INTER-AGENCY DISPUTES

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Introduction

1. In this paper we address two specific issues: disputes which arise between local authorities and the NHS in relation to their respective responsibilities; and disputes which local authorities concerning community care provision.

2. The law regarding whether the care needs of an individual should be provided by a local authority's social services department or by the National Health Service is unfortunately complex. The importance for the individual is that while NHS services are generally free at the point of need, those provided by a social services department are generally charged to the individual on a means tested basis.

3. There has been ample judicial criticism of this complexity. The Court of Appeal in ***Crofton v. NHS Litigation Authority***[1] expressed its "*dismay at the complexity and labyrinthine nature of the relevant legislation and guidance, as well as (in some respects) its obscurity*" and went on to state what many practising in this area consider to be self-evident: *"[s]ocial security law should be clear and accessible*" before concluding that it was sadly neither.

4. The unfortunate consequence for both parties is that funds which might otherwise be spent on providing services are instead channelled into litigation. Lord Justice May in ***St Helens BC v Manchester PCT***[2] expressed the concern of the court by stating:

   "It is not satisfactory when two publicly funded public authorities engage in expensive litigation to decide which of them for pay for the care in her home of a woman whose mental and psychological conditions require constant and expensive case. In the end, the money for the care and the money for the litigation is all coming out of the same purse."

[1] [2007] EWCA Civ 71

[2] [2008] EWCA Civ 931

Legal Framework

5. The Law Commission in its recent Consultation Paper on Adult Social Care (CP/102) described this area as a "*confusing patchwork of conflicting statutes enacted over a period of 60 years.*"

6. The main statutes and statutory instruments are:

(i) The National Health Service Act 2006 ("the NHSA 2006")
(ii) The Community Care (Delayed Discharges etc) Act 2003
(iii) The Health and Social Care Act 2001 ("the HSCA 2001")
(iv) The National Health Service and Community Care Act 1990 ("the NHSCA 1990")
(v) The Mental Health Act 1983 ("the MHA 1983")
(vi) The Local Authority Social Services Act 1970 ("the LASSA 1970")
(vii) The Chronically Sick and Disabled Persons Act 1970 ("the CSDPA 1970")
(viii) The Local Authorities (Goods and Services) Act 1970
(ix) The National Assistance Act 1948 ("the NAA 1948")
(x) The NHS Continuing Healthcare (Responsibilities) Directions 2007 (the Responsibilities Directions 2007")
(xi) The Delayed Discharge (Continuing Care) Directions 2007
(xii) The NHS Bodies and Local Authority Partnership Arrangements Regulations 2000
(xiii) The National Health Service (Payments by Local Authorities to NHS Bodies) (Prescribed Functions) Regulations 2000

7. In order to examine the different obligations of a local authority's social services department and the Health Service, it would be best to identify their respective obligations.

Key Statutory Provisions for Local Authorities

8. The key provisions empowering local authorities to provide community care are as follows:

(i) Section 21(1) of the NAA 1948 provides that a local authority may, with the approval of the Secretary of State, and to such extent as he may direct, make arrangements for providing:

(i) Residential accommodation for persons in need of care and attention; and

(ii) Residential accommodation for expectant and nursing mothers.

(ii) Section 21(5) of the NAA 1948 provides for the provision of other services delivered in connection with accommodation under s. 21(1).

(iii) Section 22 of the NAA 1948 permits the local authority to make charges for the provision of accommodation.

(iv) Section 29(1) of the NAA 1948 contains the broad provision that

> *"a local authority may with the approval of the Secretary of State, and to such extent as he may direct shall, make arrangements for promoting the welfare of persons… aged eighteen or over who are blind, deaf or dumb, or who suffer from mental disorder of any description as may be prescribed by the Minister."*

(v) The relevant approvals from the Secretary of State for both ss. 21(1) and 29(1) are to be found in LAC(93)10.

(vi) Section 2 of the CSDPA 1970 imposes a number of duties on local authorities for the provision of welfare services to persons to whom s. 29 of the NAA 1948 applies. The duties are those that are necessary in order to meet the needs of that person.

(vii) Section 254 and Schedule 20 of the NHSA 2006 empowers local authorities to exercise functions in relation to the care of pregnant women and women who are breast-feeding, training and occupation or ancillary and supplementary services for the prevention of illness. The relevant approval is contained in LAC(93)10.

(viii) Section 117 of the MHA 1983 places a duty on local authorities, in cooperation with NHS providers and relevant voluntary agencies, to provide after-care services to persons who have ceased to be detained until such time as they are satisfied that the person is no longer in need of such services.

Key Statutory Provisions for the National Health Service

9. The key statutory provisions relating to the provision of community care services by the National Health Service are as follows:

(i) Section 1 of the NHSA 2006 provides that the Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and in the prevention, diagnosis and treatment of illness. Subsection (3) provides that the services so provided must be free of charge except in so far as the making and recovery of charges is expressly provided for by or under any enactment, when ever passed.

(ii) Section 3 of the NHSA 2006 provides that the Secretary of State must provide throughout England

"…to such extent as it considers necessary to meet all reasonable requirements:

(a) hospital accommodation,
(b) other accommodation for the purpose of any service provided under this act...
(d) such other services or facilities for the care of pregnant women, women who are breastfeeding and young children as he considers appropriate as part of the health service, and
(e) such other services or facilities for the prevention of illness, the care of persons suffering from illness and the aftercare of persons who have suffered from illness as he considers appropriate as part of the health service, and
(f) such other services or facilities as are required for the diagnosis and treatment of illness."

(iii) The duties set out in sections 1 and 3 of the NHSA 2006 are executed on behalf of the Secretary of State by Primary Care Trust pursuant to section 7 of the NHSA 2006 and the NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements (England) Regulations 2002.

Cooperation between local authorities and health authorities

10. There are statutory duties to cooperate at both a general strategic level and in specific circumstances. The general duties to cooperate are as follows:

(i) Part 3 of the NHSA 2006 consolidates a number of provisions governing the relationship between local authorities and the NHS.

(ii) In particular, section 82 of the NHSA 2006 provides that NHS bodies and local authorities must cooperate with one another in order to secure and advance the health and welfare of the population. It states:

> *"In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales."*

(iii) Section 74 brings Health Authorities, Strategic Health Authorities **("SHA")** and Primary Care Trusts **("PCT")** under the Local Authorities (Goods and Services) Act 1970. Section 74(3) provides that each local authority must make services available to each NHS body acting in its area, so far as is reasonably necessary and practicable to enable the NHS body to discharge its functions under this Act.

(iv) Section 75 and the NHS Bodies and Local Authority Partnership Arrangements Regulations 2000 (preserved by the National Health Service (Consequential Provisions) Act 2006 s. 4, Schedule 2 paragraph 1) empower NHS bodies and local authorities to enter into partnership arrangements including pooled fund arrangements and the delegation of functions by local authorities to NHS bodies and vice versa.

(v) Section 76 empowers local authorities to make payments to a SHA, PCT or Local Health Board towards expenditure incurred in connection with prescribed functions. The National Health Service (Payments by Local Authorities to NHS Bodies) (Prescribed Functions) Regulations 2000 (again preserved in force) define these functions broadly to include services under section 3 of the NHSA 2006.

(vi) Section 77 consolidates the power of PCTs or NHS Trusts party to local authority delegation arrangements to apply to the Secretary of State to form a Care Trust, a separate entity with legal responsibility to discharge both social and health care functions.

(vii) Section 78 provides the Secretary of State with the power to take action to direct service providers to enter into arrangements with other providers where they are exercising their functions inadequately. Section 78(1) empowers the Secretary of State to direct a SHA, PCT, NHS Trust or local authority ("the first body") to enter into delegation arrangements or pooled fund arrangements made with another body ("the second body") where the first body is failing to exercise its functions adequately. In relation to local authorities, the section applies only to failures in health-related functions as defined under section 75(8) of the 2006 Act which are also social services functions within the meaning of the Local Authority Social Services Act 1970 (c 42).

(viii) Section 79 empowers the Secretary of State to make provision for the determination by agreement, or in default of agreement by the Secretary of State or an arbitrator appointed by him, of the amount of any payments which need to be made by one body to another for the purpose of the effective operation of the specified arrangements. Section 79 also empowers the Secretary of State to direct a body to make capital assets available to another body in pursuance of directions under section 78.

11. In addition to general duties of strategic cooperation contained in the NHSA 2006, there are also specific duties to cooperate in certain cases namely (i) the assessment of community care needs by the local authority; (ii) the discharge of a patient from hospital; (iii) in the requirement of consultation on the NHS; (iv) in mental health after care cases and (v) in respect of children.

(i) **Assessment of community care needs by LA**: section 46 of the National Health Service and Community Care Act 1990 ("**NHSCA 1990**") imposes the obligation on local authorities to prepare and keep under review a plan for the provision of community care services in their area. Section 46(2) provides that in performing these duties, including the duty to review, the local authority must consult, *inter alia*, any Health Authority and Local Health Board the whole or part of whose area lies within the area of the local authority. Section 47(3) provides that where a local authority conducts an assessment of needs for community care services and it appears that there may be a need for provision to that person by health bodies the local authority must notify that health body to invite them to assist, to such extent as is reasonable in the circumstances, in the making of the assessment. The local authority must also take into

account any services which are likely to be made available for the individual by the health body in deciding what the authority itself should provide.

(ii) **Discharge from hospital**: under section 2 of the Community Care (Delayed Discharges etc) Act 2003, the NHS must notify the relevant social services department of a patient's possible need for services on discharge from hospital, following which social services have a minimum of three days to carry out an assessment of the patient's need for community care services and arrange necessary care prior to discharge. Before issuing such a notice, under direction 2(2) of the Delayed Discharge (Continuing Care) Directions 2007, the NHS must first take reasonable steps to ensure than an assessment for NHS continuing health care is carried out where it appears the patient may have a need for such care in consultation, where the NHS bodies considers it appropriate, with the relevant social services authority.

(iii) **Consultation requirements falling on the NHS**: direction 3 of the NHS Continuing Healthcare (Responsibilities) Directions 2007 **("the 2007 Responsibilities Directions")**, requires PCTs to consult, so far as is reasonably practicable, with the relevant social services authority before making a decision about a person's eligibility for NHS continuing health care. It further requires the relevant social services authority to provide advice and assistance to the PCT, so far as is reasonably practicable, including use of any information obtained as a result of an assessment it has carried out under section 47 of the NHSCA 1990. Such co-operation is imperative given that neither the PCT nor the local authority can unilaterally dictate what the other agency should provide.

(iv) **Mental health aftercare cases**: section 117 of the Mental Health Act 1983 provides that the PCT and the local social services authority shall provide in cooperation with relevant voluntary agencies, after care services for those persons who have ceased to be detained under section 3.

(v) **Cooperation under the Children Act 1989**: section 27 of the Children Act 1989 empowers a local authority to request the help of, inter alia, an NHS body. The body who is the recipient of such a request has a duty to cooperate, see subsection (2).

The Use of Judicial Review and the Dispute Resolution Procedure

12. In the majority of applications for judicial review, the contest is between the public authority and one or more individuals affected by their decision. In inter-agency disputes, the contest is between two public authorities each with a statutory decision making power, where the decision of one authority may affect the other.

13. This was one of the issues in the recent *St Helen's* litigation. In ***St Helen's Borough Council v Manchester Primary Care Trust***[3] it was contended that where there are conflicting decisions of two public authorities, each exercising statutory powers, the court should decide for itself the substantive question of whether the individual's care needs are the responsibility of the local authority social services or the health authority.

14. In giving the leading judgment, May LJ set out a summary of the nature of judicial review proceedings:

> *"13. Judicial review is a flexible, but not entirely unfenced jurisdiction. This stems from certain intrinsic features. The court's relevant function is to review decisions of statutory and other public authorities to see that they are lawful, rational and reached by a fair and due process. The public authority is normally the primary decision maker with a duty to apprehend the facts underlying the decision by a fair procedure which takes properly into account all relevant facts and circumstances. If the public authority does this, the court will not normally examine the merits of the factual determination. Accordingly, a court hearing a judicial review application normally receives evidence in writing only, and does not set about determining questions of disputed fact. The court will therefore not normally entertain oral evidence nor cross−examination of witnesses on their written evidence. The normal limit of the court's enquiry into the facts is if the primary decision maker is said to have reached perverse factual conclusions or to have decided the facts without taking relevant material into consideration, or to have considered and been influenced by irrelevant material. If factual decisions of the primary decision maker are shown to have been materially flawed in this way, the normal result is to quash the decision and remit the matter for reconsideration. The court does not often itself make a factual decision which the primary decision maker has not made."*

15. May LJ concluded that the role of the PCT in deciding whether the individual was eligible for continuing care was a decision which had to be determined before a local authority had to consider whether it was required to provide social care services.

[3] [2008] EWCA Civ 931

16. The first question is whether the PCT is required to provide the necessary support; if it is not, the individual's needs fall to be met by social services. He stated:

> *"37. It follows that there is one primary decision maker, not two, and there is no head on collision between two comparable decisions. It then follows that a challenge to this decision will be by orthodox judicial review and the court is not required to determine the conflicting substance of two decisions of equivalent standing."*

17. Importantly, pursuant to direction 3(4) of the 2007 Responsibilities Directions, any dispute between a PCT and the relevant social services authority about a decision as to eligibility for NHS continuing healthcare, or the contribution of a PCT or social services authority to a joint package of care must be resolved in accordance with a dispute resolution procedure agreed between the two bodies. Paragraph 161 of the ***National Framework*** (2009) states that this procedure should proceed in a "*robust and timely manner*", "*should not delay the provision of the care package*" and should make clear how funding for services will be handled pending resolution of the dispute. In the ***St Helens BC*** case, the Court of Appeal considered that this resolution procedure should have the effect that such disputes should not in future normally require resolution by way of judicial review, thus saving expense.

18. The Local Government Ombudsman has criticised social service and health authorities for failing to provide the necessary care to an individual while arguing as to which body bears the responsibility for providing and/or funding that care. It is vital that local health and government bodies have systems in place to prevent such disagreements as far as possible; and that when such disagreements arise that an individual is not left without appropriate care while disagreement is resolved.

The Dividing Line between Medical and Social Care

19. The National Framework 2009 has indicated that "*[t]here should be no gap in the provision of care."* In ***St Helen's BC*** May LJ recorded common consent between the parties that there was no gap between community care services to be provided by the local social services authority and the health care services to be provided by the PCT: the only question was where to draw the dividing line in an individual case. The question therefore is where to draw the line between medical and social care needs.

20. The key decision in this area is still ***R v North and East Devon Health Authority ex p Coughlan***[4], where the Court of Appeal accepted that there are circumstances in which a local authority might have responsibility for providing nursing care for a chronically sick patient as part of its role as a social service provider. Whether or not a local authority can do so depends on whether that nursing care could be regarded as being provided in connection with accommodation being provided under section 21 of the NAA 1948. If the nursing care could not properly be regarded as part of the provision of social services, then it could not lawfully be provided by a local authority. The focus is on identifying the nature of the primary need of the individual concerned. At paragraph 31, it was held the Secretary of State accepted: "where the primary need is a health need, then the responsibility is that of the NHS, even when the individual has been placed in a home by a local authority".

21. ***Coughlan*** went on to hold that the distinction between those nursing services that can and cannot properly be provided by a local authority was recognised as being one of degree, with no possibility of a precise line being drawn. Instead, in borderline cases it required a careful appraisal of the facts, to include in particular:

    (i) **a quantitative assessment**: whether the services are merely incidental or ancillary to the provision of accommodation which the local authority is under a duty to provide; and

    (ii) **a qualitative assessment**: whether the services are of such a nature that an authority whose primary function is the provision of social services can be expected to provide them.

22. This distinction was applied and developed in ***R (T, D & B) v Haringey London Borough Council***[5], which case considered, *inter alia*, whether the respite care needs of a mother and her two children, the youngest of whom, D, had a tracheostomy fitted, were of a nature that social services could provide. The applicants in this case wanted the services to be provided by the local authority, as they would be more extensive than the reduced service the PCT was willing to provide. Ouseley J had to consider the scope of section 17 and Schedule 2 of the Children Act 1989 and of section 2 and 28A of the CSDPA 1970 (s. 28A provides that the CSDPA will

[4] [2001] QB 213
[5] [2005] EWHC 2235

apply to those who fall under the Children Act 1989 as it does to those who fall under the NAA 1948).

23. At paragraph 61 Ouseley J accepted that there was a broad distinction to be drawn between health and social care provision, both in the context of the Children Act 1989 and section 2 of the CSDPA 1970. Although section 2 of the CSDPA makes broad provision for a local authority to provide, *inter alia*, "practical assistance" in the home, Ouseley J held that this could not extend to the provision of day or night respite care provided by a nurse. This reasoning would apply to adults as well as children. This was before considering whether such care would anyway be excluded by section 49 of the Health and Social Care Act 2001, discussed below.

24. At paragraphs 62-67, Ouseley J, drawing on the discussion of the Court of Appeal in ***Coughlan,*** identified a number of factors as relevant to the characterisation of particular care services as social, medical or overlapping:

    (i) the scale and type of care;

    (ii) the question whether the care is incidental or ancillary to the provision of some other service which a social services authority is lawfully providing;

    (iii) whether or not the service is of a nature which such authority can be expected to provide;

    (iv) whether the care is incidental to or arises out of other medical treatment;

    (v) the gravity of the consequences of a failure in care;

    (vi) the duration of the care need; and

    (vii) the nature of the training an individual needs to provide the care.

25. On the facts, he concluded at paragraph 66 that "*the gravity of the consequences of a failure in care, the duration of the care need, which required [D's] carer always to be present lest*

something had to be dealt with rapidly, underscores the medical rather than social service nature of the provision".

26. If the care envisaged is characterised as essentially medical care then it may fall to be provided by the NHS even before considering any statutory exclusions on the power of a local authority. This may be the case even where, as in the ***Haringey*** case, the assessment indicating the need for such care was conducted by the social services authority.

27. In ***R (on the application of Grogan) v Bexley NHS Care Trust***[6], Ms Grogan argued, inter alia, that the decision to deny her full NHS funding for her significant care needs was unlawful on the basis the SHA's eligibility criteria was contrary to the findings in ***Coughlan***.

28. Charles J allowed her application and remitted the question of her entitlement to the PCT for further consideration. Key points from the judgment of Charles J are as follows:

    (i) In assessing whether Mrs Grogan was entitled to NHS continuing healthcare, the care trust did not have in place – and did not apply –criteria which properly identified the test or approach to be followed in deciding whether her primary need was a health need.

    (ii) The court identified the fact that there can be an overlap, or a gap, between social care and NHS provision, depending on the test, or tests, applied. The court accepted, as had been submitted by the Secretary of State, that the extent of her duties was governed by NHS legislation, not the upper limits of local authority lawful provision, and that therefore there was a potential in law for a gap between what the Secretary of State provided and those 'health services' that the local authority could 'lawfully' supply.

    (iii) If the policy of the Secretary of State was that there should be no gap, then, when applying the primary health need approach, this should be considered against the limits of social services lawful provision, not just by reference to a 'primary health need'.

[6] [2006] EWHC 44 (Admin)

29. The protracted dispute between ***St Helens Borough Council*** and ***Manchester Primary Care Trust***[7] turned on the allocation of financial responsibility between the NHS and the relevant Local Authority. The dispute between the Council and the PCT centred on whether the needs of a woman, PE, who suffered from Dissociative Identity Disorder, were primarily for health care, to be provided by the PCT, or for community care to be provided by the social services authority. The PCT had decided after intensive consideration that PE's need was not primarily for health care. St Helens Borough Council maintained that the care was not such that the social services department should be required to undertake it. Permission to bring judicial review proceedings was refused by Beatson J and the Council appealed to the Court of Appeal on the sole ground that, in a case where there are conflicting decisions of two public authorities each exercising statutory powers, it is a substantive question for the Court whether PE's care needs were the responsibility of the Council or the PCT. May LJ, giving the leading judgment, held that the PCT was the primary decision maker whose decision was susceptible to judicial review.

30. However, St Helens subsequently renewed its application orally to the Court of Appeal,[8] arguing that the determination of whether the primary need was for social care should be judged by reference to the nature and complexity of the user's needs and not exclusively by reference to the nature of the care which was required. May LJ, who again gave the leading judgment, found that it was not irrational, on public law grounds, for the PCT to have reached the conclusion it did as to the dividing line between health care and social services care. However he left open the question of whether the same result would be achieved under the new ***National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care*** 2007 (revised 2009). A fresh multi-disciplinary team had concluded that under the new guidance, PE's needs were primarily health needs. It seems probable, therefore, that under the Guidance a broader assessment is required.

31. The ***National Framework*** (2009), which sets out the Secretary of State's policy for the provision of NHS continuing healthcare, is mandatory for use by local authorities and NHS bodies. Paragraphs 23-29 explains that the Secretary of State has developed the concept of "a primary health need" to assist in distinguishing between those services that should be provided under the NHSA 2006 and those local authorities may provide under community care

[7] [2007] EWHC 2391, [2008] EWCA Civ. 932, [2009] EWCA Civ. 53
[8] [2009] EWCA Civ. 53

legislation, such that where a person's primary need is a health need, the NHS is regarded as responsible for providing all their needs, including accommodation if that is part of the overall need, which he calls NHS Continuing Healthcare. A practical approach suggested in the National Framework is to have regard to the following factors:

(i) The nature of the individual's needs and the type of those needs;

(ii) The intensity of the individual's needs and level of support required to meet them;

(iii) The complexity of the individual's needs and skill required to treat the symptoms; and

(iv) The unpredictability of the individual's needs

32. Under direction 2(4) of the ***Responsibilities Directions*** 2007 the PCT must ensure that a multi-disciplinary team undertakes an assessment that is to be used to inform a decision as to a person's eligibility for NHS Continuing Healthcare. Pursuant to direction 2(5), PCTs must use a completed Decision Support Tool to inform the decision as to whether a person has a primary health need and, if so, must decide that the person is eligible for NHS Continuing Healthcare, defined in the Responsibilities Directions as "*a package of care arranged and funded solely by the health service for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of illness*".

33. Under direction 2(6), in deciding whether a person has a primary health need, PCTs must consider whether the nursing or other health services required by that person are 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 of a nature beyond which a social services authority whose primary responsibility is to provide social services could be expected to provide. If in their totality it decides they are, then it must decide the person has a primary health need. This gives direction to the guidance contained at paragraph 26 of the National Framework that there should be no gap in the provision of care to be provided by the NHS and a local authority whether separately or together, by expressly taking into account the legal limits of local authority provision when deciding whether the NHS should assume responsibility for care provision in a particular situation.

34. The Decision-Support Tool's User Notes point out at paragraph 4 that the tool cannot directly determine eligibility and that professional judgement will be necessary in all cases to ensure the person's overall level of need is correctly determined and the appropriate decision is made. Nevertheless, those notes go on to provide strong guidance, at paragraphs 16-18, as to the excepted recommendations depending on the results generated by the tool, having assessed the level of need across 11 care domains, namely: behaviour, cognition, psychological & emotional needs, communication, mobility, nutrition (food and drink), continence, skin & tissue viability, breathing, drug therapies & medication (symptom control) and altered States of consciousness.

35. In ***R (Booker) v. NHS Oldham***[9] the Claimant was a ventilator dependent tetraplegic as a result of injuries sustained in a road accident in January 2001. The Claimant brought proceedings in respect of the road accident which were settled on terms in October 2009 that included an agreement by the defendant to those proceedings to make periodic payments starting from 15 December 2011 to enable the Claimant to fund privately the provision of her continuing health and social care needs. With knowledge of the terms of that order the PCT decided that it would not provide care for the Claimant beyond 1 October 2010 on the basis that she had no reasonable requirement for the provision of such care by reason of the terms in her settlement.

36. The Claimant sought judicial review of that decision. Judge Pelling QC sitting as a deputy Judge of the High Court held:

    (i) There is nothing within the ***National Framework*** that supports the conclusion that the PCT was entitled to refuse continuing healthcare provision on the basis adopted in this case (see paragraph 24).

    (ii) The PCT argued that the decision not to continue to provide care for the Claimant was not made by reference to her ability to pay but rather by reference to her decision to receive continuing care on a private basis. The PCT considered that it was entitled to draw a distinction between someone who has the means to pay for care privately and someone such as the Claimant who has recovered damages for personal injury. The Judge stated that the distinction was not as clear as maintained by the PCT and that it

9 [2010] EWHC 2593 (Admin)

did not form a sound basis for arriving at the conclusion that the PCT did (at paragraph 25).

(iii) In each case to refuse treatment by reference to the means of the patient would be contrary to the principle in section 1(3) of the NHSA 2006.

(iv) The "tortfeasor pays" principle had no application.

Statutory Bars to Healthcare Provision by Social Services Authorities

37. The next question is to ask whether, if the services to be provided do prima facie fall within one of the local authority's powers, the social services authority is nonetheless barred from providing them.

38. There are three statutory bars to the provision of care services by local authorities:

(i) First, section 21(8) of the NAA 1948 applies to the provision of accommodation under section 21(1) and services provided in connection with accommodation under section 21(5). Services in connection with accommodation can include nursing services (see *Coughlan* at paragraph 27(c)). Where those services are *authorised or required* to be provided under the NHS Act 2006 (or by or under any other enactment) the local authority cannot provide them.

(ii) Second, section 29(6) of the NAA 1948 applies to the making of arrangements under section 29(1) for promoting the welfare of adults who are blind, deaf, dumb, or suffer from mental disorder or are substantially and permanently handicapped by illness, injury or congenital deformity or other prescribed disabilities. Section 29(6) makes it unlawful for a local authority to provide accommodation or services pursuant to such arrangements where that accommodation or services are *required* to be provided under the NHS Act 2006 or to be provided by or under any other enactment; it is not sufficient that provision of the accommodation or services is merely authorised under the NHS Act 2006.

(iii) Third, section 49(1) of the Health and Social Care Act 2001 prohibits a local authority from providing, or arranging for any person to be provided with, nursing care by a registered nurse in connection with the provision of community care services. However, section 49(2) defines nursing care by a registered nurse so as to exclude services which, although provided by a registered nurse, do not need to be provided by a registered nurse, having regard to their nature and the circumstances in which they are provided.

39. The Secretary of State's duty under section 1(1) of the NHS Act 2006 is a target duty, not an absolute duty: to continue the promotion in England of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and in the prevention, diagnosis and treatment of illness. The Secretary of State's duties under section 3 are limited to providing a wide range of possible services to the extent he considers necessary to meet all reasonable requirements. A further potentially significant qualification is that under subsection 3(e), which provides that in relation to the care of persons suffering from illness and the after-care of persons who have suffered from illness, the Secretary of State is obliged to provide services other than those specified elsewhere in subsection 3 "*as he considers appropriate as part of the health service*".

40. The powers of the Secretary of State under the NHS Act 2006 are therefore very broad. The mere existence of a power to provide a particular service under that Act does not exclude the powers of a local authority under s. 21(8) or s. 29(6) of the NAA 1948; they are excluded only where the provision is authorised or required to be made under the NHSA 2006. In ***Coughlan*** Lord Woolf MR stated (in relation to the legislation in force at that time) (at paragraph 28):

> *"The powers of the local authority are not excluded* by *the existence of a power in NHSA 1977 to provide the service, but they are excluded where the provision is authorised or required to be made* under *NHSA 1977. The position is different in the case of 'any other enactment', where it is sufficient if there is an authority or requirement to be made* by or under *the enactment."*

41. The line of demarcation between services that can and those that cannot lawfully be provided by local authorities is therefore subject to change as the Secretary of State's policy towards the provision of services by the NHS changes.

42. As was pointed out by May LJ in the ***St Helens BC*** case, the Secretary of State's assessment (through guidance as applied by PCTs) of what services to provide under the NHSA 2006 will

determine (subject to challenge on public law grounds) whether the care needs are to be provided by the PCT or social services. To this extent, as May LJ further commented, "*the [NHSA 2006] is the dominant Act, and the decision under it is the determinative decision*".

43. Therefore, although these statutory bars are potentially far-reaching, it is important to recognise their limits. Thus where section 21(8) of the NAA 1948 applies, it only applies to bar a local authority from providing accommodation and services in connection with accommodation under section 21(1) and 21(5) of the NAA 1948. Likewise section 29(6) only bars a local authority from providing accommodation and services under section 29(1). These provisions do not prevent the local authority from providing other care to an individual under other community care powers such as section 254 and Schedule 20 of the NHSA 2006; nor do they exclude the local authority's duties to do so. So for example, any adaptations necessary to enable a person to live at home could be provided either by the NHS under the NHS Acts or by a local authority under section 29 NAA 1948 and section 2 of the CSPDA 1970, and (post *St Helens*) that a person qualifies for NHS continuing care would not displace the local authority's duty to provide such services if they are not met by the NHS.

44. In follows, that the fact that an individual is receiving some types of care from an NHS body does not mean that the local authority can assume that all types of care that are needed by that individual are being met or should be met by that NHS body.

45. For this reason, even where an individual receives care from an NHS body, that individual may nonetheless remain entitled to a community care assessment (for services provided by the local authority) under section 47(1) of the NHSCCA 1990. That duty is triggered by the mere appearance of need: ***R v Bristol City Council ex p Penfold***.[10] There will be circumstances in which the local authority is entitled to consider that all of an individual's needs will be or are required to be met by the NHS bodies but this should not be assumed.

Disputes between different local authorities

46. There have been a few recent cases which have examined the duties to provide community care provisions where there have been disputes between local authorities.

[10] (1998) 1 CCLR 315

47. In ***R(Buckinghamshire County Council) v Kingston***[11] the Court of Appeal held that a local authority, in moving a person whose care it had funded into supported housing in another local authority's area following an assessment under section 47 of the National Health Service and Community Care Act 1990 s.47 was not under any duty to consult the other local authority. Although health authorities and the secretary of state had a status in the process under s.47, no status was expressly conferred on local authorities in B's position. The Secretary of State had not given a direction under section 47(4) which affected a duty to consult Buckinghamshire and in guidance under section 47, he had not indicated that there should be such consultation. The Court of Appeal therefore held that there was no legal basis upon which to establish a duty of fairness to Buckinghamshire in the form of a duty to consult it when making a decision as to the placement.

48. Kingston had exercised powers in performance of a duty to the service user in accordance with a statutory procedure. Buckinghamshire's role, as potential payer for services, was incidental to that process. Kingston was not n a quasi-judicial position in relation to Buckinghamshire out of which a duty of fairness would arise. Fairness to the service user was central to decision-making. However, fairness to Buckinghamshire could arise only if performance of the duty to the service user required a duty to consult Buckinghamshire, and there was no basis to create such a duty. The Court of Appeal took the view that consultation would complicate the decision-making process: there would be a large potential for differences of view and for delay, and a real danger of satellite litigation between local authorities. If any duty was to be imposed it should be created and its scope defined by statute or in directions from the secretary of state.

49. The extent to which the right to be consulted could be implied into a statute was a matter of statutory construction. The issue would be whether the language used was inconsistent with the common law presumption that an administrative power conferred by Parliament would be exercised in a manner that was fair in all the circumstances as required by ***R v Secretary of State for the Home Department Ex p Doody***. [12] Absent the express exclusion of the right to be heard, it usually required strong language to justify the same right by implication. However, although an express duty to consult specified persons was not necessarily a complete bar to a wider duty, it would usually be a powerful starting point which was likely to trump all but the strongest contextual considerations pointing the other way. The starting point should be not

[11] [2011] EWCA Civ 457
[12] [1994] 1 AC 531

whether the statute limited the duty to what it permitted but whether the duty in the context of the statutory process required anything more. Nothing in the circumstances had required Buckinghamshire to be consulted.

50. Furthermore, in the ***Buckinghamshire*** case Wynne Williams J decided another issue concerning housing benefit which has considerable practical implications. When the claimant was moved into supported living accommodation, Kingston relied on the assertions about the complex housing benefit position from a manager where he previously resided: and Wynne Williams J found that Kingston had acted unlawfully by failing to take reasonable steps to inform itself of the true position in relation to housing benefit in line with the approach of Laws LJ in ***R (Khatun) v Newham LBC***.[13]

51. Another recent dispute between two local social services authorities was considered in ***Hertfordshire County Council v London Borough of Hammersmith and Fulham***.[14] Usually, no substantive relief was sought from the court other than a declaration designed to settle the legal position in the future. The main issue was the meaning of 'ordinary residence' for the purpose of s. 117 of the MHA 1983. In addition, the court also decided that an agreement between local authorities that one or other of them would be responsible for the after-care of a patient could not give rise to a legitimate expectation which would override the statutory responsibility of the appropriate local authority.

52. The Court was required to determine the allocation, as between social services authorities, of responsibility for meeting the care needs of a patient who was discharged into the community following a period of detention in hospital for mental health treatment. The local authority had issued judicial review proceedings seeking declaratory relief concerning the effect of s 24(5) of the National Assistance Act 1948 which deemed a person provided with residential accommodation to continue to be ordinarily resident in the area in which he was ordinarily resident immediately before the residential accommodation was provided for him, upon s 117 of the Mental Health Act 1983, which imposed a duty to provide aftercare for a discharged patient upon the local services authority for the area in which he was resident or to which he was sent on discharge. The local authority subsequently accepted responsibility for the community care user on the case but case proceeded because the issue was of more general importance.

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13 [2005] QB 37, para 35

14 (2011) BLGR 536

53. The Court of Appeal took the view that it was not easy to see why Parliament had not simply followed the precedent of the 1948 Act when enacting the duty under s.117. However, the 1948 Act precedent had to have been well-known to those involved in drafting the new bill, and the Court had to proceed on the basis that Parliament had deliberately chosen a different formula- so that, by implication, Parliament accepted the possibility of responsibility for patients changing over the period of detention, including the potential impact on continuity of patient care. The relationship of the two sets of provisions had been considered by the House of Lords in ***R (on the application of Stennett) v Manchester City Council***;[15] and the argument that s.117 was simply a "gateway" section opening the way to use of the powers under the 1948 Act had been rejected. The Court of Appeal therefore held that s 117 was intended to be a freestanding provision, not dependent on the 1948 Act.

Conclusions

54. A Report on Adult Social Care recently published by the Law Commission on 10 May 2011 (No. 326) and presented to Parliament noted that:

> *"The overwhelming message from consultation was that the arrangements for NHS continuing healthcare is an area that continues to be contentious between health and social care authorities and lacks transparency for service users. Most responses on this issue pointed to the need to introduce greater clarity to the inferface between health and social care, not least with regard to the limits of what local authorities are able to provide."*

The complexity of the legislative framework is especially regrettable in view of the importance of community care to those individuals whom it affects.

17 October 2011

[15] [2002] 2 AC 1127