. It is asserted on behalf of the claimant that the CCG conducted an "audit and review" process which resulted in persuading Ms Flynn to make changes to the original evaluation and in turn that Ms Flynn sought to persuade Ms Blackman to make changes to the DST. This arises as a consequence of an e-mail sent by Ms Flynn to Catherine Crocker of CHC Direct, received in June 2015, in which she said that following an audit and review she had felt the need to change some of the scores, having reduced scores within the domains of psychological, communication and mobility but increased the scoring within the domains of nutrition and medication. Subsequently, following further communication between Ms Flynn and Ms Blackman on 7 September 2015 a completed DST was provided to the CCG for consideration by its panel. The DST made it clear that the assessment of levels of need had been amended and noted the difference between Ms Flynn and Ms Blackman.

30. It is denied on behalf of the defendant that an audit and review process was carried out by the CCG which persuaded Ms Flynn to make changes. In fact it is said that Ms Flynn had decided of her own volition that some of the ratings should be revised, because she considered that the evidence to support the previous ratings was "rather sparse". Ms Flynn's witness statement of 29 July 2019 elaborates on this. Although Ms Blackman did not agree with all the suggested amendments, the DST was approved in September for submission by both members of the MDT.

31. I accept what is said on behalf of the defendant in this regard. Ms Flynn has asserted that it was her change of mind that led to the amendments that she suggested, and I see no reason to disbelieve that.

32. In the grounds of challenge it is contended that the completed DST was referred by the CCG to an "assessor" appointed by the CCG and that the assessor took the decision to reduce the MDT's assessment of the severity of the claimant's needs in three of the domains, namely psychological and emotional needs, communication and mobility. By way of clarification, as a consequence of a misconception that arose in the detailed grounds, it is asserted on behalf of the defendant that in fact the only comment on the DST from the CCG's assessor was a statement in section 3, "Unable to agree with the above outcome due to lack of evidence". In other words, the comments under the three sections were not provided by the assessor. Those amendments had been made by Ms Flynn. Again, I accept what is said about the amendments in this regard. It is in my view sufficiently clear that the amendments were made by Ms Flynn rather than by the assessor.

33. Thereafter a CCG panel met on 14 October 2015. There is, surprisingly, little evidence of what precisely happened. Handwritten notes were added to section 3 of the DST as follows: "Unable to agree with above outcome due to lack of evidence. File to go to panel". There is a note on the system, as follows:

> "Panel unable to verify due to no supporting evidence for the DST scores. Evidence to be gathered prior to a new MDT DST being completed. SCC to request that the PA provides 4 weeks of diaries of day to day management of Mr Gossip's needs. Booker – please arrange MDT DST assessment when the diaries are complete."

34. The claimant was not informed of the October 2015 meeting until January 2016, when he was told he would need to provide evidence of his care needs by way of a diary. In March 2016 he provided notes of his care needs, and also a copy of his daily care plan. He was unable to attend a further MDT meeting on 4 May 2016, and stated that he was not willing to start a new assessment until the last one was completed. He put in a formal complaint about the CCG's failure to reach a decision on 13 July 2016. In a letter of 2 September 2016 the claimant was told that the defendant did not have enough information to make a decision on his case, and without the carer's notes that remained the case. He was offered the choice of supplying carer's notes or having a new DST. Four weeks of carer's notes were provided in October 2016.

35. In February 2017 the claimant was informed by e-mail that his case was going to panel "that week". There was correspondence between the claimant and Dino Adams, who had been asked by Clare Davies of the defendant to explain to the claimant why the original DST conclusions had not been upheld. Ms Adams considered the records and provided the information for Ms Davies to make a response (Ms Adams' statement of 3 July 2019). She states clearly that she was not taking a decision on behalf of the CCG's Eligibility Panel, and did not recall sending her rationale to anyone other than Clare Davies.

36. An eligibility panel, consisting of Alma Trozado, Locality Lead Nurse, Becky Munuwa, Interim Locality Lead Nurse, and Dr Stevens, of the defendant made the decision under challenge on 29 March 2017. The claimant appealed that decision via the internal process, on 27 April 2017 and, following the dismissal of that appeal on 6 October 2017 he appealed to the Independent Review Panel, which upheld the defendant's decision that he was not eligible for CHC, in a decision dated 6 July 2018.

Discussion

37. I will address first of all the argument raised by Mr Sachdeva QC and responded to by Mr Lock QC that the challenge is fundamentally misconceived, in that it addresses the wrong target. It is argued that the decision that should have been challenged is that of the IRP which upheld the decision of the eligibility panel. It is noted that none of the grounds are directed at the IRP decision which, as is pointed out at paragraph 45 of the defendant's skeleton, expressly considered further evidence not considered by the MDT or the eligibility panel, carers' notes and other evidence filed on behalf of the claimant. It is argued that where there has been an appeal and a review by an independent panel, earlier procedural or substantive errors are fully capable of being cured by that subsequent appeal. Reference is made to paragraph 5.51 to 55 and 5.59 in *Auburn, Moffett and Sharland*: "Judicial Review: Principles and Procedure". As is said at paragraph 5.51, the correct analysis is that, because of the appeal or review process, the procedure as a whole is fair and therefore there is no unfairness requiring a cure. It is said at paragraph 5.52 that where there has been a fair appeal before an appellate decision-maker which considered the case afresh, heard all relevant evidence and redetermined the merits of the case, it is difficult to see how the ultimate decision could be impugned on the basis of any unfairness arising during the decision-making process leading up to the initial decision, unless that unfairness infected the ultimate decision in some real sense.

38. In *Calvin v Carr* [1980] AC 574 it was held that, following an initial decision by racing stewards who adopted an unfair procedure, followed by an appeal to a committee, where the appeal was conducted by way of rehearing de novo and involved hearing all the witnesses who had given evidence to the stewards, and cross-examination of those witnesses, the overall decision-making process was fair, despite flaws in the procedure adopted by the stewards.

39. It is said at paragraph 5.54 that where the appeal does not involve a full rehearing, such as an appeal restricted to consideration of whether there has been an error of procedure or law, or where the appellate decision-maker is bound by findings of fact made by the initial decision-maker, it is more likely that unfairness arising in the decision-making process leading up to the initial decision will render the overall procedure unfair. In paragraph 5.59 it is said that where an appeal against, or review of, a decision is available, the courts will usually regard it as an adequate alternative remedy justifying the refusal of permission to apply for judicial review. Paragraph 26.90 in Auburn, Moffett and Sharland includes the reminder that because judicial review is a remedy of last resort, where an adequate alternative remedy is available the court will usually refuse permission to apply for judicial review, unless there are exceptional circumstances justifying the claim proceeding. The availability of an adequate alternative remedy is a matter that is relevant to the exercise of the court's discretion to grant permission to apply for judicial review; it does not go to the jurisdiction to entertain a claim for judicial review.

40. On behalf of the claimant it is argued that this was not a curative appeal because the CCG was not obliged to implement the IRP's decision, but this point is met by the argument that the Regulations provide that the CCG must implement the decision of the review panel as soon as possible, unless there are exceptional circumstances. No such exceptional circumstances have been identified.

41. I consider that the defendant's argument is to be preferred. The hearing before the IRP was a full hearing, including a careful and thorough evaluation of the evidence and submissions and concluding that the decision was sound. The IRP noted that its process can only be used where a person is dissatisfied with the procedure followed in reaching a decision as to their eligibility for NHS Continuing Healthcare or with the primary health need decision. This covers the issues of challenge in these proceedings. Insofar as it is argued that the same errors infect the decision of the IRP as that of the CCG, that in no sense deflects the argument that the former was the proper target. Accordingly, and bearing in mind that judicial review is discretionary only, I refuse relief on the basis that any challenge should have been to the decision of the IRP, not the defendant. In this context it is also relevant to observe that, since the claimant has had the full opportunity of a challenge to the defendant's decision in the review carried out by the IRP, discretion to grant judicial review is also properly withheld on that basis.

42. It is appropriate to address here also the alternative argument made on behalf of the defendant that since it is a fundamental principle of judicial review that a claimant must exhaust alternative remedies before claiming judicial review, there could have been a complaint in this case to the Parliamentary and Health Services Ombudsman which amounted to an appropriate alternative remedy. Reference is made inter alia to what was said in *R (Cowl) v Plymouth City Council* [2001] EWCA Civ 1935 at paragraph 14 where Lord Woolf stated:

> "The courts should not permit, except for good reason, proceedings for judicial review to proceed if a significant part of the issues between the parties could be resolved outside the litigation process."

43. Of relevance in such a case are such matters, as identified by Glidewell LJ in *ex parte Waldron* [1985] 3 WLR 1090 at 1108 as:

> "whether the alternative statutory remedy will resolve the question at issue fully and directly; whether the statutory procedure would be quicker, or slower, and procedure by way of judicial review; whether the matter depends on some particular or technical knowledge which is more readily available to the alternative appellate body".

44. On this basis, it is argued, there is no reason why the claimant should not have pursued a complaint to the ombudsman. Though the ombudsman looks to the question of maladministration rather than illegality per se, there is, it is argued, no reason why he/she could not have considered the substance of the allegations made by the claimant and there was no reason to consider that it would be a slower process. It is however clear, as argued on behalf of the claimant, that the ombudsman must not conduct an investigation where there is a remedy in a court of law. Maladministration is not the same as a public law claim, and this, I accept, is not a case of maladministration. Hence I agree that the failure to take the claim to the ombudsman cannot have any adverse implications for this application for judicial review. However, as set out above, relief is refused on the basis that the wrong target was addressed.

Grounds

45. It is clearly appropriate that in any event I go on to consider the grounds of challenge. Ground 1 contends that the appointment of the assessor was unlawful, on the basis that there is nothing in the National Framework or the 2012 Regulations permitting an "assessor" to be appointed by the CCG to review the outcome of the MDT process and/or to reduce the assessment of need in each of the care domains produced by the MDT. It is contended that this intervention was unlawful because it was a process that was entirely outside the established policy arrangements set up by the CCG and the document provided to the panel was the DST as amended by the assessor and not in accordance with Regulation 21 of the 2012 Regulations.

46. As noted above, the position of the defendant is that Ms Flynn, the nurse assessor employed by CHC Direct (the defendant's agent) as part of the MDT, had decided of her own volition that some of the ratings should be revised because she considered that the evidence to support them was "rather sparse". It is contended that the CCG's "assessor" was asked to provide a view on the MDT's conclusions owing to problems being experienced with CHC Direct assessments. There was no question of the assessor being given the authority to vary the MDT's conclusions. The assessor did not consider that the recommendation could be supported but the matter was sent to the panel for consideration.

47. The evidence of Dr Alice Stevens, who is a Head of Operations for NHS Continuing Healthcare at Surrey Downs Clinical Commissioning Group (CCG) and at the relevant time up to the summer of 2017 was the Clinical Manager in NHS continuing care at the CCG, is that the role of the assessor was not to review DSTs in order to reduce the CCG's exposure.

48. I accept that that was the case. There is no reason in my view to conclude that the motives of the CCG were other than proper ones in the process that was adopted in relation to the DST which was approved in September 2015.

49. Nor do I consider that there was anything improper in the process of appointing an experienced nurse or other appropriate professional to review the DST before it was provided to the panel. The defendant had, as has been argued, identified concerns with the robustness of the assessments undertaken by CHC Direct and there was therefore good reason to provide as far as possible for an appropriate quality assurance and review process. The assessor did not take on any role as a member of the MDT. Also it was not inappropriate for Ms Flynn to have further thoughts and express those and for those views, together with the disagreement of Ms Blackman, to be put to the panel.

50. In any event, the MDT did not change the recommendation that the claimant should be found to be eligible for CHC funding. Changes were made to various domains, but the actual decision in favour of CHC funding eligibility was not changed.

51. The fact that there is no provision for an assessor in the Regulations and the National Framework or the defendant's policy or elsewhere gives rise in my view to no unlawfulness. The absence of provision for such an element does not preclude its lawfulness. It was properly open to the respondent to have a review by a person such as the assessor in this case. The assessor, as noted above, did not have the authority to vary the MDT's conclusions, and the assessor element was simply part of a process of ensuring compliance and adherence to proper standards.

52. In ground 2 it is contended that the CCG acted unlawfully in failing to provide the DST assessments as completed by the MDT to the CCG panel. The detailed submission in this regard contends that it was unlawful not to provide the "original" DST as completed by the MDT but the document subsequently amended in lowering relevant scores.

53. On behalf of the defendant it is argued that the version of the DST which was needed to inform the panel's decision was the approved DST and not the original DST which had never been approved by the MDT for transmission to the CCG. As a consequence, it is argued, the approved DST was provided to the panel with the additional commentary from the assessor who wrote: "Unable to agree with the above outcome due to lack of evidence. File to go to panel". As a consequence, it is contended that all the information contained in the approved DST was submitted to the eligibility panel and therefore the approved DST did "inform" the panel's decision in accordance with Regulation 21. It is further argued that the submission of the approved DST with the assessor's comment rather than the comment being provided separately could not convert a lawful process into an unlawful one as there was no more than the addition of a sentence at the end rather than a modification of any information provided.

54. I agree with the submission made on behalf of the defendant in this regard. The panel was provided with the DST completed by the MDT, including the points of disagreement between Ms Flynn and Ms Blackman. I do not agree that the document was amended by the assessor, and that contention, it would seem, comes from the confusion engendered by what was set out in the detailed grounds of defence and subsequently corrected in the defendant's skeleton. The amendment was made by Ms Flynn and the assessor did no more than comment which, as I have concluded above, was not unlawful. As a consequence the requirement of Regulation 21(5)(b) that the decision as to whether the patient has a healthcare need requires to be "informed" by the completed DST was satisfied.

55. Ground 3 contends that the CCG panel undertook an unlawful decision- making process in October 2015, in breach of the terms of the national guidance, in that there was more than sufficient evidence in the DST to support a recommendation: the panel did not appear to appreciate that it was required to accept the recommendation unless there were exceptional reasons to depart from it, no exceptional reasons were formulated and no proper reasons were given for rejecting the recommendation that the claimant was eligible for CHC.

56. As is noted in the challenge in this regard, no minutes of the meeting of the panel on 14 October 2015 have been disclosed and the only document is a running log (referred to above at paragraph 33) which states as follows:

> "14-10. Panel unable to verify due to no supporting evidence for the DST scores. Evidence to be gathered prior to a new MDT DST being completed. SCC to request that the PA provides four weeks of diaries of day-to-day management of Mr Gossip's needs. Booker – please arrange MPT DST assessment when the diaries are complete".

57. Reference is also made to paragraph 91 of the National Framework which states as follows:

> "The CCG may choose to use a panel to ensure consistency and quality of decision making. However, a panel should not fulfil a gate-keeping function, and nor should it be used as a financial monitor. Only in exceptional circumstances, and for clearly articulated reasons, should the multi-disciplinary team's recommendation not be followed. A decision not to accept the recommendation should never be made by one person acting unilaterally".

58. PG 33.1(g) of the National Framework reiterates the requirement for the CCG to accept the recommendation except in exceptional circumstances which could for example include insufficient evidence to make a recommendation, or incomplete domains.

59. Further detail, as noted above, is provided at PG 41.1 of the National Framework as to the kind of exceptional circumstances which might lead to a CCG not accepting recommendations, including:

> "- where the DST is not completed fully (including where there is no recommendation)
>
> - where there are significant gaps in evidence to support the recommendation
>
> - where there is an obvious mismatch between evidence provided and the recommendation made
>
> - where the recommendation would result in either authority acting unlawfully.
>
> 41.2 In such cases the matter should be sent back to the MDT with a full explanation of the relevant matters to be addressed. Where there is an urgent need for care/support to be provided, the CCG (and LA where relevant) should make appropriate interim arrangements without delay. Ultimately responsibility for the eligibility decision rests with the CCG".

60. The point is made in the grounds that the MDT was completed thoroughly, each domain was completed and proper reasons were set out with the conclusions in each case and there were no significant evidence gaps.

61. On behalf of the defendant it is argued that the phrase "no supporting evidence" clearly meant "insufficient supporting evidence", quoting observations of Lord Neuberger in *Holmes-Moorhouse v Richmond-upon-Thames LBC* [2009] UKHL 7, in a case concerning review of a housing officer's decision. Among other things it was said at paragraph 50:

> "Accordingly, a benevolent approach should be adopted to the interpretation of review decisions. The court should not take too technical a view of the language used, or search for inconsistencies, or adopt a nit-picking approach, when confronted with an appeal against a review decision. That is not to say that the court should approve incomprehensible or misguided reasoning, but it should be realistic and practical in its approach to the interpretation of review decisions."

62. It is acknowledged in the defendant's skeleton that there clearly was some evidence in support of the claim but equally it was clear that the panel and the assessor considered that the evidence submitted was insufficient. It is also argued that there is no provision in the Regulations stating that the question whether the patient has a primary health need is one to be determined by the DST, unless there are exceptional circumstances. As long as the decision is "informed" by the completed DST, whether the patient has a primary health need is a matter for the judgement for the CCG (in this case through an eligibility panel).

63. It is also argued that where the National Framework suggests that the decision-maker should accept the conclusion of the DST unless there are exceptional circumstances, that does not reflect the law and is an unwarranted gloss. In any event, it is argued,

the National Framework is a document to which regard must be had, but it is not binding.

64. With regard to whether or not exceptional circumstances are required, the defendant quotes from *Lock and Gibbs*: "NHS Law and Practice" at 16.115, where it is said that if the statutory scheme in the Regulations had wanted decision making panels to be bound by the conclusions of the MDT as expressed in the DST in all but exceptional circumstances it could have said so but did not do so. The passage from the book goes on to say the following:

> "It is therefore probably an unacceptable gloss on the statutory decision making scheme for the decision making panel to be required to find 'exceptional circumstances' before it is entitled to reach a different decision from the MDT as expressed in the DST. The better view is that the panel has a duty to make its own decision as to whether the patient has a primary health need, duly informed by the views of the MDT as expressed in the DST and that in doing so it should place considerable weight on the views of the DST. However, notwithstanding the duty to give considerable weight to the contents of the DST, the panel has to reach its own conclusions and is not limited to following the DST unless it finds that there are exceptional circumstances".

65. Quite apart from this, it is argued, as noted above, on behalf of the defendant that exceptional circumstances within the meaning of the National Framework were in fact found by the panel on 14 October 2015. Noting what was said in the DST itself concerning the limitations of the evidence, in section 1:

> "… there was no documentation/risk or assessment tools to use as supporting evidence within each of the domain areas, as there aren't any. This would include tools such as Waterlow, Must or care plan/evaluation sheets. The scorings and recommended outcome were therefore based predominantly on verbal evidence from Mr Gossip. … Mr Gossip was made aware of limitations not having documented supporting evidence …".

66. Given this, it is argued that it was unsurprising that the eligibility panel found:

> "Panel unable to verify due to no supporting evidence for the DST's scores …".

67. On behalf of the claimant it is argued that bearing in mind that the CCG website states and at all material times stated: "We follow national guidance and criteria in assessing your care needs and eligibility", as a consequence the CCG committed itself to making CHC eligibility decisions in accordance with the National Framework and that that promise gave rise to an enforceable legitimate expectation that the CCG would act in accordance with the National Framework in making CHC eligibility decisions.

68. On behalf of the defendant it is argued that the Regulations do not provide that health authorities must comply with the National Framework, simply that they must have regard to it, noting what was said in *Whapples*.

69. It is also disputed that what is said at paragraph 6.2 of the CCG's operational policy comprises a representation giving rise to an enforceable legitimate expectation. There the following is said:

> "Eligibility for NHS Continuing Healthcare
>
> The National Framework for NHS continuing healthcare and NHS funded-nursing care (revised, 2012) provides a consistent approach to establishing eligibility for NHS continuing healthcare. This is achieved through the use of the revised National Tools and Guidance developed to assist in making decisions about eligibility for continuing healthcare".

70. The defendant argues that no representation which could give rise to a legitimate expectation can be found in either or both of these passages. It is argued that no representation was made to the claimant that the policy was implemented and not departed from in his particular case and it could not fairly be said that there was a commitment made by the CCG to accord to the National Framework a status that it does not have in law. Reference is also made to the section in the operational policy headed "Procedures" which makes it clear that while the MDT will make recommendations, it is the panel that will make decisions. The operational policy also makes it clear that the DST cannot itself directly determine eligibility.

71. I agree with the submissions made on behalf of the defendant in this regard. The defendant did not commit itself by way of representation amounting to a legitimate expectation or otherwise that it would make CHC eligibility decisions in accordance with the National Framework. It is clear that it was the panel that would make decisions and no reliance let alone detrimental reliance has been shown. As quoted above at paragraph 10, the defendant is required as a matter of law to have regard to the National Framework rather than being required to comply with it.

72. Returning to ground 3, though I accept that in the absence of such a requirement in the Regulations, the decision-maker was not required to find that there were exceptional circumstances to justify departing from the DST which must inform the ultimate decision in whether the patient has a primary health need, a decision for the CCG through the eligibility panel, I do not consider that one can interpret the phrase "no supporting evidence" as meaning "insufficient supporting evidence". This would appear to me to be within the category of misguided reasoning referred to by Lord Neuberger at paragraph 50 in *Holmes-Moorhouse*. Clearly there was evidence before the panel in the form of what the claimant himself said about his condition and situation and also the medical evidence that had been provided. But the "no supporting evidence" statement has to be seen in light of what was said in the DST (see paragraph 58 above) concerning the absence of documentation/risk or assessment tools to use as supporting evidence within each of the domain areas. It may be that it would have been open to the panel to conclude that in light of the limitations of the evidence as referred to in section 1 of the DST, there was insufficient evidence, but

that was not what it said. There was evidence before it and yet it concluded that there was no evidence.

73. That said, the point lacks materiality, bearing in mind the fact that as is pointed out at paragraph 76 of the claimant's skeleton, as the CCG subsequently appears to have rescinded any decision made by the October 2015 panel, it may be no more than arguable evidence of the CCG, at least at that stage, not understanding at least an element of the legal regime in which it was required to work, and the decision under challenge is that of 29 March 2017.

74. Ground 4 is concerned with the claimed failure on behalf of the CCG to refer any concerns that it had back to the MDT. It is provided in the Guidance at PG 41 that where a recommendation is not accepted:

> "… the matter should be sent back to the MDT with a full explanation of the relevant matters to be addressed. Where there is an urgent need for care/support to be provided, the CCG (and LA where relevant) should make appropriate interim arrangements without delay".

It is argued that in this case the CCG had a positive recommendation that it did not accept, but the panel failed to follow the guidance in not referring the matter back to the MDT and despite the fact that Mr Gossip had an urgent need for care, no interim arrangements were made to provide services to him.

75. On behalf of the defendant it is argued that the National Framework does not prescribe an obligatory process in the event that the DST is inadequate, when read as a whole, and nor do the Regulations. It is said that paragraph 91 of the Guidance does no more than provide that the CCG "may" (not must) ask a multidisciplinary team to carry out further work on a DST if it is not completed fully or if there is a lack of significant consistency between the evidence and the DST and the recommendation and it is a discretion and not an obligation under that paragraph of the Guidance. The point is also made that there was a proper reason not to refer the matter back to the MDT, given the need for further evidence and the uncertainty whether the exact same MDT would be available to consider the case once the evidence was received.

76. The point is further made by the defendant that, in any event, the National Framework Guidance is merely a relevant factor in the process and failure to adhere to it does not of itself generate a breach of the law. The final decision-maker was always the CCG regardless of which MDT completed the final DST.

77. I agree with the defendant that no unlawfulness is made out in respect of ground 4. I see force in the argument that there was a proper reason not to refer the matter back to the MDT given the need for further evidence as perceived by the panel prior to a new MDT/DST being completed and the more permissive than mandatory nature of paragraph 91 of the Guidance. The decision was to have a new MDT/DST. It is clear from paragraph 92 of the National Framework that the CCG:

> "may ask a multidisciplinary team to carry out further work on a Decision Support Tool if it is not completed fully or there is a

> significant lack of consistency between the evidence recorded in the Decision Support Tool and the recommendation made",

and that, as it seems to me, does not require the same MDT to do the work. What was done was consistent with the guidance in the National Framework. I agree also with the argument that in any event any failure to adhere to the National Framework Guidance does not amount to unlawfulness (provided it was not ignored) as it is a relevant factor in the process and no more than that. It is clear from the Regulations that the final decision-maker is always the CCG.

78. Ground 5 asserts unlawfulness on the basis that under PG 42 of the National Framework the CCG should communicate with the patient. It is said at PG 42.1 that once the recommendation is confirmed by the CCG the individual should be informed in writing in an appropriate language or format as soon as possible, including the reasons for the decision and details of whom to contact if they wish to seek a further clarification or request a review of the decision. After the meeting of the panel, as is pointed out, the CCG failed to communicate the outcome to the claimant for several months. He was only informed on 16 January 2016 that the CCG had "met in October" and decided they needed a diary for a month.

79. On behalf of the defendant it is accepted that the decision of 14 October 2015 could and should have been communicated earlier to the claimant, but it is argued that the delay in communicating the outcome of the eligibility panel was not capable of impugning the substantive legality of the panel's decision. The point is also made that the matter is essentially academic in light of the decisions taken and that also some of the delay in obtaining an up-to-date assessment of the claimant's needs was due to his approach in not agreeing suitable dates for assessment and wanting to wait for a report on his needs.

80. That latter point does not explain the delay between the decision and the initial communication to the claimant on 6 January 2016, but I accept that it is not a case where delay can be said to give rise to any unlawfulness in the decision reached, in particular bearing in mind the essentially academic nature of the point in light of the decision subsequently taken.

81. Ground 6 comprises a contention that an unlawful decision was made by Ms Clare Davies, a Complaints and Relationship Manager at the CCG. This concerns a letter that she wrote to the claimant on 13 March 2017 (see paragraph 36 above) concerning the outcome of the DST of 22 April 2015 that, it was said, had now been verified by a clinical lead nurse, Ms Dino Adams. The letter said that it was providing a rationale as to why the evidence that had now been provided indicated that he was not eligible for continuing healthcare, provided by the clinical lead nurse, Ms Adams.

82. It was argued in the grounds that Ms Adams had taken the decision that the claimant was not eligible for CHC but that this was a decision which could only have been made by the CCG panel and was consequently unlawful. The claimant wrote to the CCG on 27 March 2017 referring to this letter and stating that he was concerned that his case was now simply going to the panel to endorse the "rationale" and conclusion already provided by the nurse Ms Adams.

83. The defence response to this is that ground 6 is based on a misconception as to the role of Ms Adams who was never part of the decision-making individuals within the CCG but who was asked to assist Clare Davies in answering a complaint (see paragraph 36 above). A complaint had been made by the claimant to the defendant on 13 July 2016, asserting that he had not had an outcome from the 2015 panel. Ms Blackman had also specifically asked the defendant for the reasons why the original DST conclusions had not been upheld. Ms Davies had asked Ms Adams to provide this explanation, having examined the records. Ms Adams considered the records and provided the information for Ms Davies to provide a response.

84. It is asserted in the defence that Ms Adams did not make a decision as to the claimant's eligibility for CHC but her main objective was to communicate why the 14 October 2015 eligibility panel had not adopted the MDT's recommendation. It could be seen from Ms Adams' witness statement that she was not making a decision on behalf of the CCG's eligibility panel, and she did not recall sending her rationale to anyone other than Clare Davies and her rationale was omitted from the CCG's "broad care" system so that it would not be available for the eligibility panel to view, since it was prepared solely for the purpose of responding to Ms Blackman.

85. It is also argued in the defence that in any event it is clear that the March 2017 panel which was the body with the responsibility of advising the CCG as to the decision was not aware of or influenced by Ms Adams' review of materials relating to the 2015 panel and the carers' notes. Ms Adams' own evidence was that they were not provided to the panel and there was no reference to them in the decision and it was clear from the minutes of the decision that the panel undertook its own consideration of the material before it.

86. I do not consider this ground is made out. It is sufficiently clear from Ms Adams' evidence as to what was the purpose of the view that she provided. She made it clear that she was not making a decision on behalf of the eligibility panel, and that is not inconsistent with the wording of the final paragraph of Ms Davies' letter. I consider that what she said about the outcome being verified by Ms Adams and the rationale being provided by Ms Adams comprised no more than explanations for the reasons behind the decision rather than indicating that the decision had been made by Ms Adams. It is also clear that the panel of March 2017 was not aware of or in any sense influenced by Ms Adams' review of the materials relating to the 2015 panel and the carers' notes. The challenge in this regard is based on a misconception as to what Ms Adams was doing, and her view was in any event not conveyed to the March 2017 panel. This ground also therefore is not made out.

87. A number of points are raised in ground 7. The first point is that the eligibility "decision" had already effectively been made by Ms Adams and the panel of 29 March 2017 was simply going through the motions rather than taking a proper decision.

88. I have already dealt with this point above and see no merit to it.

89. The second point is that the DST before the panel had been revised by the assessor in a way that was not permitted by the Regulations, the National Framework or the CCG's policy. Accordingly, it is contended, the CCG panel decision was never "informed" by the MDT assessment as required by Regulation 21. It is argued that

the document before the panel had been unlawfully changed to reduce the assessment of the severity of the claimant's needs before it reached the panel.

90. Again this is a matter that I have addressed above. I do not consider that there is anything in this point that goes beyond what had already been raised in ground 2. The reasoning I have set out above in relation to that ground is repeated here.

91. The third element to ground 7 comprises a contention that the panel had not treated the expert findings of the MDT in the way required by the National Framework. That provides that the assessment of need is a matter for the MDT not the panel and that the panel should only depart from the recommendations of the MDT in exceptional circumstances. It is said that it did not appear that this requirement had been drawn to the attention of the panel. In contrast to the way that the conclusions of the MDT are required under the Guidance to be treated, the panel proceeded on the basis that it was entitled to form its own view about the level of the claimant's needs and reached its own decision entirely independently of the MDT conclusions as set out in the DST. It is argued that this approach misunderstood the procedures set out in Regulation 21 and in the National Framework.

92. In the defendant's response to this, it is argued that there is no evidence at all that the panel did not understand its legal responsibilities which were to analyse the evidence and inform the CCG, as the decision-maker in law, as to whether the claimant was properly eligible for CHC.

93. The requirements of Regulation 21 are clear. The relevant body, the defendant, has to make a decision as to whether a person has a primary health need in accordance with paragraph (7), using the completed DST to inform that decision. The Regulation does not require referral back to the MDT. The decision is that of the panel as it was in this situation, informed by the completed DST. The defendant had not bound itself, and was not bound to follow the procedures set out in the National Framework in this regard. Regulation 21(12) requires a relevant body to have regard to the National Framework, but in my view that does not mean that a failure in this situation to refer the matter back to the DST amounts to unlawfulness. It is stated in PG 41.2 of the National Framework:

> "In such cases [where a panel does not accept an MDT decision regarding eligibility] the matter should be sent back to the MDT with a full explanation of the matters to be addressed."

94. This has to be seen in the context of the final sentence of that paragraph: 'Ultimately responsibility for the eligibility decision rests with the CCG'". Clearly, that must be so, given the risk otherwise of a potentially perpetual ping-ponging between the CCG and the MDT, and that may explain the use of the word "should", rather than "must". And it needs to be remembered that guidance is no more than guidance, and the Regulations establish the ultimate responsibility of the CCG, informed by the DST. The absence of any reference to the National Framework in this context and the absence as a consequence of any reasons as to why the matter was not referred back to the MDT does not in my judgement amount to unlawfulness.

95. The final element of this ground is that the panel failed to follow the guidance in the assessment of severity. Reference is made to paragraph 90 of the National Framework which provides as follows:

> "CCGs should be aware of cases that have indicated circumstances in which eligibility for NHS continuing healthcare should have been determined, and where such an outcome would be expected if the same facts were considered in an assessment for NHS continuing healthcare under the National Framework (e.g. *Coughlan* or those cases in the Health Service Ombudsman's report on NHS funding for the long-term care of old and disabled people)".

96. The reference to *Coughlan* is to *R (Coughlan & Ors) v North and East Devon Health Authority* [2001] QB 213 (see above paragraph 21) which is a seminal authority on the question as to whether the correct boundary had been identified between what was the proper responsibility of the NHS and what was the proper responsibility of local authorities. The grounds contend that the claimant's needs were significantly greater than those of Ms Coughlan in that case and therefore in applying the guidance the CCG ought to have compared the two cases in accordance with paragraph 90 of the National Framework.

97. The defendant points to further remarks in paragraph 90 in the National Framework stating that the authorities should be:

> "wary of trying to draw generalisations about eligibility for NHS continuing healthcare from the limited information they may have about … cases [that have indicated circumstances in which eligibility for NHS continuing healthcare should have been determined]"

and going on specifically to mention *Coughlan* in this regard. The point is further made that the CCG considers that the claimant's needs are in fact less significant than those of Ms Coughlan and does not, pursuant to paragraph 90 of the National Framework, consider that a comparison with Ms Coughlan's needs is illuminating for the purposes of answering the question whether the claimant was or is eligible for CHC funding. It is relevant also that the National Framework at paragraph 90 states: "There is no substitute for a careful and detailed assessment of the needs of the individual whose eligibility is in question". That, in my view, is the key point in paragraph 90. Inevitably cases will be fact-sensitive, and it was fully open to the defendant, following the panel's thorough and careful review, to conclude as it did without the need to refer specifically to *Coughlan* or any of the cases in the Ombudsman's report.

98. Ground 8 comprises an assertion that the defendant failed to apply the test under Regulation 21(7). In particular, it is contended that the defendant failed to consider the second statutory route by which a patient could be determined to have a primary health need, breaking the test down into the following steps: first the CCG must ask itself whether the individual requires any "nursing or other health services", and then, if the answer to the question raised at Regulation 21(7)(a) is yes, the next question is whether the nursing or other health services required by that individual are either

"more than incidental or ancillary to the provision of accommodation which a social services authority is … under a duty to provide" or, in the alternative, "of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide". If the answer to questions (a) and (b) above is "yes" to both, the CCG is required to find that the person has a primary health need. In an undertaking of this task the CCG is required to look at a person's needs "in their totality".

99. It is argued that in this case the CCG did not expressly address this part of the statutory decision-making process. There is nothing in the minutes of the panel meetings to suggest that the panel addressed the issues set out in Regulation 21(7).

100. It is said to be clear for two separate reasons that the claimant required nursing or other services of a nature beyond which a social services authority, whose primary responsibility is to provide social services, could be expected to provide. First, the CCG had decided that he required nursing services, as acknowledged in the decision letter. This led to a letter to the claimant, dated 4 April 2017, from Ms Lorna Hart of the CCG, stating that he was eligible for NHS funded nursing care ("FNC"). As a consequence of section 22 of the Care Act 2014, a local authority is effectively prevented from employing registered nurses to deliver "any services which, having regard to their nature and the circumstances in which they are provided, do not need to be provided by a registered nurse". As a consequence, it is argued that if a patient who is accommodated in a care home has a need for some level of medical support which has to be provided by a registered nurse, this is a need which cannot fall within social care support funded by a local authority under the Care Act 2014. It is argued as a consequence that the nursing services identified by the CCG as being needed by the claimant were by definition services of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide. As a consequence the CCG was required to find that he had a primary health need.

101. The second reason is said to be that he has a higher level of need than Ms Coughlan had and those, the Court of Appeal had decided, were needs which were "services of a wholly different category" from the services a local authority could be expected to provide.

102. Though where a patient is living in their own home with care provided by a specialised carer, as in this case, FNC is not applicable, it was argued that the decision by the CCG in the claimant's case decided that some of his medical needs were of sufficient medical complexity that they ought to be provided to him by a nurse. It is argued that that finding ought to have led to the inevitable conclusion that if the test in Regulation 21(7) had been properly applied the CCG would have been bound to find that he had needs that were of: "a nature beyond which a social services authority whose primary responsibility to provide social services could be expected to provide".

103. The defendant's response to this is first that the assertion made by the claimant relies on proving that an expert panel charged with making eligibility decisions had misdirected itself in law, and a court would be cautious before drawing an inference that such an expert body had misunderstood the law. Reference is made to the remarks of Baroness Hale at paragraph 30 of *AH (Sudan) v Secretary of State for the Home Department* [2007] UKHL 49.

104. The defendant goes on to argue that it is a matter of degree calling for evaluation by the appropriate professionals as to whether the degree of need entitles an individual to CHC funding in a particular case. The assessment of eligibility for CHC funding is a matter that Parliament has entrusted to the CCG as a specialist decision-maker to answer having regard to specialist professional input. There are good reasons why it is particularly important that the court should not purport to step into the role of decision-maker.

105. It is further asserted that the primary question is whether a person has a primary health need in accordance with Regulation 21(5)(b). Regulation 21(7), it is said, provides further details as to how that question should be answered, depending upon whether the applicant is accommodated in "relevant premises" or not.

106. The point is also made that there is frequent reference to the question of "primary health need" in the minutes of the 2017 panel and the panel members were clearly experienced in their task, comprising Dr Stevens and the Clinical Manager NHS CCH, Alma Trozado, Locality Lead Nurse NHS Continuing Healthcare and Becky Munuwa, Interim Locality Lead Nurse, at NHS Continuing Healthcare.

107. It is argued that there is no evidence at all that the 2017 panel asked the wrong question. In fact it had clearly asked itself the right question which was whether the claimant had a primary health need. There was never a dispute that the claimant had an element of health need, but neither panel considered that those needs in their totality were such as to require health services going beyond what a local authority could reasonably be expected to provide.

108. It is further argued that the concept of a need going beyond that expected to be provided by social services recognises that a need for some nursing health services is not itself necessarily enough to confer eligibility for CHC funding. It is argued that this is also reflected in the National Framework (paragraphs 35 to 37). It is further argued that so far as NHS funded nursing care is concerned, the premise of such care is precisely that a person may be entitled to a contribution from health towards meeting their needs, but not be eligible for full CHC funding. The panel's conclusion that although there was not a primary health need there was an element of health need implied that it was fully aware of the conceptual difference between an element of health need and health needs of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to be provided.

109. I think the points made on behalf of the defendant set out above are well-taken. The decision of the March 2017 panel is detailed and careful. The panel was clearly aware of the key question which is that of "a primary health need", and the fact that there may be a need for some nursing health services does not, as is argued on behalf of the defendant, necessarily amount to sufficient to confer eligibility for CHC funding. The existence of an element of healthcare needs and the panel's awareness of that is of relevance here. It was open to it to conclude that the element of health need in this case was not such as to be of a nature beyond which a social services authority could be expected to provide. Accordingly, I find no merit in this ground either.

110. Ground 9 comprises a contention that the failure of the CCG to consult with the local authority and then to refer the claimant's case to the joint review panel when there

was a dispute was unlawful. Reference is made to the witness statement of Philippa Corney, who is the Senior Practitioner Specialist Lead (Continuing Care) for mid Surrey, part of Surrey County Council's Continuing Care team. She expresses concerns about the decision-making process adopted by the defendant in this case, including, at paragraph 101 of her statement, failure to involve the local authority properly in or consult about decision-making in the claimant's case. She also states, at paragraph 82, that a joint panel gives the Council the chance to have its say on whether a patient has nursing or health care needs which are of a nature beyond which a local authority could be expected to provide.

111. Reference is made in ground 9 to Regulation 22 which requires the CCG insofar as is reasonably practicable to consult with the relevant social services authority before making a decision about a person's eligibility for NHS continuing healthcare. It is argued that the CCG acted in breach of Regulation 22 in failing to consult with the council prior to the panel meeting of 29 March 2017.

112. On behalf of the defendant it is argued that the failure to consult with the local authority is not capable of impugning the legality of the CHC assessment. It is argued that the fact that the obligation is only to consult insofar as reasonably practicable and that the CCG is ultimately the sole decision-maker are reasons to suggest the contrary, particularly in a case where the MDT has included a social worker from the relevant local authority. It is also argued that precisely because Ms Blackman, the claimant's social worker, was involved as part of the MDT, the obligation to consult was fulfilled. There was no obligation to include a social services representative in the MDT and, it is argued, where a social services representative is on the MDT, that fulfils the duty of consultation under Regulation 22(1).

113. The point is further made that the CCG did invite the local authority to participate in its eligibility panels so that they would be joint panels. The council was not able to send representatives to all of the panel meetings, or to send written representations to those meetings. In Dr Stevens' witness statement at paragraph 49 it is said that the local authority only had capacity to attend one half-day Eligibility Panel per week and despite regularly requesting their increased attendance, the local authority remained of the view that they did not have capacity to support more than one panel a week. It is argued that the CCG was not obliged to provide yet further opportunities for the council to participate, or to delay its decision-making to enable the council to participate post-panel in circumstances where the council had plainly not provided sufficient resources to the relevant team. In the circumstances, it is argued that the requirement to consult "so far as reasonably practicable" was satisfied on the facts.

114. There is a further argument that any defect was cured by the Independent Review Panel (IRP), which dealt with the question of eligibility and substance on the facts. This is a point I have addressed above.

115. The further point is made that ground 9 has no weight because on 11 September 2018 Surrey County Council ended its dispute with the local authority following the IRP decision and the consultation could not now yield any dispute and the alleged failure to consult could not be a material error and it was not open to the claimant to seek to resurrect that dispute in this claim for judicial review.

116. It is also argued, with reference to the witness statement of Ms Corney, that given that Surrey County Council has a substantial financial interest in this claim as it presently funds the bulk of the claimant's case, little weight can be given to that statement.

117. I see merit to the defendant's argument that the council's inability to send representatives to all of the panel meetings or send written representations, in the context of the limited duty to consult insofar as reasonably practicable, justifies the failure to consult. Again, it is relevant to bear in mind that the CCG is the sole decision-maker, and in the circumstances I do not accept that this ground is made out.

118. Ground 10 is the contention that the panel which met on 29 March 2017 had no delegated authority to make the decision as it was not a "joint panel of NHS and social care officers". This argument arises as a consequence of the change in the CCG operational policy in 2016 which defined a "continuing healthcare panel" as: "Joint panel of NHS and social care officers that decide the eligibility of clients/patients to funding based on the DST and MDT recommendation". The point is made that it is clear from the evidence now provided by the Council that the CCG did operate joint panels but the claimant's case was not sent to a joint panel. The panel that met on 27 March was not a "joint panel" but one solely consisting of CCG staff.

119. I consider this ground of challenge to be made out. The defendant had clearly bound itself to a policy in accordance with which a joint panel of NHS and social care officers was to decide funding issues of this kind. The purpose, and indeed significance of this is clear: as Ms Corney observed in her witness statement at paragraph 82 a joint panel provides the opportunity for the local authority to have its say on an issue which is clearly of direct relevance to it. In that sense the fact that Surrey County Council has a substantial financial interest in the claim, argued as a point against Ms Corney's evidence, in fact reinforces the argument in respect of this ground. There is no limitation, such as reasonable practicability, and the failure to set up a joint panel cannot, in my view, be excused by the fact that the CCG is the ultimate decision-maker.

120. However, I agree with the defendant that section 31(2A) of the Senior Courts Act 1981 is properly to be applied in this case. I accept that, although I have found that unlawfulness is made out in respect of the issue raised at Ground 10, the defendant would have reached the same conclusion. Even if there had been a joint panel, bearing in mind that the CCG is the ultimate decision-maker, it is, in the words of the statute: "… highly likely that the outcome for the applicant would not have been substantially different …"

121. A separate argument advanced on behalf of the defendant is with regard to remedy. In essence the claimant's aim is to freeze time in April 2015 and relief is sought on the basis, inter alia, under paragraph 98b of the grounds, of an order to require the CCG to make the decision that the claimant has been entitled to CHC from the date of his first application for CHC in 2013 or such other date as the court may direct. The point is made by the defendant in this regard that if the claimant had been found to be eligible for CHC funding, that decision would have been subject to review on at least an annual basis; and Regulation 21(2) would require an assessment where there is reason to believe that a person who is receiving such funding "may not be eligible for it". The point is made that plainly there would be such reason here, particularly given

that the claimant's prime motivation for bringing this challenge is to ascertain his right to CHC funding when he retires sometime in the future. Accordingly, it is argued, at best the claimant would be entitled to a quashing of the decision under challenge rather than some form of declaratory relief. I agree with the defendant's submissions on this point. Though I have found unlawfulness in the decision under challenge, the highest at which the claim in terms of relief could properly be put is the making of a quashing order. There is clear force in the point that even if the claimant had been found to be eligible for CHC funding, the decision would have been reviewable, probably annually, and it is not for the court to second-guess the decisions of the defendant over subsequent years.

122. However, since I have found that the claim founders on the failure to address the proper target, and also that section 31(2A) of the Senior Courts Act is applicable, the application for judicial review is refused.