In the case of *ITW v Z* [2009] EWHC 2525 (Fam), Munby J (as he then was) gave the following guidance with regard to the different considerations listed in section 4 which the decision-maker must have in mind:[8]

> i. *The first is that the statute lays down no hierarchy as between the various factors ... beyond the overarching principle that what is determinative is the judicial evaluation of what is in P's "best interests".*
>
> ii. *The second is that the weight to be attached to the various factors will, inevitably, differ depending upon the individual circumstances of the particular case. A feature or factor which in one case may carry great, possibly even preponderant, weight may in another, superficially similar, case carry much less, or even very little, weight.*
>
> ***iii.*** *The third, following on from the others, is that there may, in the particular case, be one or more features or factors which, as Thorpe LJ has frequently put it, are of "magnetic importance" in influencing or even determining the outcome.*

The fact that the individual's past and present wishes, feelings, beliefs and values must be considered tells us that this is not a sterile objective test of best interests. It is not a case of trying to determine what some hypothetical objective or rational person would decide in this situation when presented with these choices. Nor are we seeking to do nothing more sophisticated than impose on the individual an objective and rational analysis based on professional expertise of what they ought sensibly to do in that situation.

The law requires objective analysis of a subject not an object. The incapacitated person is the subject. Therefore, it is *their* welfare in the context of *their* wishes, feelings, beliefs and values that is important. This is the principle of beneficence which asserts an obligation to help others further their important and legitimate interests, not one's own.[9] In this important sense, the judge no less than the public authorities is AM's servant, not his master.

That this is so is emphasised by Lady Hale in the *Aintree* case:[10]

> *45. Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should*

8 *ITW v Z* [2009] EWHC 2525 (Fam), per Munby J, at para. 32.

9 *Westminster City Council v Sykes* [2014] EWHC B9 (COP) (24 February 2014), at §10.

Aintree University Hospitals NHS Foundation Trust (Respondent) v James (Appellant) [2013] UKSC 67 at para. 45.

accompany AM should the necessary adaptations be carried out. Similarly, the nursing home would be willing to provide a carer to facilitate this (I/43).

- Dr AJ (the GP at X Nursing Home) states that the collective decision of the multidisciplinary team is that AM requires this present level of care in a structured multidisciplinary environment. It is unlikely that this level of care can be safely delivered in the community. In the past, care in the community did not work and placed him at risk.[18] 'Subsequent opinions from a range of hospital specialists have maintained that AM's needs can only be met in a good long-term care unit that is able to cater to his complex medical and care needs.' (I/42).

- At X Nursing Home, AM has access to 24 hour nursing care and active medical management. Any significant clinical concern is assessed by a specialist nurse, and during office hours (9am – 5pm Monday to Friday) a referral can be made to the on-site GP service, which enables a response straight away. Overnight, and at weekends, the on-call GP service is called by the nurse and a GP is expected to be on site within one hour if required to attend. (The oral evidence of AG and HH was that this is not always the case.)

It can be seen that AM has very significant disabilities, requires substantial support, and benefits from a very good package of care, treatment and family contact.[19]

This is highly relevant. AM's case is not of the kind that I see all too frequently, that of an older person having to endure minimum standards of care, and little in the way of social stimulation, in a care home far away from family and home. If I give up AM's place at X Nursing Home, I am giving up something of real benefit to him — Something that only by chance will be available to him again should home care break down.

With regard to this risk, I should make two observations. Firstly, the CCG can or will only keep his place at X Nursing Home open for 14 days if he goes home.[20] Secondly, for this reason, and because ECCG is unwilling to incur the costs of adapting the family home and training family carers for a trial at home, to establish if home treatment and care is viable, a trial at home is not an option available to me.

If a three-month trial at home were an option then it is likely to have been my preferred option. Without that option, if I discharge AM and matters go awry after 14 days, he stands

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18 I was referred to events and reports from many years ago, for example, a failed attempt to discharge AM home in December 2008. This resulted in a hospital admission and then discharge to a care centre, rather than back home. The situation is very different now. The family and CCG have devised a thoughtful and considered home care package, the level of conflict is greatly reduced, and some of the proposed family carers were children at that time. I have assessed their case on how matters presently stand, and do not find that the circumstances in 2008 and 2019 are sufficiently similar to significantly assist me.

19 The ward on which AM is a resident was subject to a safeguarding report and inquiry shortly prior to the hearing in November 2019. However, having regard to the evidence that I received and X Nursing Home's CQC report, I am satisfied that care and treatment AM receives there is very good, and that the general service provided is good.

20 I asked IR whether ECCG might reconsider for how long it could keep open AM's bed at X Nursing Home, and for its position to be confirmed at a higher level. The CCG later confirmed its position: Although 14 days is necessarily a somewhat arbitrary figure, it believes that it should not offer longer, having regard to its budget and reasons of equity (the need to be fair to other local patients with a claim on its budget).

to lose a lot:[21] a place at a nursing home with a national reputation, within a short drive from home, which provides him with good quality care and treatment, staff who know his needs, family visits daily for 8-9 hours, and the possibility of visits to his Mosque and the family home.

His wife's answer to this observation was, in part, that she cannot go on as she has been. If her application is refused, she is too worn out by many years of driving and caring for AM to be able to continue to visit him at X Nursing Home, or at any rate to do so regularly (see e.g., G/295-G/304). It is not the case therefore that her husband will have the benefit of her presence and care for much of the day regardless of the outcome. Her absence will not only cause him distress. It will adversely affect the quality of his care at X Nursing Home. Staff rely on her to perform oral care and other tasks, and her presence means that his behaviour is less oppositional. Nor, if he remains at X Nursing Home, is it possible (or, at any rate, likely) that he can also have the benefit of enjoying time at the family home and his local Mosque. His sitting tolerance and the journey time make visits to his local Mosque impractical, and a Disabled Facilities Grant will not be available to fund adaptations to the family home if he is not residing there.

I have given considerable weight to AG's evidence, and I greatly admire all that she has done to support her husband. Her contribution to his care and well-being is particularly significant. Her presence makes him calmer.[22] She does sometime pick up on things that other people, including his children and care assistants, do not notice. She has a good record of appreciating when he is unwell or is not behaving normally; she will ask him questions, and he will respond either verbally or with gestures, pointing to an area of his body. She has demonstrated an understanding of knowing when to call the GP, for example in August 2018, which led to AM being prescribed antibiotics and then being admitted to hospital (see I/47–48; K/190).[23] She also assists staff with communication. For example, the daily record sheet on 21 September 2017 records that AM's 'wife reported that AM also requests for feet to be elevated' (K/15).

Fulfilling a caring role in the conscientious way that AG has been doing over many years is exhausting, and a 30-45 minute drive to the nursing home in urban traffic adds to the strain. I hesitate to turn her own virtue against her. However, it is because of her unwavering devotion and commitment over so many years that I find it implausible that she will cease to visit AM if the court refuses her application, or visit only occasionally. I accept that she is suffering from long-term fatigue and that her own health may well have suffered. I am her husband's decision-maker and, if he realised the strain she is under, he would no doubt want me to give weight to her comfort. I have therefore factored into my decision the fact that caring for him at home will spare her the daily drives, be better for health and add to her happiness.

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[21] Ms TR considered that any deterioration in AM's health would be likely to result in admission to an acute hospital, whilst a breakdown in the care package would necessitate admission to a different nursing home, unless it were to occur within the first two weeks.

[22] DL, the Head of Service at X Nursing Home, stated that, 'The RN agrees that AM is calmer when his wife talks to him in his first language, Somali' (G/305).

[23] As concerns the care provided to AM in August 2018, when he was admitted to hospital with a chest infection, Ms TR could find no evidence of a lack of care, commenting that medical, nursing, therapy and care input had been appropriately delivered and recorded. She was, though, critical of the fact that a hyoscine patch had not been appropriately administered during this period, which would have contributed to AM's oral secretions.

On balance of the evidence, I find that AM's sitting tolerance has improved and that visits to his local Mosque are now likely to be possible. As to the possibility of visits home, it was not established that the £11,000 cost of adaptations to the family home cannot be funded. If an application for a Disabled Facilities Grant is refused, this still leaves open the possibility of obtaining funding under other legislative schemes, such as the Chronically Sick and Disabled Persons Act 1970. In my view, home visits ought to be a key part of any care and treatment package at X Nursing Home.

Available Home Care Package

The CCG is willing to fund a care package at home. However, given its finite resources, the following was the most that could or would be funded:

- Four care visits per day, carried out by two carers each visit;

- One overnight waking carer, 'to observe that AM's position in bed remained optimised to mitigate the risk of aspiration of his overnight feed via PEG tube' (see G/344);

- Once daily district nurse visits, in order to give insulin and to monitor blood sugars.

- As to who would actually provide the paid care:

  - Local community nurses, combined with a Clinical Nurse Specialist provided through the community dietician service, would be able to manage AM's basic needs relating to the PEG feeding tube system and his insulin management:

    'NHS Community Nursing would be able to provide daily administration of subcutaneous insulin injections, reading of blood glucose levels and providing response to concerns raised by family members and care provider staff regarding skin integrity' (G/348).

    '[The] NHS Community Dietician service … provide telephone contact within 5 working days of receipt of a fully completed written referral to check there are no immediate concerns following discharge and will provide a Dietician home visit within 2 weeks. Once AM is set up and has a stable regime, Dietician follow up AM face to face every 6 months with telephone calls in between. AM's weight and Body Mass Index would be monitored every 6 months most likely by taking a mid-arm circumferential measurement as his safety would not be able to be maintained in a standard weigh chair. // The service provides a Clinical Nurse Specialist who is able to train family members and care provider staff on how to look after the gastrostomy tube, stoma site and administer feeds. The Nurse is able to change the balloon gastrostomy tube when it is due for changing and the Dietician will ensure that spare consumables are available at home' (G/348).

    'Any deterioration in his condition would require referral to the GP for assessment and to initiate treatment or therapy management options' (G/344).

— A care agency called CM had visited AM to assess him. It reported that they would be able to care for him with a team of six carers who had the required competencies. Furthermore, their insurance would not prevent them from being able to work with trained and competent family members.

- The remainder of the personal care at home would need to be provided by family carers. They had agreed a family care rota to provide the additional care which AM needs that the NHS cannot fund. The original rota is at G/473. At the time it was written, it was likely that AG would require knee surgery and be out of action for several weeks. The rota is carefully thought out and comprises three weekly alternatives: a rota for when AG is fit to provide day and night care; a rota for when AG is fit to provide day care but not night care; a rota for when AG is unfit to provide any care. In the event, AG underwent a right total knee replacement on 19 August 2019. In my view, by the time the hearing resumed in November 2019, the general concerns which the Third Respondent raised at the hearing in April 2019 — that AG's own health might prevent her from being a carer or from performing some of the care tasks required of her — were not supported by the evidence (see the OT assessment and the letter from her Consultant Orthopaedic Surgeon, at G/496).

- The competencies which paid and unpaid carers will require were assessed and set out by IR on behalf of ECCG at para. 5 of his statement of 31 January 2019 (G/344-G/345). They include matters such as manual handling, positioning requirements, correct use of equipment to ensure AM's safety, personal care, PEG and water system operation, respiratory management, communication strategies, social activities and stimulation, and the identification of when to alert clinical services as required. All of the proposed family carers were willing to undergo necessary training and accepted the need to meet the required competencies. The CCG told me that it would support them in accessing the appropriate training. Evidence of completion would be required prior to discharge. Many of the required competencies are considered valid for one year only and therefore refresher training will be necessary (G/345).

- I have no concerns about the suitability of the proposed family carers. AG has been providing care to her husband at X Nursing Home over many years. AM's sister works as a paid carer for a care agency, and she already spends 2-3 days at X Nursing Home caring for her only brother. AG's and AM's daughter HH was previously co-President of her university student union, and impressed me by her willingness to make considerable personal sacrifices to look after her father. MH2 runs a tutoring company and, as a diabetic himself for 20 years, has a particularly good understanding of that area. HAM is a qualified optician. All of the children can assist AG with translation and interpretation. As to the required competencies, they are able to understand and implement some quite technical requirements.

- Given their commitment and skills, and the careful way in which they have devised a home care package, I do not share TR's reservations about the sustainability of a home care package. Nor do I believe that they have under-estimated the level of care and expertise required to continually care for someone with AM's needs (I/49-I/50). They have been providing a great deal of care for many years already, are highly intelligent and have a very good understanding of what is required. They consider that it is their duty, and an honour, to care for AM within the family home. Their devotion and commitment to him, and their willingness to give up their time and comfort, and in one case their job, to care for him is admirable.

- The local authority's Adaptations Team considered that it was reasonably straightforward to adapt the family home to suit AM's needs (see the statement and plans at I/9-I/12). The necessary work could be completed within around six weeks of approval by the relevant housing department, and the preliminary view was that the proposed adaptations would probably be approved. TR, the independent nursing expert, also considered that the proposed adaptations would be appropriate and provide adequate accommodation. However, the accommodation would be 'cramped' and carers could be hampered in their delivery of care. She raised a concern that AM's dignity could be compromised during transfers to the bathroom, but I think it likely that overall being cared for in his own home, with his wife or a family member present, will be a more dignified experience for him.

Looking at this package, it can be seen that the family have worked thoughtfully and assiduously to construct a viable alternative to X Nursing Home. Equally, ECCG and the relevant local authority have put in a lot of hard work to assist the family with their endeavour. That is particularly commendable given their limited resources and the fact that they believe that remaining at X Nursing Home is in AM's best interests.

There is much that can be said in favour of AG's application. AM wishes to live at home with his wife and family, and therefore my starting point is to try to enable him to live the life he wishes if it is feasible: the underlying purpose of the Act is that it is an enabling Act. He is fortunate in having a devoted wife and family. The family home can be adapted to suit his needs. The CCG have constructed a care package which, taken with the family care rota, meets his day-to-day care requirements. Furthermore, although the package is not equivalent to what is provided at, or readily-available, on-site at X Nursing Home, it is nevertheless a significant package of care.[24]

I agree with much of TR's balance sheet (I/33-I/35) but not with all of her assessment of the burdens of home care. The family carers are competent, devoted and willing to undergo training; it is inevitable that assuming a care role comes at a cost; on the evidence I believe that the pool of carers is sufficient; I do not agree without more evidence that the fact that AM has not been home since 2009 is likely to be a significant problem; the family home can be adapted and 'made fit for purpose' quite easily; the family carers are sufficiently experienced and committed that I find it is more likely than not that they can sustain their care roles; a suitable domiciliary care provider appears to have been identified; and I believe that regular visits to AM by MH can be managed by the court if necessary. The burden that I agree with is that, 'AM will not have immediate access to the Primary Care Services i.e. GP, Community nurses and therapists.' This, it seems to me, is the fundamental difficulty.

Despite the fact that AG's application and care package has many positives, there are difficulties. There is a past history of conflict; the service provided will be reactive rather than active in many areas; and the issue of GP and medical input has still to be considered.

A past history of conflict

[24] ECCG has recently 'reprocured' its adult community, nursing, dietician and therapy services, which resulted in a new NHS provider taking over the delivery of the contract (G/349). Given AM's vulnerability and need for support, I have borne in mind that there is always a risk that some services may not remain available to AM, and also that the current configuration of local services may change, for better or worse.

I am mindful that the Third Respondent, MH, says that his family life with his father will be negatively affected by a return to the family home. He says that AM's residence at X Nursing Home ensures both that his health and care needs are well managed and that he is able to spend time with all of his family, who are all kept aware of his wellbeing.

The Court of Protection bundle for the original proceedings contains significant evidence of conflict between AG and proposed family carers, on the one hand, and professional carers and the Third Respondent on the other. In my opinion, the Third Respondent was unfairly and unjustly treated. Most of the criticism of professionals was also unfair and damaging to AM's interests. The picture is a familiar one for a Court of Protection judge, of tension and conflict between distressed step-relations with different perspectives, and of conflict between a distressed family and professional services that spiralled completely out of control.

The picture is different now. The oral evidence of AG and the proposed family carers was measured and fair. All of them reiterated that they understand the need to work co-operatively with medical staff and professionals. They also emphasised that the Third Respondent would be welcome to visit his father at the family home. I believe that their offer is sincere, and a genuine attempt to move forward in a more collaborative way. The history of past conflict does make it inevitable that, at least initially, there would be a certain tension or awkwardness in the air during such visits, which the Third Respondent does not have to endure when he sees his father at X Nursing Home. However, I do not think that this in itself would justify denying his father the opportunity to live in his own home if his needs can be met there and the risks can be adequately managed. The family carers would have a considerable incentive to avoid MH's visits breaking down and the matter coming back to court. Furthermore, if it ever became necessary, the court could facilitate visits by way of a visiting schedule and/or undertakings or orders concerning the behaviour of family members who are not carers, such as AG's son GH. I would be fairly confident that the court could deal with any difficulties.

Medical and GP input

This is, I believe, the critical issue. The Official Solicitor submitted, and I agree, that the evidence establishes that the proposed care package at home comes with risks but is potentially viable save for the issue of the medical input that AM requires.

It was the Official Solicitor's submission that the concerns about the quality of the clinical and medical care which can be provided in the community, and the consequential health risks, are so significant in the balancing exercise that they amount to the 'magnetic factor' in the overall determination.

Having reviewed AM's records, Ms TR told me that there is very little day-to-day GP input at X Nursing Home when he is well. However, when he is unwell and needs medical input, he tends to need it quickly. He will then be visited daily at X Nursing Home, which (she says) is more often than is likely to be available from a GP practice at the family home.

In the original proceedings, no general practitioner was willing to provide GP services to AM should he be discharged home.

A letter from local GP Dr VT dated 25 September 2013 (G/431) states:

> *'I have reviewed the details provided and based on my opinion and experience on managing brain injury patients … I believe this gentleman will require enhanced medical and nursing support to be able to remain at his home address. He will most likely require daily nursing intervention and I suspect anything up to three times a week medical review and intervention … I believe it would be very unlikely that a Primary Care Surgery would be able to provide this service without enhanced provisions and capacity.'*

There is then a letter from local GP Dr ML (G/53-G/54), undated but written in 2014. Dr ML visited AM on 24 April 2014, and his letter has that extra weight. He reported:

> *'It is my opinion after my visit that our practice will definitely not be able to give an adequate level of support to this patient in a home environment. Indeed, I feel that he needs to be in an environment with 24 hour nursing care and a home discharge would be dangerous and potentially disastrous ….*
>
> *I also understand that AM is prone to getting frequent chest infection and silent aspirations which do not present with the normal symptoms, and he tends to deteriorate very quickly. It requires skilled medical staff, who know him well, to identify early signs and initiate early treatment to prevent him getting very ill. I am afraid that primary care and GPs are simply not able to give that level of care and supervision at home, and again I think it is imperative that he remains in some kind of facility with 24 hour nursing input.'*

By the time the previous proceedings concluded, it had not been possible to secure GP services for AM at home, despite the involvement of NHS England.

The carefully constructed home care package which the family and CCG have put together in the current proceedings was not a feature of the earlier proceedings. There are also other reasons to be more positive now, for example much reduced conflict. However, as will be seen, it remains the case that no local GP considers that they are able to provide AM with sufficient medical input at home.

If AM does return home, the service provided to him by whichever GP practice he is registered with would be provided in accordance with the GP's contractual requirements.

It is important to note that the CCG 'do not expect GPs to provide active management home visits for patients in the community' (G/347). They provide reactive care. IR deals with this distinction at paragraphs 8 and 11 of his statement of 31 January 2019 (G/346-G/347):

> *'8. At [X Nursing Home], AM has access to 24 hour nursing care and active medical management … any deterioration results in … prompt access to medical treatment and therapy. The optimisation of AM's health and care needs has resulted in stabilisation of his well-being and fewer hospitalisations. At [X Nursing Home] any significant clinical concern is assessed by a specialist nurse who is part of a 24 hours per day service. A referral will be made to the unit's dedicated on-site GP service which is available Monday to Friday from 0900hrs to 1700hrs enabling response straight away. Out of hours and on weekends the on-call GP service is called by the nurse and expected to be onsite within one hour if they are required to attend … the ward has 24 hours a day, seven days a week nursing presence … A SALT [Speech and Language Therapist] and two physiotherapists are allocated to the unit Monday to Friday 0900 to 1700hrs who are able to see AM straight away for urgent swallow and chest*

> *physiotherapy. A Dietician reviews AM monthly, or as required to monitor and adjust his nutritional intake ….*
>
> *11. The CCG's position is that reactive GP care would be adequate but sub-optimal compared to level of service he currently has access to at X Nursing Home. The CCG has concerns that the services available in the community are unable to respond in the rapid manner he is currently able to access. At X Nursing Home his ability to access early assessment and treatment has helped mitigate escalation of medical deteriorations when they occur, enabling him to remain where he is familiar by limiting the need for hospital admissions. His poorly controlled blood pressure and blood glucose levels have now been optimised with this level of medical input. In the community, if unable to access GP or other community services for assessment and treatment, AM would need to attend hospital to meet his needs. The current GP service at X Nursing Home is experienced at working with patients such as AM due to their relationship with the unit.'*

Most of AM's contact with carers is with paid care assistants and family carers and this will not change if he goes home. However, it is obviously a benefit for AM that at present there is an on-site GP service between 9am and 5pm, that out-of-hours a GP is expected to be on-site within one hour, and that X Nursing Home has a nursing presence 24 hours a day. This, I am told, has facilitated early assessment and treatment and avoided an escalation of medical deteriorations, which in turn has reduced the number of hospital attendances and/or admissions.

It is significant that it is not just local GP services that are reactive rather than active:

- The time of NHS Community Nursing home visit can only be approximated reflecting the daily fluctuations in demands on the NHS Community Nursing service.

- The NHS Community Dietician service is a Monday to Friday service. The Clinical Nurse Specialist is able to respond to urgent issues within 2 working days. If for any reason the nurse cannot make it to the visit or it is outside working hours, the patient would need to go to hospital.

- The NHS Community Speech and Language Therapy (SALT) service requires referral from a GP or Clinician. They respond to urgent referrals within three days or alternatively within six weeks as standard. The service is not able to provide on-going monitoring and maintenance therapy once the reason for referral has been resolved or stabilised.

- The NHS Community Physiotherapy service will respond to urgent referrals within three days or alternatively within six weeks as standard. The service is not able to provide on-going monitoring and maintenance therapy once the reason for referral has been resolved or stabilised.

Most of the relevant therapies — such as physiotherapy, speech and language, and dietician input — will be reactive only once the home care package is established. There would be a delay of 2-5 working days in obtaining face-to-face assessment and input in most instances. In contrast, at X Nursing Home, a speech and language therapist and two physiotherapists are allocated to AM's unit between 9am and 5pm on weekdays.

The response of GP practices contacted in the current proceedings

The GP practice initially contacted on AM's behalf was that nominated by AG, namely C Rd GP Surgery. IR told me that it is open from 8am to 6.30pm from Monday to Friday. It provides a home visit service in between the morning and afternoon clinics when GP capacity allows; this would have to be requested first thing in the morning. If there is no GP capacity on the day, a GP would attend the following day. The practice nurses are not able to make home visits. Out of hours, the NHS 111 telephone service would have to be used. If a blood sample is required for diagnostic purposes this could be undertaken through the domiciliary phlebotomy service on a Thursday. There is a 2-3 week wait for domiciliary phlebotomy.

What this seems to mean is that if a GP cannot visit in the middle of the day (between the morning and afternoon surgeries) or AM needs immediate medical evaluation or attention outside this window, the gap will need to be filled by NHS 111, the local Rapid Response Service and, where necessary, an ambulance to A&E.

The local Rapid Response Service (RSS) is part of the local Home Ward service. It requires a telephone referral from the ambulance service, a GP or from members of a patient's primary care team after discussion with the GP, e.g. district nurses. It is an urgent service and would not be an integral part of AM's care package. It can be contacted between 8am and 10pm daily. This multi-disciplinary team is composed of consultants, doctors, advanced nurse practitioners, nurses, an occupational therapist, a physiotherapist and rehabilitation support workers. There is no defined limit on how often the service can be used. However, IR said that the frequency with which it is used could indicate that a home care package is insufficient to meet the patient's needs.

The service provided by the Rapid Response Service is described at G/501. Following referral a member of the team will triage the patient. In practice, it is most likely to be a nurse or an 'associate healthcare professional' who is sent out (oral evidence of IR).

Broadly speaking, the triaged patients are then dealt with in one of three ways:

- Some patients will be suitable for the 'Home Ward' service. The Rapid Response Service's admissions guidelines state that the 'Home Ward' service 'aims to avoid admissions into local hospital and facilitates the safe treatment of patients in their own home, for example in cases of, *inter alia*, 'simple' chest infection; exacerbation of COPD/shortness of breath with 'observations stable'; falls/reduced mobility; hyperglycaemia ('no ketones/not unwell').
- At the other end of the scale, the suggested outcome is usually that the patient should be taken to Accident & Emergency (A&E). The admissions guidelines give as examples the following types of medical condition: acute dysphagia/swallowing disturbance, acute eye disturbance, chest pain, choking, new altered level of consciousness, seizures, suspected new CVA. IV antibiotics can, however, be dealt with by the district nursing service.
- In the middle are an intermediate range of medical conditions which 'may warrant discussion with doctor to consider the safest and most appropriate alternative service'. These cases do not fit so easily into the Home Care or A&E paths, and the triage outcome turns on a careful weighing up of all the signs, symptoms and options. In some of these cases, 'if the suggested alternative service does not have capacity and the next option is to refer to A&E, we should consider whether we can safely manage the patient in the short term to avoid an acute admission'. Examples of medical conditions that may come within this intermediate band are blood tests

in the context of acute care, delirium, acute/chronic lower back pain, 'primary PEG issue', 'primary problem – wound care/blocked/bypassing catheter'. The outcome options include District Nurse service, A&E, palliative care service, domiciliary phlebotomy, Home Ward, GP service and hospital.

Unfortunately, C Road GP Surgery declined to register AM. The surgery stated that it is a 'smaller' practice and there are more suitable larger practices closer to the applicant's home. Furthermore, 'it would be a safeguarding issue for a patient with AM's needs to be managed in the community' (G/344). An email was received by IR from Dr F at C Road Surgery during the April hearing, which was admitted into evidence as 'Exhibit 2'. In that email, Dr F set out his reasoning for strongly recommending that AM should not be registered with his surgery. His reasons included that AM requires a doctor and team with specialised skills

> *'which is over and above what we could provide and is not covered by our GMS [General Medical Services] contract with NHS England;*[25] *the input needed from a GP practice contractual arrangements do not cover a practice for the amount of input that a patient with AM's needs should receive and these types of patients are normally cared for under separate enhanced contractual arrangements … Registering a patient like this in an unplanned way and assuming a practice could cope, would potentially put staff and other patients at risk due to the disproportionate amount of time needed by such a complex patient.'*

According to Dr F, caring for AM at home would put him 'at massive risk of hospital admissions, re-admissions and rapid deterioration in his health due to the nature and relatively slow response of primary care to urgent issues'. He went on (J/33):

> *'Registering him with a GP practice …. amounts to willingly harming his health and the first thing a GP team would do upon being faced with such a patient would be to admit him to hospital again and seek placement for him in a nursing home as a matter of urgency.'*

The CCG told me that under contractual arrangements it would compel C Road GP Surgery or another surgery to register AM if the court ordered that AM should return to live at home with his wife.

In oral evidence, IR stated that no patient would or should be admitted to hospital unless there was a clinical need. He disagreed with Dr F's view that there would be a 'massive' risk of hospital admissions, and described that as 'an exaggeration'. A move home, and registration with a GP surgery, would be 'moving from a proactive to a reactive service'. The

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[25] General medical services (GMS) contracts deliver core medical services and are agreed nationally. The funding for these types of contract is calculated based on the practice's registered list size with a fixed, nationally agreed, price per patient, and the actual amount paid is calculated practice-by-practice. Patients such as AM are likely to require significantly more care from their GP than the standard nationally agreed price per patient. Enhanced Services (ES) require enhanced service provision over and above what is included under core GMS contract funding. They are commissioned nationally through the GP contract. ECCG provides local enhanced GP services to all but three of 41 local nursing homes through the A GP Surgery, in order to prevent unnecessary hospital admissions. When I asked IR whether ECCG might allow AM to receive an enhanced service at home from A GP Surgery, he told me that it could be done 'in law but we don't do it. It would not be equitable to do it for one patient'. I asked for that position to be confirmed at a higher level, and the CCG's position was confirmed after lunch on the third hearing day.

CCG considered that reactive care would be 'adequate but sub-optimal' compared with the care which AM receives at X Nursing Home. The CCG was concerned that community services would be unable to respond in the same rapid way as at present, which has limited AM's need for hospital admissions.

I agree with IR with regard to Dr F's evidence. IR's assessment and language was measured in a way that Dr F's was not, and was based on a careful and thoughtful balancing of the relevant factors. I find that Dr F's stated view was exaggerated. To my mind, the use of phrases such as 'willingly harming his health', and the suggestion that a GP would simply have AM readmitted to hospital if he was discharged from X Nursing Home, cannot be supported. The weight I give his evidence is that he is another GP who strongly believes that AM should remain at X Nursing Home.

Because the problem of GP and medical support at home could not be resolved adequately at the hearing in April 2019, further evidence was filed about other local GP practices with whom AM might potentially be registered (G/461-G/464).

The CCG contacted B Road Surgery, the closest GP practice to AG's home. It responded that it was 'not willing to register' or 'would prefer not to register' AM as a patient. Having reviewed the report of Dr AJ, it was their opinion that it is not possible safely to provide, in the community, the level of medical input that AM requires. Their view was expressed in measured tones.

AG then asked that EP Health Centre be approached and the CCG contacted it. The response was similarly negative. The partners had reviewed AM's case. They felt that his needs would be 'extremely difficult to meet in primary care'. Furthermore, it would be better if he was registered at the same practice as the rest of the family. However, as the practice could not refuse to register a patient within their catchment area, if a request was made that AM be registered with them, they 'would have no option but to accept'.

Unfortunately, the position therefore is that no GP practice has at any stage in the two sets of proceedings been willing to provide community medical support for a home care package. I find that there is an economic factor, as well as a safety factor, in this. To my mind, Dr F's email and Dr VT's letter make this clear. No doubt a GP would be professional and do all that is professionally required of them under their general GMS contract. The problem is that they might not be willing to continue to do, or be in a position to do, more than is professionally required of them under the contract; and their common evidence is that that is insufficient. I understand their point that enhanced services are required.

A suggestion that the family might wish to investigate whether supplementary GP support could be available from a medical practitioner within the local Muslim community, perhaps as a religious obligation, was not practical. Although in theory it might fill some service gaps, such a GP would not have access, or sufficient access, to NHS GP notes, and there might be problems of insurance, working or liaising with NHS community nurses, and so forth.

Given this situation and the current configuration of local NHS services, what then would be the likely consequences ('risks') for AM of receiving home treatment and care if the medical input is provided by a local GP under a GMS contract?

Dr ML referred to the fact that AM is prone to getting frequent chest infections and silent aspirations which do not present with the normal symptoms, and that he tends to deteriorate very quickly. It requires skilled medical staff, who know him well, to identify

early signs and initiate early treatment to prevent him getting very ill. Consistent with this, IR states that the additional medical risks include increased vulnerability to a deterioration in his health and increased risk of hospital admissions ('almost inevitable'), of more severe illness and of premature death (G/347-G/350):

> *'12 … The likely consequences of community GP, nursing and therapy services being unable to meet his needs in a timely manner include:*
>
> - *AM will be more vulnerable to deterioration in his health and increase his risk of premature death.*
> - *AM will be at increased risk of requiring hospital to access assessment and treatment.*
> - *Delays identifying deteriorating health conditions may result in a more severe form of illness each time. Non-clinical care staff and family are providing 24 hour care, their scope of practice does not require them to have the assessment skills of a trained nurse who are currently accessible 24 hours per day. Community nurses would attend once per day and AM may need to wait 72 hours if over the weekend to see a GP.*
> - *The medical management available in the community is sub-optimal compared to the current team of GPs, nurses, therapists and care staff with a special interest and skills training in his areas of need.*
> - *Reduced consistency of staff availability and frequency of visits in community. There would be a reliance on the family to be able to communicate what is of concern for AM who is unable to communicate for himself.*
> - *Increased stress on family members when/if he becomes unwell to co-ordinate all the service providers involved in his care.*
>
> *14.1 The CCG believe that with the medical supervision and access to the community services available, management of AM's health and wellbeing needs would be sub-optimal. His risk of frequent hospital admissions would be increased as would his potential for a premature death as compared to if he were to remain in a 24 hour nursing care environment. The level of care and safety that he is able to access in a 24 hour nursing care environment cannot be replicated in the community.*
>
> *14.2 In the community, GP services available are reactive, all treatment and therapy as a result of GP assessment would require GP referral and may take 3 days for face to face service initiation.*
>
> *14.3 The CCG believe, that the increased risk of delays in accessing services in the community would require more hospital admissions than he has required while at X Nursing Home.*
>
> *14.4 AM would need to admitted to hospital to access the nursing, medical management and therapy he is able to receive currently in house at X Nursing Home.*

> *14.6 AM's situation at home would result in significant risks being sub-optimally managed leading almost inevitably to increased admissions to hospital.*
>
> *14.9 If AM is discharged from X Nursing Home, he is most unlikely to be readmitted there, given the high demand for places and lengthy waiting list.*

Some of these risks may not materialise. However, they are sufficiently serious that they can properly be categorised as risks connected with AM's safety, because they include increased 'vulnerability' to a deterioration in AM's health and increased risk of hospital admissions ('almost inevitable'), of more severe illness and of premature death.

Conclusions

A trial is not needed if one can be reasonably sure of the outcome. It is sensible to test an alternative that may or may not be viable before 'burning one's bridges'. That is not possible here and I must choose.

On balance, I do not believe that currently it is in AM's best interests to be discharged home under the proposed package of treatment and care.

There is much to be said in favour of AG's application. Home has very significant benefits in terms of the warmth and personal care his family provide, cultural familiarity and customs, and visits from friends and neighbours. The valuable contribution which his family now make to his care would be enhanced because a family member would be present to interpret and attend to his needs all the time. His home can be adapted, and the CCG has constructed a care package which, taken with the family care rota, meets his day-to-day care requirements. Although it is not equivalent to what is provided at, or readily-available, on-site at X Nursing Home, it is nevertheless a significant package of care.

I agree with the Official Solicitor that the proposed care package at home comes with risks but is potentially viable save for the issue of the medical input that AM requires.

At present most of AM's contact with carers is with paid care assistants and family carers, rather than with GPs and nurses, and this will not change if he goes home. However, it is a considerable benefit for him that at present there is an on-site GP service between 9am and 5pm, that out-of-hours a GP is expected to be on-site within one hour, and that X Nursing Home has qualified nurses on-site 24 hours a day. This has facilitated early assessment and treatment and avoided an escalation of medical deteriorations, which in turn has reduced the number of hospital attendances and/or admissions. His ward also has a speech and language therapist and two physiotherapists allocated to it on weekdays.

The services provided by AM's local NHS are mainly reactive rather than active.

The CCG has declined to provide AM with enhanced GP services and therefore his medical input will be provided by a GP under a General Medical Services contract.

Under a GMS contract, that GP will not be required to provide more than reactive care. For example, the expectation is that the GP will visit between morning and afternoon surgeries if capacity allows.

The likely consequences for AM of this reduced medical input indicate the appropriate weight which I should attach to this risk: some delays in being assessed and treated (i.e. from time to time, a prolongation of suffering when ill), an increase in the number of

hospital admissions and an increased risk of premature death (compared with how long he would be likely to live at X Nursing Home).

AG has not been able to find a GP who is willing to try to support her husband at home, nor has the court received evidence from a medical practitioner in support of home treatment. As a judge, I am bound to accept the evidential position.

While I accept that most often AG will quickly identify changes in her husband's presentation, and request professional help, it does not follow that the NHS will be able to respond quickly, or be able to offer an alternative to taking him to hospital.

No local GP practice has wished to register AM. The strong resistance of local GPs to assuming responsibility and a caring role for AM has weighed heavily with me, and been decisive.

Someone with AM's complicated needs requires maximum effort and commitment from all involved in providing home care for it to have a chance of success. I cannot rely on the GP who is forced to register AM being able or willing to do more than is required under their general contract.

It is a considerable negative that AM would be the responsibility of a practice that does not wish to receive him as a patient, one that believes that his needs are greater than it can fulfil under its contractual obligations.

AM's medical condition is complicated, he can deteriorate quickly and some signs and symptoms may be difficult to recognise. Given that he will not always have prompt access to medical treatment and therapy from his GP at home, necessarily there is an increased risk of his health further deteriorating before his condition is diagnosed and treated. The fact that a delayed medical response may mean that he is more ill than he would be at X Nursing Home before treatment is commenced brings with it an increase of suffering and an increased risk of hospital admissions.

The Rapid Response Service cannot sufficiently plug the gap in terms of the medical input that will be provided by a GP practice operating under a GMS contract. The RRS is an urgent service and it is not a 24-hour service. It would not be an integral part of his care package. Most importantly, given AM's history and the fact that my concern is with those occasions when he is at risk of becoming significantly unwell, the guideline response will most often be that he should be taken to A&E. Given the unanimous and often frank views of the GPs and other medical practitioners about the inadvisability of home care, it is likely that on reaching hospital there would then be a considerable drag back in the direction of hospital admission and then discharge to another nursing home. Local NHS services are not configured to care for a person with AM's needs at home.

As matters presently stand, on the balance of probabilities it would be self-defeating for me to give practical expression to AM's wishes by authorising his return home. Without committed GP input at home, it is very likely that home treatment would be unsuccessful. By committed support, I mean the type of support that in a different field a legal aid practitioner so often gives to their client, which is willingly given for meagre financial gain and over and above what is legally or contractually required.

It follows that, on the balance of the evidence, I believe that granting AG's application carries a significant risk of her husband losing his place and current quality of life at X Nursing Home without there being a corresponding 'risk of gain' which justifies this risk of

harm. The benefits which he has at X Nursing Home are considerable. He is medically stable, receives good quality care and treatment, is cared for by staff who know him, enjoys excellent contact with his wife and family, and most often appears content. There is also the possibility of visits outdoors, including to his local Mosque and, depending on funding, to the family home.

It is a very sad situation and I am sure that everyone involved in the case regrets the fact that it has not been possible to find a way of reuniting this couple.

Deprivation of liberty provisions

As regards the best interests requirement, AM is being detained at X Nursing Home for the purpose of being given care or treatment in circumstances which amount to a deprivation of his liberty. This is common ground.

For the reasons given, I have found that it is in his best interests to continue to reside at X Nursing Home, and to be cared for there in accordance with the current treatment and care plan, notwithstanding that the arrangements involve a deprivation of liberty.

This is necessary to prevent harm to him. If I permit him to go home in the current circumstances, he will be at significant increased risk of suffering a deterioration in his health, and an increased risk of hospital admissions ('almost inevitable'), of more severe illness and of premature death.

Furthermore, for the reasons given, the current arrangements for his treatment and care at X Nursing Home are a proportionate response to the likelihood of him suffering harm, and the seriousness of that harm (if he were not so detained).

Whether the relevant purpose can be achieved in a less restrictive way

In reaching my view, I have had regard to section 1 and the need for me to consider whether AM can receive treatment and care in a less restrictive way at home. For the reasons stated, I have decided that this is not the case.

Compliance with the European Convention on Human Rights

In my opinion, the interference with AM's home and private life is prescribed by law (the Mental Capacity Act 2005), proportionate (to the identified risks concerning his health and safety) and for a permitted purpose (his health and safety).

Other matters

It is, I believe, very important to AM's happiness that he should have the opportunity to visit his local Mosque and have other regular opportunities for outings. I would therefore ask the parties to agree suitable wording for a condition to this effect.

It is also very important that he has the benefit of visits home. It is worrying that he has not been home for so many years. The cost of adapting the family home to facilitate this is not

large in proportion to the fundamental importance of enabling him to enjoy family life at home from time to time.

If funding cannot be secured, I would ask his solicitor and his wife's solicitor to ascertain whether in the past he was able to visit his home in its present unadapted state, and whether that is feasible now.

I am sure that it will give AM pleasure to be reintroduced to his home, Mosque and local community, and it could open up further possibilities for him.

Future applications

As someone who is deprived of his liberty, AM is entitled to make further applications periodically. How much time the court will allocate to each application will depend partly on whether his circumstances have materially changed. Material changes might include significant changes to local GP and community medical services for people in his position (IR said that the CCG were looking to expand the Rapid Response Service); identifying a GP who is actually willing to try to support treatment and care at home; eligibility for enhanced GP services; the fact that his house has been adapted combined with a willingness to keep his place at X Nursing Home open for longer than two weeks; new medical evidence in support of treatment at home; new medical evidence setting out ways in which he could be successfully treated at home; improvements in his cognitive functioning and/or communication abilities, and/or the devising of new communication strategies by a Speech and Language Therapist, which enable him to say more about his wishes and the risks of home care; more reliable evidence about his past wishes and feelings, when he had capacity.

District Judge Anselm Eldergill

13 January 2020