



**Personalisation and the law: Implementing Putting People
First in the current legal framework**

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Putting **People First**
Transforming Adult Social Care

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Contents

Executive summary	4
The current legal framework, in light of the aims of Putting People First	7
Introduction	7
Personal Budgets.....	7
Prevention	8
Deployment options for people lacking capacity, within Personalised Budgets.....	8
Identification of needs	8
The carer’s role and other informal or universally available support	9
The indicative amount	9
Support planning	9
Sign-off.....	10
Deployment options.....	11
Contracts.....	11
Disputes and challenges	12
Safeguarding and the duty of care	13
Financial matters – charging/individual contributions	13
On review	14
Transparency	14
The range of services or support options that can be bought with a personal budget....	15
Appendix 1:.....	17
The main features of the existing ‘social care’ legal framework	17
Appendix 2 :.....	24
What should be avoided, and why; and what is similar in outcome, but not so risky	24

Executive summary

ADASS has obtained an opinion as to why the main tenets of Putting People First can be implemented within the current legal framework.

Headlines

- Duty of care can be properly met within an SDS system, but with safeguards built in.
- (Universal) Services meeting needs below an LA's eligibility threshold can, as now, render ongoing support packages unnecessary.
- Staff dealing with 'first contact' responses must be suitably skilled and experienced to ensure they can give the right info and make the right judgements.
- Self-assessment 'per se' is not lawful; but 'self-directed assessment' is.
- The authority is the **ultimate decision maker** regarding resource allocation, irrespective of the system in use. Any change to the system should be regarded as a change of council policy.
- 'Contracting out' of eligibility, resource allocation and support planning **decisions** is not lawful, but the contracting in of help, in terms of fact-gathering and support for clients, in relation to the decisions that the authority ultimately needs to make, is already legitimate.
- Support Planning can be flexible, and should be proportionate.
- Personal budgets can be offered as direct payments, or as one of several types of council/provider managed arrangements; they can also be a combination of these. Whatever the arrangement chosen, it should be signed off in the support plan.

Detailed Summary

The over-arching duty of care to all social care clients can be honoured within a personalised system. This will be done through

- proportionate monitoring of the success of the individual's support plan;
- compliance with the new regulations governing the Direct Payment system, in force from November 2009;
- the understanding of all concerned that safeguarding is a form of risk management which should already be integral to assessment and support planning functions, and
- a commitment to providing a backstop service for the few whose experience of a personal budget ultimately fails to meet their needs.

Preventative and enabling services can already be provided under an authority's FACS threshold.

- This may be done by contracting with private or voluntary sector providers (or grant-funding of voluntary organisations).
- Those services should be seen as universal services which may lawfully be seen as rendering the authority's funding of a support package unnecessary for an individual, in legal terms.

Screening and signposting – it is lawful and desirable to give apparently capacitated clients enough information, at **first contact**, to enable them to make an informed decision as to whether

it is in their interests to continue with assessment, given the means test for any council subsidy of their care or support needs.

- Staff dealing with first contact need enough social work skill and experience to recognise indicators of mental impairment which may affect insight and understanding of the options, and the processes involved in assessment, so that those applicants may be assured of their right to assessment.
- Staff also need to know when someone is asking for something that is simply not the responsibility of adults' social care.

The full assessment duty and the duty to meet assessed eligible need appropriately can all be accommodated within a streamlined process.

- The process can give the lead to the applicant/existing service user, in terms of identifying their needs and the preferred means to meet them.
- Local authority staff with various skills and levels of experience can perform formally required eligibility and support planning decisions, subject to supervision and competence, in proportion to the level and complexity of tasks allocated.

Resource allocation is required as part of the legal framework already (ie is part of meeting eligible unmet needs, based on local views as to what is appropriate by way of services, all of which cost money.

- Local authorities already do a form of approximate resource allocation based on social work staff's consensus about what is right and proper, against a backdrop of a finite amount of money from Members.
- Such allocation occurs lawfully, notwithstanding the corporate local authority duty to meet assessed eligible need, regardless of the resources available to social services in some circumstances.
- Approximate resource allocation maximises co-production of the plan, whilst recognising that the law makes the authority the ultimate decision-maker in relation to what is appropriate, for any individual service user, subject only to correction by the courts on public law grounds of irrationality, illegality, etc.
- Changes to any authority's allocation system will be changes in local authority policy, effectively, about altering the local FACS threshold or the authority's view of what constitutes an appropriate response to need, and must be made transparently and in line with equalities and diversity duties.

Contracting out of eligibility, resource allocation and support planning decisions is not provided for in the current legal framework, but

- the contracting in of help, in terms of fact-gathering and support for clients, in relation to all decisions that the authority ultimately needs to make, is already legitimate.
- anyone is free to make referrals to social services based on what they know of a person or their own service users, e.g. after a re-ablement or general well-being or enablement programme has been delivered.

Support planning can be flexible, in relation to what can be bought, subject only to organisational confidence that the nature of the thing or service being bought fits somewhere within the 5 statutes that constitute community care legislation.

- Support planning can be as minimal or as detailed as the client's needs or preferences suggest, so long as the plan has regard to DH guidance about the possible contents and so long as it amounts to a set of solutions to meet need, acceptable to the authority, ultimately, and from which a cost can be calculated.

- The statutory language is not tightly worded. The assumption should be that if a person's preferred outcomes can be seen to relate to assessed eligible needs, and can feasibly be met by something an LA can lawfully buy, then it is probable that wording exists to legitimise its purchase, whether that is done by the authority's commissioners, or by the client using a Direct Payment.
- For services that are not clearly within the language of these statutes, s2 Local Government Act 2000 permits financial assistance to be given to people, independently of community care legislation, so long as no other legislative bar on that outcome is thereby flouted, and it can be seen, also, as good for the area, that the proposed assistance be provided. Further advice has been obtained by ADASS on the use of s2, which may be made available to authorities, on request.

Deployment options for a personal budget divide into two, before sub-categorisation into new models of organisation.

- The first method is a Direct Payment, under the current legislation (and as extended by the coming into force of the arrangements for Direct Payments for people lacking capacity, in November 2009).
- The second method is via a range of contractual arrangements between local authorities and providers for services, but with more client involvement in provider or staff selection or calling-off.
- Where a provider agrees, an arrangement made to place the person's budget with the provider for sub-contracting or for calling off, over a given period, by the client, can be made by either a Direct Payment recipient, or an authority contracting for social care in the conventional way.
- Clients may choose to have their Direct Payment payment or payroll needs managed privately by the authority's in-house contracts staff for assistance in discharging the client's obligations to their own employees or providers.
- The option that is finally selected governs important legal issues such as the identity of the contractual parties for the service provision contract; the legal liability for payment, the application of public procurement rules and standing orders (or not) and the existence of a duty of care in relation to actual service provision. So the route chosen must be clearly signed-off, as part of support planning, and recorded.

The current legal framework, in light of the aims of Putting People First

Introduction

Person-centred care and support planning is not new. It is already required by the Assessment Directions (in force since 2004), which require the client to be kept at the centre of the process, and require the client and the carer to be consulted before the assessment is completed, with agreement of the *plan*, so far as is possible, between the authority and these parties. Direct Payments have existed since 1996. No new legislation is planned before government targets for implementation will have passed. So if it is going to happen, it needs to happen within the current legal framework.

Personal Budgets

A 'personal budget' is simply the name given to a sum of money which the person's needs ought reasonably to be able to be met within. Generally, in cases where the client is interested in a Direct Payment, that budget will be the net sum after the user's contribution has been deducted. In conventionally-arranged packages managed by local authority commissioners, the Personal Budget will also be the net sum, but the full cost of the package will be paid by the authority and the user's contribution recouped as happens at present, unless the provider agrees to collect it as the authority's collection agent.

Telling the person within roughly how much money, the authority would hope that the necessary input can be procured, in terms of its duties of equity and fairness across all its local service users and tax payers, is simply part of giving the person him or herself the largest possible measure of control and choice as to the spending of that money. Offering a Direct Payment is just one way of giving someone control over how their preferred outcomes can be achieved, and whether he or she wants one, or would prefer to have the authority do conventional arranging of services, does not detract from the value of the authority's having made the offer of control. Using the authority's staff to work more closely with the clients and families, but still offering internal contracting for preferred services from providers, is simply another way of offering more control than is currently the general practice.

There is no new 'vehicle' in the legal framework called a 'Personal' Budget' which is different from the funding invested within a Direct Payment or spent on local authority arranged services. But there are many ways of organising Direct Payments and contracts which will possibly deliver greater satisfaction and enable re-configuration of services across the country. The development of mixed packages of *partly* Direct Payments, and *partly* services commissioned by one's responsible authority, will enable everyone, even those in residential care, to have the benefits of a personalised budget, so long as the resource allocation calculation process does not simply translate the residential care fee currently being paid into the person's personal budget – and providers are willing to re-configure the way in which they charge for different elements of their packages.

A Direct Payment, whilst not passing irrevocably to the client, even when it is in his or her own bank account, counts as money in the hands of the client, i.e. private sector money, for purchasing purposes. Such clients can use it to obtain **casual** help, as and when they need it, and are free of standing orders and public procurement rules when spending it, whereas LAs could only ever employ or engage a formal service provider, and abide by the latter rules mentioned. Direct Payment clients, are however, private purchasers, and may be expected by providers to

pay an individual or private purchaser rate, which will have to be taken into account by clients when weighing up the pros and cons of the various deployment options.

Prevention

If an authority wants to do preventative work, properly, which is in reality, *below* its FACS threshold, it is essential EITHER to build in extra discretionary preventative references to 'risk to independence' in the lowest eligible category of FACS, locally. (That is, including wording in the bottom of the 'Substantial' category under FACS, if that is where one's threshold is, as follows: "The avoidance of deterioration within 1 month, into this eligible category" is an appropriate exemplar of an extra eligibility trigger to put at the bottom of Substantial, if that is where the authority wants the threshold to be, without having automatically to *cut* services for people who are already only in Moderate, after review). OR, alternatively, authorities could decide to *contract* for, or *grant*-fund preventative services up to the level of actual formal FACS descriptors of needs (and hence up to eligibility for social services via a support plan). Signposting of clients to these NON care-plan services (without falling into the reviewable error of refusing an assessment to those who want one) will then minimise the number of eligible people above the FACS threshold.

Deployment options for people lacking capacity, within Personalised Budgets

One new deployment option is the anticipated coming into force of the Health and Social Care Act 2008 which allows people lacking capacity to have Direct Payments, regardless of their inability to give informed consent to what this involves. That will mean that people's relatives or friends can present themselves as a fitting third party, to manage the client's package, even though the person is not capacitately aware of their involvement.

Authorities are going to need a policy about how they intend to decide whether a person is suitable as a Representative. Would it make sense, for instance, to exclude people who are the main beneficiaries of a person's estate, from acting as their Representative? Most people's most obviously willing helpers will be their adult sons and daughters, and so it would seem not. On the other hand, paying such people out, 'gross' of the charge for social care, rather than net, would be consistent with appreciating that such people do have an inevitable interest in the preservation of the assets of the individual client, and that this fact puts them in a conflict of interest situation when it comes to spending the money, that simply has to be risk managed. It also appreciates that most sons and daughters have not got a power of attorney or deputyship over their parents' finances, and as such, would have no lawful authority to access the part of the cost of the support package represented by the netted-off charge, which would be in the person's bank account. So giving the Representative merely the net amount would clearly be inadvisable, leaving them short of necessary funds, and might be regarded as contributing to adult abuse risks. Paying them gross and sending the bill for the statutory support charge to the service user in the normal way, and waiting to be paid out of the person's estate, if no arrangements are made for payment, would seem to be an alternative approach, which manages this risk.

Identification of needs

People will still be 'assessed' but will be able to *drive* that process themselves, whilst not actually deciding their own eligibility, which is a role reserved to the local authority. The process should not be seen as self-assessment. It should be called 'person-' or 'user-' 'led' or 'centred' or 'self-directed' assessment, and the person must be asked to do it according to FACS, (translated into what the authority believes the more ambiguous and value-laden words in FACS actually *mean*, eg 'vital'); and the LA must still make a judgement as to eligibility across each domain which has been explored.

The client must also be given a proportionate amount of help and support to design their own care/support plan, according to their level of mental capacity to deal with the questionnaire exploring the domains of risk to independence, in the absence of social services intervention. There is no need for this help to be given by a qualified social work professional, other than in Mental Health Act cases and where the presenting issues rationally compel such a judgment to be made. An example would be where a person has communication difficulties and his or her supporting circle includes people themselves known to Criminal Justice, Mental Health or Safeguarding services. Another would be where the person in question must rationally be seen as a person who appears to be deluded about, or otherwise lacking in insight into, their actual situation.

All that authorities need to do is to ensure that the questionnaire which gives rise to the FACS decision is compliant with the law and government guidance about the content of a community care assessment. That is, the paperwork should cover the domains in the person's life in which they are experiencing potential or actual problems. What are the risks to independence in the absence of social care, across those domains?

The carer's role and other informal or universally available support

Nobody is legally automatically *obliged* to care for their relatives or household members in this country. A person who is willing and able to care, however, may be regarded by the local authority as a means of meeting some or all of the person's identified needs, and so the existence of a carer who fulfils those criteria is a critical part of the decision about eligibility categories, in relation to particular needs domains. And hence it is a critical part of resource allocation, which is for unmet need, not the totality of the need. Carers' assessments must therefore be offered, and done at or before the point of final resource allocation, if the system is to be seen as consistent with the current legal framework.

The indicative amount

The service user will then be told roughly how much money they can expect to receive, via the Resource Allocation System. That system, in current terms, is already the manifestation of the policy of the authority as to what it regards as 'appropriate' by way of support to meet identified needs, and also of the policy of the authority towards the state of the local market. As such, once finalised, its rationale must be treated as subject to disclosure under Freedom of Information rules.

After being given an indicative guideline resource allocation, the client must then be given a proportionate amount of help and support to design their own care/support plan, according to their level of mental capacity.

There is no need for this help to be given by a qualified social work professional, other than in the mental health field and in cases where the presenting issues in relation to support planning, would rationally *compel* such a judgment to be made. An example would be where a person has a history of failed placements due to challenging behaviour towards self or others.

Support planning

There is flexibility in the current system about the level of detail needed in the plan, and it naturally depends on the complexity and range of needs that it is addressing. Given liability and safeguarding concerns, record keeping within manageable limits is prudent and desirable, but the focus of the plan is what matters. What is the range of feasible alternative appropriate means to meet need, and how does the cost of those compare with the resource allocation that was provided by way of an indicative guideline, once the person's eligibility was identified?

What universally available services might be accessed to meet the person's needs? Will use of an informal carer's help, or use of services available from community based organisations, in one domain, have an impact in terms of an increase or a reduction in other parts of the list of needs, and thus change the resource allocation?

In relation to needs, the outcomes which are preferred by the client and acceptable to the authority must be signed-off in relation to the **final** resource allocation to be provided, by the authority.

There may need to be adjustment because the outcomes must be related to the eligible assessed **unmet** needs; the risks arising from the needs must be managed within the authority's local approach to FACS, and solutions for managing risk translated into a plan which the authority would otherwise make arrangements to implement if it was to be responsible for provision. Further, for those wanting Direct Payments, the sum of money to be given must relate to the authority's estimate of what it would be prepared (in accordance with its obligations to meet need appropriately and lawfully) to spend to meet the eligible assessed needs, through services set out in the support plan. The duty to meet needs, appropriately and lawfully, is one that the authority must make the final decision about. The DH paper "Independence, Choice and Risk" should be referred to for the design of sign-off processes. See the link below

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_074775.pdf

Ideally such decisions are best taken by competent experienced staff with a social care value-base. This might be individual staff members, a group or a panel or line management system, depending on the nature of the decision that has to be made and whether the decision is a disputed one or not.

Any challenge to the legality of such decisions will scrutinise the rationality of these people's view, in terms, at least, of competent, experienced opinion, as to how the support plan could or will, in fact, feasibly meet the eligible needs. The greater the experience and the presence or otherwise of qualifications of the decision-maker, will be a factor that will be highly likely to attract the respect of the judiciary, in relation to whether the decision in question, constitutes a **rational** decision, as opposed to one which deserves to be quashed on judicial review.

Sign-off

The indicative resource allocation may be different to the sum finally allocated because the person may be able to meet their own needs through reliance on universally available services, social capital such as willing and able carers, or may prefer, before or after a charging assessment, to meet their own needs through self-funding arrangements. That fact will correlate to a revised FACS eligibility decision, retrospectively, in legal terms, because FACS eligibility depends on unmet need in the absence of social care, not the overall size of the need itself.

The person can suggest to the authority what he or she would like to spend the money on, in order to achieve their preferred outcomes. If those outcomes accord with the meeting of assessed eligible needs, the authority can approve the plan, having made a decision as to whether the Resource Allocation needs to change.

The cost of the plan needs to be considered against the management accounting tool of the Resource Allocation, in the interests of fairness and equity, but the legal duty is to meet need, and to meet it appropriately, lawfully, and in accordance with a person's human rights. If an authority cannot see a link between an aspect of the plan and an eligible assessed need the authority needs to point this out to the client because it would tend to suggest that some other such need has been overlooked, and the plan must meet the eligible needs.

If an authority thinks that an aspect of the plan is disproportionately excessive, in terms of a reasonable cost in comparison to what it would do itself, to meet the need, it must negotiate a resolution of that impasse with the client. This does not mean that a high cost on something in

one week/month that is offset by lower costs later for a person with fluctuating needs is not acceptable – the authority is lawfully able to accept that people can budget over longer periods.

Deployment options

The signed off support plan could envisage the person choosing to spend some of the money directly, via a Direct Payment. The recipient can decide whether to give it to a helper, a support organisation, a broker, or a provider. Clients who don't want a Direct Payment, but want to benefit from perhaps cheaper arrangements secured by the local authority's commissioning arrangements, need not have one. They can work closely with the contracts or commissioning team to make contracts with providers more client-focused, and more responsive, assuming agreement from the market to variations or new contracts. This has been called a virtual managed account but it is important to note that this is still a public sector contract for community care services bought with a personal budget, **not** a Direct Payment arrangement.

A half-way house (but within the category of a Direct Payment) is that a person might elect a Direct Payment, for formal responsibility purposes, and then choose the authority itself as his or her private purchasing **agent**, which would combine the benefits of local experience with freedom from standing orders and public procurement rules, but which would also involve a need for transparency about the capacity in which the officer then made contracts – they would be privately purchased services in this latter example, not local authority procured.

The advantages and disadvantages of authorities offering this service would have to be carefully considered, in terms of exposure to allegations of favouritism or prejudice against non-approved providers, liability risks as fiduciary agent, charging decisions, etc. The main advantage is that the officer would be acting as a private person's agent, free of local authority rules about procurement and Best Value, and could therefore deliver a more personalised service, whilst still utilising years of experience of the local market. Further advice can be obtained via ADASS, referring to the use of powers under s2 Local Government Act 2000, to act as the agent of any person in this manner, if so doing would be good for the well-being of the area (so long as there is no other bar in legislation, preventing that outcome). The advice explains how this decision should be taken either by a capacitated person taking a Direct Payment, or a person's surrogate, or chosen Representative under the new rules.

Existing options such as vouchers, cards, the authority's provision of a Shop4Support website, commissioning arrangements through Slivers of Time agencies etc, all break down into one of the two sorts of arrangement mentioned above – Direct Payments (whether for capacitated or people lacking capacity (after November 2009)) or local authority arranged packages with providers or intermediaries such as banks, credit unions, support agencies etc. So it is crucially important that the authority's paperwork divides its clients up into those who are taking Direct Payments, on paper, at least, and those who are not. It is not advisable to arrange for 3 way agreements between councils, clients and providers, because the legal framework does not envisage the client having to make a contract promising to pay over their social care charges owed to the authority, under HASSASSA 1983, to providers, for any part of their eligible unmet need, unless they have elected to take a Direct Payment.

Contracts

Service contracts will either be between the local authority and the provider or alternatively, between the provider and the *client*, or his or her third party Representative. A contract between a local authority and a provider can allow, through its terms and conditions, for whatever level of involvement of the client or third party that the two parties are willing to include, short of delegation of the ultimate responsibility of determining how to meet the needs of the client via the contract, which must remain that of the local authority.

Contracts between a provider and the actual service user in receipt of a Direct Payment, or for that part of the person's overall needs for which they have chosen to make their own arrangements to meet, are a matter for them. The local authority has no statutory part to play in the contents of such contracts. Some voluntary sector or indeed other commercial providers may not be used to contracting with individual clients, and local authorities may suggest standard forms of contract covering the basics of terms as to fitness for purpose of the services concerned, and compliance with national minimum standards, payment, interest on late payment, pricing reviews etc. However, if they do offer a draft, this is not a duty and it is not a local authority contract.

Direct Payments clients will need to sign agreements with local authorities, as has always been the case, in relation to accountability for the use of public money. The new law relating to people lacking capacity having Direct Payments will mean that those selected to act as Representatives need to contract with the local authority, in their *own* name, in relation to the management of the money.

All Representatives, under the new provisions, including Surrogates, can be asked to contract in their own name with the local authority, unless otherwise stated. The fact that a full surrogate also has legal capacity to contract for the client as his or her agent will enable that surrogate to manage that person's **own** money and make contracts with other providers in the name of the actual service user; but contracting directly with the local authority in his or her own name will mean that the client is protected by the authority's ability to take legal action against the Representative, if the money management goes wrong. This is something that authorities need to be open about, so as to enable people to take informed decisions as to whether they wish to act as Representatives.

Where a third party happens to have lawful authority to act as the statutory agent of the individual service user, through a deputyship or lasting power of attorney, or an old Enduring Power of Attorney over money and property, that third party will be contracting FOR and ON BEHALF of the client when purchasing services. In all other cases, including where trustees act to purchase services, the third party will be contracting in their own name and will bear personal liability for all the ordinary aspects of employment law, tax, national insurance, liability etc. arising out of the service contract.

Disputes and challenges

The best process for resolution of disputed plans is a form of internal review (this need not be a panel, but the nature of the dispute will tend to drive the number and skills base and range of staff to be involved). The review personnel need to work to transparent guidelines for procedural fairness, the presentation of costing evidence, and use of written observations concerning management of risk if the plan is or is not implemented as preferred, from competent experienced staff and the client, their carer, if one is involved, and an advocate who is well-informed about community care law (and mental capacity law, if relevant). The process should not be seen as a complaint, as such, but as part and parcel of the discharge of the authority's responsibilities under the current legal framework.

As long as a local authority considers the legal status of the proposed deployment options for service arrangements, and of the parties involved, knows what function it is acting under, knows what the case law says about the discharge of those functions, understands the extent to which human rights law pervades social care judgements, and takes account of English law as to the mental capacity of clients and the need for lawful authority of third parties to make arrangements involving money or property for their loved ones, the risk of legal challenge is thereby managed and minimised.

When as part of review of contract *performance*, or review of the person's *assessment*, any concerns about the ability of the plan to meet needs, arise, the local authority acts under the community care legal framework in making a fresh decision about the identification of needs, the eligibility of needs, the support planning or the approval of deployment options. This includes

withdrawal of a Direct Payment or the imposition of fresh conditions on that payment, or the imposition of fresh terms and conditions on providers.

In 2010 the Local Government Ombudsman acquires a jurisdiction over complaints by private purchasers against social care and support providers, which will operate outside of the local authority complaints system.

Safeguarding and the duty of care

The overall duty of care of the authority will be honoured through proper and regular but proportionate monitoring of the success of the plan in meeting the outcomes, and hence the needs, of the client.

CIPFA guidance governs the financial probity of the Direct Payment scheme itself, and FACS guidance requires regular re-assessment, but any change in a person's situation that impacts on unmet need triggers a duty to re-assess, if it is known about.

Under the regulations, the taking of a Direct Payment suspends the authority's duty of care in relation to provision, but not in relation to ongoing care management. Where there is concern or failure of that plan, the duty to re-configure the plan, by way of a change to the allocation, the means of meeting need, or the deployment options through which the fund is managed, will still be the care management duty of the authority.

Safeguarding of people lacking capacity will pervade care management as it already must do, through the Mental Capacity Act, and information sharing powers and discretions which local authorities enjoy, such as in relation to Deputyship, and the decision to bring an application in the Court of Protection.

Financial matters – charging/individual contributions

To a limited extent, other monies to which the person may be entitled can be drawn into the person's own meeting of their own needs.

A person's own financial means cannot be treated as relevant to eligibility for assessment or for services in the first place, because FACS guidance (the FAQs appendix to the main guidance) advises against this. And a person's means cannot be assessed for non-residential care charging purposes, until after their needs have been assessed (because until then, it cannot be said that the person has 'availed' him or herself of any service). However, it is important for people to be aware, at the earliest possible moment, that there is a means test that will determine whether accessing services through a social care assessment will bring any financial benefit to the client, so that he or she can decide whether or not to go through with assessment. If a person volunteers their relative financial well-being, and enquires whether they would be likely to benefit from continuing through the process, it cannot be wrong to tell them the truth, even if it results in their withdrawal from assessment.

The person's income can be maximised during the charging assessment process, by encouragement to apply for benefits to which they would or might be entitled. But authorities cannot force a person who does not want to apply, to make an application, or treat them as ineligible if they will not avail themselves of the money. There is no scope in the regulations or guidance for regarding people as in receipt of notional income that they do not actually *have*, in the non-residential charging framework. The judiciary is not likely to hold that it is inherently unreasonable to choose *not* to apply for benefits.

The person must continue to be charged according to the charging framework applicable to the type of care that they are going to have. So if it is residential care, they must be charged by reference to the National Assistance Act framework, the regulations, and CRAG. Short term residential care or respite which is eligible for a Direct Payment can be charged for under either framework depending on how long it is for (CRAG provides guidance on the meaning of

temporary) but the Direct Payment regulations prevent a personal budget being taken as a Direct Payment for any greater number of days than the regulations permit.

If it is non-residential services, within a support plan, or universally available services purchased by the local authority under a service level agreement with a provider in the discharge of community care functions, they must be charged for by the authority, according to Fairer Charging and HASSASSA 1983. If the person has been signposted to services which have merely been grant-funded by the local authority, there is scope for them to be charged for directly by the service provider outside of Fairer Charging, but that is a matter for the grant conditions, as between the LA and the provider.

On review

Unmet eligible assessed need is a breach of statutory duty, which can be challenged by way of judicial review, and which may lead to actions for damages for a breach of human rights, or even, very exceptionally, if it arises through extremely bad support planning, for negligence. In any case where a person has run out of funds during a period for which they have been funded, authorities not providing a back-up means (which has been directly provided, or commissioned) of meeting need *at least pending a concluded investigation of what has happened to the money*, will risk challenge. Authorities need to provide for a competent and experienced member of staff, probably having links with an authority's safeguarding arrangements, to take on this role, as serious implications for all concerned – client, employees, agency staff, in-house staff, etc., could arise out of investigations of allegedly misused money.

At the conclusion of any such investigation, which must be fairly conducted, the authority must act on its findings. That may mean that the individual is regarded as knowingly and with insight, persistently having failed to follow advice, or rejected assistance or guidance about their own impact on the package or plan or relationship with the provider.

If the client can lawfully be regarded as having rejected the offer of social services, by failure to behave reasonably, despite knowing the consequences, then in accordance with the *Muriqi Kujtim* doctrine, the authority can be regarded as having been discharged of its duty of care. But it will be an exceptional case in which a client is left to their own devices, in the face of eligible assessed unmet need which they can no longer meet through the Direct Payment, because of their own misuse of the money.

Transparency

Clients must always be told they can have a DP and have this explained positively and supportively, but will also need to know that it does not mean that they have to become an employer, and indeed, that they do not have to take control of a personal budget if they do not want to. They will need to understand the benefits and responsibilities of taking one, in terms of employment and social security benefits law. The alternative for the client is to allow the authority to operate a more personalised form of contracting for the discharge of the provision and commissioning functions within community care legislation.

There must be clarity about the implications of taking a Direct Payment for someone else, and then trying to pay oneself for doing the work, as it will make the person into both the employer and the employee at the same time, in theory. Receiving regular payment for services rendered means that one is employed or engaged. The Revenue treats most people working in social care as employees, not self-employed people, although the justification for that stance, can be individually challenged, and should be, if a person is making decisions about an incapacitated client, for instance. Receiving payment in return for work also means that at some indefinable point, the individual doing the work ceases to count as a carer, for the purposes of Carers' legislation, because carers are people who do not get paid for their care, and they have to do a *substantial* amount of care, unpaid, for the person, before they count as a carer. A person's

receipt of wages for care can affect their benefits position, pound for pound, and once one goes above the earnings threshold for income support, one may lose a host of other benefits, the loss of which will have an impact on the whole household. Young carers can only do a certain amount of paid work before losing their status as students, and losing financial advantages via that student status. So there is much to be considered when supporting a person to pull in benefits, social capital and mainstream services, in the context of a Direct Payment, and the training must be put in hand to equip the social care work force within local authorities (or the voluntary or advice sectors), for the task.

The range of services or support options that can be bought with a personal budget

If eligible individuals are to be supported to consider properly whether to take a DP they will need to know, in general terms, what they can and cannot buy. Legal departments should go back to the CSDPA 1970, ss 21, 26, 29, 30 of the NAA 1948, the HSPHA 1968, s117 MHA 1983 and schedule 20 of the NHS Act 2006, if necessary. In this way they can consider purposefully stretching the wording so as to give assurances to management about what should be perfectly *acceptable* expenditure, to decision-makers, and what might *not*, and what definitely *could* not be seen to come within the wording found there. Clearly, registered nursing care, long term non-respite residential care and anything that it would be illegal for the LA to buy, would be the sort of things to exclude from any such list.

The scope of social care functions in legislation is extremely broad. The legislation is deliberately worded in as loose a manner as was semantically possible to the Parliament of the day. Rules of statutory interpretation enable old-fashioned terms to be interpreted in a modern way, much of the time, because legislation is 'always speaking'. So the concept of 'a wireless' could be stretched to cover 'a laptop' because the legislation is clearly aimed to enable people with disabilities to stay in touch, and the modern form of that could be seen to be use of the internet.

Given that English is a language full of nuance, the stretching can be quite muscular and purposive – no-one wants to see people with disabilities, hide-bound or constrained as to what they can buy. But use of a personal trainer, for instance, could not be authorised under the concept of 'a wireless' – that would be stretching language past what is feasible in most people's opinion. Funding for a personal trainer could much more legitimately be accessed under the rubric of 'instruction in overcoming the effects of one's disability', or 'facilitation' of leisure or recreational activities. There is a need for any staff signing off PBs/support plans (and staff actually making arrangements with providers, for those who don't want to take a formal Direct Payment) to be better trained in the liberality of what the legal framework already permits.

There is no doubt whatsoever that services related to personal care and practical assistance in the home are community care services, and that support to access education and work and leisure activities can also be provided under the legislation already. These things are what the majority of people will want to buy with their budgets.

Just because it *could* buy a caravan, to facilitate the taking of holidays under s 2 CSDPA 1970, an authority *need not* buy a caravan, however. It could legitimately use its experience in having bought caravans in the past, and then having had to cope with the stationing of them, their insurance and maintenance, as very good policy reasons for *not* buying caravans. If authorities decide to give people a Direct Payment, (calculated by reference to the services the authority would otherwise think appropriate to fund), and they choose to buy such an item, instead, the authority must anticipate that the person will, him or herself, need to station, maintain and insure it, and this will be part of the implicit cost of the Direct Payment. If the person tries the caravan out, doesn't like it, and sells the caravan on eBay, the money will have to be put back into the care package, because that was public money for the meeting of a need. The agreement between the client/Representative and the authority will have to cater for all these eventualities.

If there is real concern that certain types of service are not within the current social care legal framework, they are likely to be part of the NHS's obligations as indubitably health care services,

in terms of their nature; or indicative of a primary health need, in Continuing NHS *health* care terms. Alternatively, they may be Supporting People Services, and the aim should be seamless liaison between all agencies working in partnership. For impasse situations, there can be recourse, subject to an authority's Sustainable Communities Strategy, to s2 Local Government Act 2000 – the well-being power, which permits financial assistance etc to be given, even to individuals, so long as the authority thinks it would be good for the area, and the outcome is not otherwise forbidden or prevented by a prohibition, restriction or limitation in any other legislation. Further advice about use of s2, where no other power or duty can be found to underpin the achieving of an otherwise desirable outcome, is available on request from ADASS.

Authorities are also entitled to see certain things as outside the ambit of community care altogether. The provision of 'company', for its own sake, for instance, as opposed to supervision in a particular setting, is an example of the distinctions that may be made. Social exclusion is not actually a term found in the legislation. And cigarettes, for instance, although not illegal, are considered to be harmful to all concerned, now. The fact that a person regards a cigarette as helpful for their own preferred outcomes does not and should not give them discretion to spend their personal budget on smoking. A meal, on the other hand, would have to be regarded differently, because meals appear as an actual service that can be provided under the Chronically Sick and Disabled Persons Act (not just help to eat one, or to prepare one) for which one might have been found to be eligible.

Leisure opportunities for people with disabilities are an area for debate and negotiation, because whilst people without a disability or long term health problem have to pay for these out of their own incomes, and must prioritise between their needs and leisure as a 'want' when spending their own money, the courts have already indicated that appropriate leisure activities may be an actual *need* for a person with a disability, in terms of their article 8 human rights to develop their personality within society.

Appendix 1:

The main features of the existing ‘social care’ legal framework

The duty to assess

In terms of the duty to assess for community care needs, in the first place, authorities are bound to offer to assess people who appear to them to be disabled under the 1986 Disabled Persons (Services, Consultation and Representation) Act, and are also obliged to assess anyone who appears to the authority to be a person who may be in need of any community care service it could lawfully provide or arrange (s47 of the 1990 National Health Service and Community Care Act).

Refusing assessment / Screening and signposting

It is lawful to refuse assessment to only a very few people – those who are asking for something that is clearly outside the range of community care services may be signposted elsewhere, for instance; but even though health and housing organisations have their own responsibilities, a person’s problem will often combine health and housing matters along with areas within the ambit of community care. It is unlawful to exclude such people from assessment, or to regard one’s duties as discharged merely by referring them onwards; and it is unlawful to ration assessment according to scarce staff resources, or to operate internal client group boundaries so as to exclude from anything that could constitute proper assessment according to FACS principles, people within s47 of the 1990 Act.

Authorities cannot ask before assessment, how much money does the applicant *have*, and refuse assessment on the basis of their financial means, because the person may, on proper assessment, lack capacity to make care home arrangements and have no-one else willing or able to do it for them. It is also contrary to the FACS Q&A guidance (and it is also the current legal consensus despite some authority to the contrary) that a person’s means are not relevant to the assessment of actual needs for care outside of the discharge of residential care functions – in other words, are not relevant to eligibility, but only to charging for what is then provided. In the field of care in one’s own home, it is more likely than not that there is a right to have the local authority arrange services and manage them for an individual, even if that person would be financially assessed as a full cost payer. That is because there is no lawful basis for assessing their financial means for non-residential care, until after the assessment process has determined their eligibility and culminated in a support plan.

Voluntary withdrawal from assessment

Capacitated people may of course choose not to be assessed if having made contact with social services, they are informed of the charging framework, and can see from that or for some other reason, that there is likely to be little benefit to them personally in going through formal assessment. That is wholly different from refusing someone who is entitled to an assessment, to their full entitlement.

Criteria for assessing need

LAs do not have a legal duty to meet **all** the public’s presenting wants, wishes and needs, but only assessed eligible needs for community care services – the *Gloucestershire* decision settled this, at the highest level, in 1997. This is because the legislation under which all services are provided envisages the local authority deciding whether the person’s situation necessitates or calls for or

demands a response from the local authority, when considered against the standards and expectations of a civilised society.

FACS guidance, which emerged from government some years later, merely built on the law as laid down in this case, and streamlined and made national, an appropriate approach to precisely what it was that assessment should seek to evaluate. A *person* is not eligible, under FACS - it is their needs in particular domains which are eligible. Those needs **MUST** be explored if they are needs for which a power or duty to provide services under community care legislation has been given by Parliament. There have been cases rendering assessments unlawful for missing out questions about leisure, recreation, transport to services, adaptations, holidays, etc, because all those services are specifically mentioned in the legislation and must have been seen by Parliament as part of community care services.

- FACS guidance prohibits cost ceilings attributable to specific categories of risk. It says the LA cannot assume that critical risks will always be more expensive to meet than lower rated ones. Cost ceilings would connote a resources-driven system, instead of a needs-led one.
- FACS guidance in England advises against age-related criteria or age-related service provision arrangements. So cost-capping of care packages for older people just because they are aged over 64 is open to challenge – it could be said to imply that older people are not entitled to the same quality of life as those of working age. The fact that ILF monies are not available to those first applying over the age of 65 is not part of social care law; it is a factor which impacts on the ability of people affected, to meet their own needs through paying for privately arranged services, however.
- FACS guidance, local government law as a whole and specific case law prohibit outsiders to the LA from doing the assessments themselves, without the statutory decision-maker – the authority – formally adopting the content. This means that whilst a specialist provider, or charitable organisation might be contracted 'in' to fact-find, or to trial the client out in a particular setting, or to support the person's exploration of their own needs for community care service and hence help with the forms, the decision as to the outcome of that assessment has to be a decision taken by a local authority employed member of staff, or given to a person to whom the function or task has been lawfully delegated, under Partnership Arrangements or functions allowing the secondment or lending of staff between Health and Social Care services.

LAs can (and should, in terms of equity and the prudent use of public monies) filter requests for assistance through *criteria* – (*Gloucestershire*) by reference to wording now imposed through FACS – LAs are supposed to assess 'necessity' for their intervention, and risk to independence, if no social care services were to be forthcoming, either from or through the LA. This means that a person's overall need is not the test of their FACS eligibility, but the size of their unmet need, once all mainstream services and help from willing and able friends relatives or neighbours or charities has been considered. So the system already *allows* for people to help themselves, or be helped by their families etc. – but it impacts on their entitlement, for the wider good of others who may not be so fortunate. Those who make the most of their social capital ought to get the smallest care/support packages or the lowest finally determined RA. The withdrawal of a carer's willing support inevitably has implications for the cost-effectiveness of meeting the person's needs in an independent setting, and this is a factor that authorities can take into account when deciding what support service profile they would be willing to fund, assuming that alternatives such as residential care would not be regarded as positively **inappropriate** to the person's needs.

Eligibility thresholds

Each LA can and should set up its own threshold for eligibility, according to the local political importance given to social services, versus other priorities for spending. (*Gloucestershire*). The ability to raise the threshold higher and higher, however, is subject to the principle that beyond a certain point, the whole purpose of social care departments, under the legislation, would be negated, as there would be no-one who could qualify, however critical their situation was, which

would defeat the Parliamentary intent. The courts have taken the same approach to overly-narrow criteria for continuing NHS health care, in the *Coughlan* case, for example.

The relevance of resources

The locally applicable threshold can move upwards, as a matter of policy, at the behest of elected Members, but that decision has political ramifications for the council, and equalities and diversity statutory duties have to be remembered (the *Gloucestershire* and *Harrow* cases).

If a client is assessed to be at risk *above* that threshold line – LAs must address all eligible risks, by coming up with a plan that will contain, improve or reduce those risks back down to below the threshold. There is no social care duty to avoid all risk, or meet *all* needs for community care services or wider needs. (*Gloucestershire*).

The duty to meet assessed eligible need

This duty to meet eligible need is absolute, **regardless of available resources** within social services funds, if the local authority accepts that there is only one way to meet the need appropriately – it is a **corporate** duty to find the money, once someone is eligible (see the *Gloucestershire* and *Wigan* cases). It is only exceptionally that there is only one way to meet need, lawfully, but a care/support package could, in theory, involve capital costs running into thousands (see the *Islington* case involving the purchase of a private house in Islington in which to house a family with an assessed need for urgent re-housing) or cost hundreds of thousands a year and still not be a continuing NHS health care package, simply based on the cost (see the *St Helens* case from 2008).

When assessing the *existence* of a need, it is reasonable to take account of existing support, if it is willing and ably offered. It is also legitimate and prudent to highlight other means of support that may be available to the person, to enable them to weigh up the pros and cons of retaining autonomy over the meeting of their own needs (such as benefits, universally available services in the community, etc) rather than relying on the State.

If a person has a reason that would make sense to the majority of people, for declining to make use of such support, then that should not affect the decision on *eligibility*. But an authority can take account of what is available to a person, through health or housing services, for instance, and decline to treat the need as an eligible one, if it does not think that the refusal to use the alternatives is reasonable.

Support planning

After deciding eligibility, the LA's duty (although it is not stated as such in the legislation) has been developed through case law, and is a duty to complete a reasonable, appropriate plan of services. That is, services within the confines of what is covered by the community care legislation, in a plan that addresses the assessed (ie eligible) risks to independence within the statutory remit (ie not providing for health, housing or education risks... or support for business investments, new clothes, top-ups for housing benefit, etc.).

'Appropriate' is shorthand for three things, in law, as developed by the judiciary in Administrative Court cases over the last 15 years:

- a package that other reasonable members of staff would approve of, as meeting the assessed needs (otherwise it would be judicially reviewable)
- a package which accords with human rights (that is, human rights, properly understood in the legal sense, together with the legislative restrictions on those rights - eg as found in article 8, which allows an authority to consider its resources, albeit only giving the budget a *little* weight – by reference to the impact of the measure or decision, on the economic well-being of the State. This means that the cost of financing dignity and respect can be weighed against a

person's right to respect for their home, their private life, their correspondence and their family life, but not determine the outcome, completely. It is also inappropriate - even in terms of UK public law, let alone UK and European human rights law - to let cost override all other relevant considerations, or to fetter discretion with a blanket cost ceiling. A recent *Bromley* case shows that this is so.

Dignity and Independent Living are principles which should be taken into account but there is no legal benchmark of just how *much* dignity, or how *much* independence, is required, and there is no civil or human right to be cared for in one's own home, regardless of the cost or risk to other people, as yet, in the legal framework. A care home package is still a lawful conclusion of a community care assessment, and may in some circumstances be the only lawful setting in which local authorities may provide care (for instance in situations compelling deprivation of liberty). Putting this another way, a care home placement can be the lawful result of an assessment based on risk to independence, even though the setting is not an independent living setting, but a setting for the care of more than just that one individual person.

- and a package that abides by other generally applicable laws such as race and sex discrimination, the duty to promote equality and diversity, laws as to health and safety, duties to employees, and such things as the Choice Direction and the rules against unlawful imprisonment and the Mental Capacity Act doctrine of Best Interests.

Relevance of resources to the support planning decision

A social services department's financial resources are not relevant to whether the person is eligible for funding on any given day. FACS guidance put paid to the common misinterpretation of the *Gloucestershire* principle that resources could be taken into account on the question of an individual's eligibility – resources are only relevant to the threshold for that eligibility decision...which should always be made clear to the client.

A shortage of financial resources is not legally relevant to whether a plan for an eligible set of needs is **appropriate**. That is because if the competent experienced staff agree that there is only one way to meet need, appropriately, the cost is irrelevant – *Wigan ex p Tammadge*. This means that there *is* a social care safety net, and an enforceable duty of care, at least for a very few people, and personalisation will not alter this.

However, if there is considered to be MORE than one way, appropriately, to meet the eligible need, (and there usually will be, because support planning discretion is a very broad concept) an LA has the **discretion** to offer the cheaper of two appropriate alternative means to meet need (see the *Lancashire* case). The fact that some people would be regarded by competent experienced staff as having an actual **need** to stay at home, rather than be cared for in a care home, means that no LA can have a blanket 'equivalent gross cost' policy for any particular client group or for its RAS.

The cost of a residential care placement is only relevant to the finalisation of support planning by the authority, if it has been decided first of all that residential care would at least not be an *inappropriate* response to the person's needs, and there is a place available.

If these two conditions are fulfilled, the authority is allowed to take cost into account in deciding whether to sign off a person's support plan, because it is spending public money, and must meet *needs* out of that fund.

It is not lawful to offer a client a final resource allocation in the sum of the cost of a residential care home placement, just because the client doesn't want to go into a home and would prefer to stay at home. A cost-ceiling on what was offered, finally, would be a fetter on needs-led assessment, and it would, without more discussion, amount to knowingly offering a package that would be insufficient to meet assessed need in the setting in question. That would be bound to attract challenge and the potential for a negligence action if harm resulted.

If the person is clearly *going to stay* at home, and the authority decides to provide the money to meet need in that setting, the setting is highly relevant to the reconsideration of the amount of unmet need that will arise. In providing funds, the authority would, in legal terms, be acting under the Chronically Sick and Disabled Person's Act, and it is under that legislation that the *Gloucestershire* case held that there is an absolute enforceable duty to meet assessed eligible unmet need. There is no statutory option for bargaining with the client so as to provide less than is needed, on the basis that the client is thereby letting the authority off of its full statutory duty, because the client can then achieve their preference of remaining at home. The client (or a welfare attorney or deputy) can absolve the local authority of its duty if he or she decides to refuse social services/funding, but if the client is to be provided with help, the client is entitled to have an appropriate adequate amount of help to meet assessed need.

If the authority is to remain involved, therefore, the need must therefore be met *properly*, at the level that being at home will necessarily involve. The cost of meeting a person's needs at home, could sometimes be less than it would in a care home, depending on who else is there and what they are willing to provide by way of voluntary input; but it could be *more* than the cost of residential care, depending on the circumstances (eg night-sitting is needed, or there is a risk of abuse from a person on the premises who is also presenting challenging behaviour).

On the other hand, a local authority can indicate to the client and the family that if the person can meet part of their own needs themselves, through reliance on willing and able external sources of help, or by accessing universal services or through spending their own money, voluntarily, on privately provided services, then the fact that it would still cost a little more to keep the client properly provided for at home, than moving him or her to a care home, might enable the authority to exercise a 'best value' discretion, even though it would not result in the cheapest possible support plan. So applying for ILF, and sensible use of a family member's presence in the house at night, for instance, might enable a person to reduce the size of what was initially seen as their unmet need, to something affordable for the local authority, and thereby maximise their own options for staying out of the care home sector for as long as possible. The person is effectively agreeing that the size of their unmet need, as first assessed, will be reduced to a smaller size by their own willingly volunteered input, affecting their resource allocation accordingly. So a person's own efforts at pulling in resources that lower the cost of helping the person to stay at home in the community, or the family's ongoing willing and able input, remain the **BEST WAY** to support the authority in **NOT** regarding itself bound by its duties to manage public money prudently, to offer the cheaper appropriate option of residential care.

An incapacitated person can have this decision made for them by a surrogate, depending on the scope of the surrogate's capacity, or by the informal volunteered input into support planning of willing and able third parties who want to help out.

Rights to a Direct Payment

A person is entitled to ask for a Direct Payment if they would like to be in charge of their own provision arrangements, through purchasing or employing support. Local authorities are now obliged to offer this route to all clients if they can consent and are not positively excluded from eligibility by Direct Payment legislation and regulations. The authority is not obliged to grant a Direct Payment to anyone unless it is satisfied that this means of provision can meet the person's assessed need for the services set out in the person's care/support plan. The authority, if offering a Direct Payment, must offer a sum of money which is its reasonable estimate of the cost of procuring the support services, and guidance makes it clear that this means procuring the services *lawfully*.

Authorities can regulate the use of a Direct Payment through conditions so far as they think fit, and in particular, with regard to seeking information from the applicant, and naming specific persons to whom the money must not be paid. Guidance, however, discourages local authorities from insisting on Criminal Record Bureau checks, as this is regarded as negating the intention of Parliament in relation to leaving the client to make his or her own decisions.

Regulations forbid the use of a Direct Payment for the purchase of long term (ie other than a specified number of days per year) residential care.

CIPFA guidance would appear to be the only professional guidance that exists around accounting for the use of the money in a way that is consistent with public sector finance officers' duty in relation to public money.

In November 2009, the legal framework is changing so as to allow for people lacking in any degree of mental capacity to understand the basics of a Direct Payment, to have one in any event, so long as the authority can identify a willing and appropriate third party to take on the responsibility of managing the payment. This development effectively ensures that the significance of deciding whether or not to take a Direct Payment does not prevent people's ordinary carers and family members from taking the decision, even if they do not have a welfare decision-making power under Deputyship or a Lasting Power of Attorney.

Other Deployment Options

There are currently several other ways of implementing the outcome of an assessment and care/support plan (other than Direct Payments). Case law has identified at least five:

- Direct provision by an in-house provider unit or placement in a council owned or run care home
- Local authority provision elsewhere, by arrangement between the authorities that one should act as the agent of the other, in return for reimbursement of the cost or some other recompense
- Contracted provision, through the voluntary or private sector, under statutory powers to make arrangements for the meeting of the needs
- An indirect payment arrangement whereby the money is given to a third party individual, so long as it is a person running a business, or to a voluntary organisation, under s30 of the National Assistance Act, for the discharge of the authority's s29 NAA functions, as the authority's agent
- Grant-funding of voluntary organisations to provide or promote similar services to community care services under the Health Services and Public Health Act 1968.

Who decides?

Subject to compliance with the Assessment Directions 2004, about consultation with, and focus upon, the client and carer's situation, LAs are the ultimate decision-makers about what should be provided, subject only to correction by way of judicial review – however good a person might be at articulating what would make his or her life 'better', and regardless of that person's mental capacity. (see the *Gloucestershire*, *Sutton* cases). There are four reasons for this:

- a) the wording of the applicable legislation makes it so;
- b) the people concerned in the statutory decisions have traditionally been professionals, and the courts will not, as a matter of principle, tell professionals that they must do or decide something other than what those professionals think is right and proper;
- c) judicial review is a supervisory jurisdiction only, not an appellate one;
- d) social work, at both an authority-wide and individual client level, involves highly complex considerations that are not easily amenable to judicial grasp.

The grounds for judicial review are irrationality, breach of human rights, illegality and procedural unfairness. The threshold for judicial intervention is high, as Parliament has given local authorities the maximum discretion possible in these very sensitive areas of welfare resource allocation,

because the courts are not equipped to investigate mere differences of *opinion* between clients, carers and the funding authorities. This means that judges will not 'correct' plans simply because they are 'a bit mean' or not what is preferred. It is sometimes true that courts seem unwilling to treat a social *care ethic* as to what 'should' be done, as a reverse measure of what people should *not* be expected to put up with. In other words, there can sometimes be a gap between what the man in the street, or the social worker thinks is intolerable for a client, and what a judge thinks the State is obliged to do, to make up for that situation.

If a client wants something in particular, or a particular service, and the authority thinks it would be harmful for them, *no professional person can be obliged by a court to recommend or implement something that they think would be bad for the client*. The client's right is to say 'No thank you' to what *IS* offered instead, and to take steps to challenge the lawfulness of the offer if there are public law grounds for so doing. But the client cannot then expect to 'tell' the authority what to provide, regardless of the impact on others, in substitution for the original offer. See the Department of Health paper 'Independence Choice and Risk' for a fuller discussion of this principle.

Appendix 2:

What should be avoided, and why; and what is similar in outcome, but not so risky

Some authorities have already embraced radical means for implementation of personalisation, with the best of intentions. Whilst these may have been well received by clients, and are unlikely to have been challenged, local authorities do have to stay within the legal framework imposed by Parliament, because they are spending public money. Local authorities do not have a free rein to develop policy, just because it seems to be a good idea or because expectations have been raised: they have to find powers or duties under which to deliver services, and the same goes for new approaches to social care. There is no change being made to the legal framework, for personalisation, other than the introduction of one new piece of legislation extending Direct Payments to people lacking capacity, due in force in November 2009.

This appendix explores some of the things lawyers would regard it as risky to do, when implementing the personalisation agenda – things which are at the riskier end of community care law, in terms of being susceptible to challenge in the Administrative Court, or which could give rise to other forms of legal liability.

The appendix explains why, in general terms, it would be advisable to avoid them. General reasons for the categorisation of these activities or practices as legally risky are given, **but authorities' own lawyers should be consulted for advice about adjusting the approach in specific situations.**

Refusing to assess people simply because they admit to having over the capital threshold for any subsidy via the charging framework – this would be contrary to FACS guidance, which says that assessment should not depend on means; eligibility (ie the acknowledgement of needs necessitating local authority intervention) should not be decided according to means.

Means are only assessable after a person has availed him or herself of non-residential services. Additionally, a person may lack capacity to arrange their own service provision, and not have a carer willing or able to take on that responsibility.

Refusing to assess people simply because they are not yet in the area, but are seriously planning on moving there, to their own home or tenanted accommodation, thereby acquiring ordinary residence status.

Since there are powers in the current framework to provide services regardless of someone's ordinary residence elsewhere, and needs need not be imminent, in order to be eligible, this approach to deterring the movement of those able to live under other than National Assistance Act arrangements, is already contrary to decided case law.

Allowing a purely clerical assistant to complete any form of needs assessment (other than a part involving the collection of basic information) – this ignores government guidance about assessment and support planning in FACS guidance, which requires a **competent** person in relation to the complexity of the task, to be allocated the statutory responsibility.

It is not necessary in law or guidance for LA staff (other than those working in mental health services) to have professional qualifications in order to discharge social care functions, including assessment. However, in relation to the defence of any decisions made, and then challenged, any

local authority will be dependent on the impression that the actual decision-makers (that is, those concerned with the final stage of the internal process), would make on the Administrative Court judge.

Additionally, guidance from central government requires an authority to have at its disposal an appropriate range of staff in relation to the complexity of the statutory functions imposed on social services authorities. The more complex (or seriously and coherently disputed) the relevant decision is, the more imprudent it is for an authority to allocate unqualified/unsupervised/untrained/inexperienced decision-makers to the matter. They are simply more likely to strike a judge as having made an unreasonable decision, or one which did not take account of all relevant matters, than would a person with more qualifications/supervision/training/experience.

Over-zealous cutting of the proportion of qualified and experienced staff, to unqualified, unsupervised and inexperienced staff, uninformed by social work ethics and values and yet still involved in complex cases, would risk *compelling* a court to set out some sort of minimum standard of expertise for an assessment, if a startling enough case came before the courts; and the system has been deliberately set up without any clear definition of what is required.

Providing for pure ‘self’-assessment without proportionate supportive input - this risks being seen as delegation or abdication of the duty to assess and to take steps to assist an *impaired* person to make a capacitated contribution in relation to their assessment and what is then offered.

Self-directed assessment, self-directed support questionnaires, and the contracting ‘in’ of help for various stages of the assessment (such as the identification of need, the identification of what is available from the market that could be accessed without cost, the logistics of support planning for unmet need, access to advocacy services etc) are not unlawful strategies, so long as adequate information, and an appropriate and proportionate level of experienced or competent staff input are provided to assist the person in filling out the form and understanding what concepts they have to address, in order to qualify for services or funding.

The duty to assess includes a decision not merely as to the existence of needs, but a decision as to whether they make a person eligible for social care services or funding, and also a decision as to how the authority would **meet** the eligible needs. A policy of offering absolutely everyone a Direct Payment would not be a proper discharge of the duty to consider whether the authority is satisfied that this option can feasibly meet the assessed needs, before saying ‘yes’.

Regardless of how much control of the process the client has been given, the final inferences or conclusions from the forms do have to be drawn, and any decisions made, do have to be ratified or adopted by a local authority officer or someone with lawfully delegated authority to discharge the statutory function of assessment.

Ignoring the Mental Capacity Act in an SDS process – it would risk challenges of various kinds to regard personalisation as an approach applying simplistically to all clients, regardless of their mental capacity. Mental *incapacity*, in relation to any particular issue, is the single most important matter for assessment within community care functions, because it goes directly to the identification and evaluation of risk, to the extent of a person’s needs, to the feasibility of any given plan for *meeting* need, to the setting in which the person can feasibly be accommodated, or cared for (and under whose contractual arrangements), and to the lawful management of an appropriate way of enabling the person to deal with the need to pay for whatever it is that is to be provided.

Contracting ‘out’ the actual decision-making part of the assessment process on eligibility or the finalisation of the support plan to outside agencies (as opposed to contracting with agencies for *help*, in advance of in-house decision-making, with the fact-gathering aspects of assessment and support planning) – the former approach risks being seen

as unlawful delegation outside of the LA's officers and outside a lawfully authorised delegate such as the NHS under Partnership arrangements. The latter is incidental and ancillary to the functions of the authority and is not controversial. The relevant decisions that cannot be delegated 'out' through contract are eligibility decisions and final Resource Allocation in relation to the signing-off of a support plan.

Informing the client of a fixed and finite (as opposed to an indicative) sum of money as their entitlement, before support planning has been formally finalised – this could look like the application of a rigid, fettered, arbitrary cost ceiling, without regard to the individual's actual situation (e.g. are he or she a person needing double handling, for instance, or does the client live somewhere where no agency wants to send staff for the going market rate?)

It would also risk being seen as breach of the duty to meet need, for a few people at least – those for whom there is only one way to meet need, and which can only be funded if the initial *indicative* resource allocation is exceeded. That is because it is already the law that the budget position of the authority is legally irrelevant to the discharge of a crystallised duty to meet eligible assessed need. Shortfalls in a council's resources are only relevant to care and support funding decisions, when there is more than one appropriate alternatives.

Notifying a client of an *indicative* sum of money, so long as its quantification is rationally linked to evidence of relevant cost bases, is not a problem (assuming that a transparent process for challenging that amount is built into the system before the formal finalisation of the RA).

Treating an SDS questionnaire as equivalent to a community care assessment, even though it only covers very few basic domains – this risks a challenge to the legality of the assessment, if someone is dissatisfied with the outcome, in the end. The assessment must, according to already decided case law, cover all the domains which are implicitly included, by reference to the sort of services set out in legislation constituting community care legislation.

Authorities whose current design for a Self-Directed Support questionnaire does not follow the legal framework, in terms of the range of services which could feasibly be seen as covered by the community care legislation, need to take legal advice about how to make up that deficit by other means or processes.

Leaving out exploration of needs for leisure or recreation, practical assistance in the home, adaptations, placements, aftercare/re-ablement, counselling, assistance to use educational services, transport to access services, facilitation of respite and holidays, medicines administration etc, would be risking challenge, even if the local authority's threshold was set at Critical.

The domains that must be covered, according to guidance and the underlying case law, are all those domains in respect of which powers or duties have been given to purchase services, within the statutes which together constitute community care services, namely, the NAA 1948, the CSDPA 1970, the MHA s117, the HSPHA 1968 and the NHS Act 2006, sched 20, and the associated Approvals and Directions in LAC 93 (10).

Leaving an assessment with *merely* a set of desired outcomes, without co-producing a set of **solutions** that will bring down the unmet risk to independence across any eligible domain of need to below the local FACS threshold – risks being seen as an unreasonable delay in concluding the assessment, or concluding it without finalising a plan to meet need.

Assessment in the legal framework includes the planning stage. The solutions are what give rise to the amount that must be spent. The solutions have to be adequate and appropriate and lawful, and the plan has to be coherent enough to lay claim to being rationally based on the actual facts, not an arbitrary judgment. This is the minimum for a support plan. There needs to be enough detail in the support plan for the authority to be able to link the resource allocation it finally awarded, to a coherent rational view that the needs would be met, within that amount.

It would be acceptable to treat the content of the support planning as open to greater or lesser detail, as suited the particular client, so long as there is a link between the identified eligible needs, the proposals for meeting it, and the budget to be provided to meet it (ie a link between the needs and the client's basically identified allocation of parts of their budget, to the broadly matching areas of agreed needs).

It is essential for the proper discharge of community care functions, that the plan, and the relationship between the plan and the resource allocation for the individual, and the deployment option which is to be used for spending it, are all considered and approved by local authority staff or those with delegated authority under Partnership arrangements with the NHS, as being feasibly able to meet – lawfully assessed needs - and therefore needs assessed compliantly with FACS guidance.

Awarding a finalised personal budget and/or Direct Payment that bears no evidenced relationship to the actual cost of providing or buying services that would be thought appropriate to meet the need, nor to the extent of the services that would be needed.

This risks challenge as unlawful and irrational in public law terms, and could (exceptionally but certainly arguably) lead to a negligence action.

The duty to follow Direct Payments guidance in the discharge of Direct Payment functions requires the authority to substitute the cost of services as set out in the finalised support plan with its estimate of the cost, to the person in question, of obtaining those services. That may be greater or less than it would cost the authority, but the authority must relate the sum of money to the support plan it would otherwise have been obliged to implement, had the client not chosen to become their own commissioner.

Current Direct Payments rules require the amount of a Direct Payment to be set by reference to the authority's view about the cost of procuring the services (not merely the outcomes) in the person's care or support plan.

This does not mean that outcome-based support planning is not possible. It means that the identification of desired outcomes is an important part of planning, but only a part of it, and that the amount of a payment cannot be set finally, without identification of actual means by which the outcomes could feasibly be achieved.

Treating the RAS outcome, based on the questionnaire, as equivalent to a community care assessment – assessment has to be done in accordance with Fair Access to Care Services guidance, Human Rights principles and the case law. These sources all import notions of acceptable standards of living for all, adequacy and appropriateness of the response to the assessed needs, which may not be concepts covered, in one's SDS form.

Advising a person that they are not eligible for community care, after the completion of an SDS questionnaire and calculation of points, if the form has not been modelled on FACS principles and the legislative framework, is risking challenge that the assessment has not been done properly, or has been done unreasonably, or unlawfully; or that the duty to assess has not been fully discharged.

It is another thing entirely to explain to an apparently capacitated person on first contact that there is a financial means test, under which the local authority is entitled to take a view about the maximum level of capital one may own whilst still qualifying for a subsidy of one's social care costs, and that as such, deciding for him or herself that there may be little point in proceeding to formal assessment. The person is entitled to know in advance the rough outline of the charging policy and the availability of services elsewhere in the community, available at little or no cost, so as to retain maximum autonomy over the meeting of their own needs. If they decide not to proceed, then that should be respected.

Giving the funds for social care support to the carer of a person so lacking in capacity as to be incapable of electing to have a Direct Payment – this might be seen as ignoring the need for consent before regarding the client as consensually taking over the arrangements for the meeting of needs from the authority which owes that **duty**.

Even after the law changes in November 2009, it will not be enough that the authority thinks that the relative wishing to take control of the money is ‘a good person’. The new rules coming into force in November require an active role on the part of the authority in the consideration of competing candidates and selection of a suitable person, and local authorities need to prepare for this role, or risk challenge for not fulfilling the duty to offer Direct Payments to people lacking capacity, where they are at least satisfied that people’s needs can be met in that way.

S29(6) of the National Assistance Act forbids direct cash payments to **clients** and this remains the law, other than so far as it is done under Direct Payments legislation.

If authorities have given or want to give money to Support Organisations or to family members, under what they regard as Direct Payment arrangements, despite awareness of the incapacity of the individual service user to consent to a Direct Payment in the first place, those arrangements need to be regularised or launched in compliance with the new scheme in November.

Some authorities will have made contractual arrangements with families, or individual parents or spouses for what has been called an ‘indirect’ payment under the National Assistance Act 1948. It is arguably stretching language to call a family or a self-appointed group of ‘trustees’ without any settlor, or trust funds in its ownership, a ‘voluntary organisation’ and thus able to be a contractual party and the authority’s agent for the discharge of community care functions pursuant to s30 NAA. Companies limited by guarantee formed by such people have been the more successful vehicle for lawful indirect payments, and that has raised domiciliary care registration issues, if the organisation has then been arranging personal care. That issue will remain a live one until the domiciliary care agency registration rules are repealed and Part I of the Health and Social Care Act 2008 is brought into force, along with regulations describing exactly what regulated activities are included and excluded in the duty to register.

Dubious indirect payment arrangements need to be regularised under the new regime for Direct Payments for people lacking capacity, or turned into ‘proper’ s30 NAA arrangements with a proper voluntary organisation, or an individual holding him or herself out as some form of professional or other business entity.

The advantage of the new rules for Direct Payments is that are designed to work consistently with the new provisions for exemption from registration with the Independent Safeguarding Authority, for those **individuals** who work for an employer using a Direct Payment for themselves, a friend or a family member.

Treating a service user’s family member, carer or relative as automatically entitled to manage the person’s bank account, or to make decisions about tenancies, when the party in question has no legal authority to do so, and any informal consent that they may once have had from the person whose affairs they are managing, has fallen in, by reason of the supervening incapacity of that person – this approach risks allegations of collusion in, or facilitation of, financial abuse of the person lacking capacity.

Pledging of a person’s credit and repaying oneself from cash, from an Appointee’s account, or from a Direct Payment in respect of which one has been made a Representative under the new rules is acceptable, under s7 and 8 of the MCA. However, treating the Representative as automatically able to access the private and distinct part of the client’s money that may be comprised of savings or income in a bank account, is not. The conferring of Representative status under the new rules does not alter the underlying common and statutory law about the need for lawful authority before one can intervene in the management of another’s bank account.

The content of the new rules for Direct Payments for people lacking capacity will be relevant to all local authorities, and is based on Mental Capacity Act principles.

Policies and paperwork are required in order to be ready for the new task of considering the suitability of third parties as Representatives of the service user. Authorities will need to distinguish carefully between fully authorised surrogates and other unauthorised (albeit well-intentioned) friends/carers/relatives, when making consequential policy decisions about whether it would be best to pay such persons from the latter group, either gross or net of the service user's contribution/charge, for the purpose of minimising the risk of abuse. Payment *net* of the user's contribution under HASSASSA and Fairer Charging may put the Representative in the position of making inappropriate use of a PIN card or online banking, to access the 'other' part of the money necessary to pay for the full package of support assessed as needed. An invoice for the contribution can be sent in the usual way, instead.

Alternatively, authorities may well need to make use of their well-being powers under s2 Local Government Act 2000 for funding the one-off Deputyship costs of willing and able Representatives, for people lacking capacity, if they think it would be good for the area, in terms of economic or social well-being, in accordance with their Sustainable Communities Strategies, for Representatives to take on full legal authority in this manner.

A further alternative is the provision of a Deputyship service, in-house, but this is a mere discretion and not a social services duty. Conflict of interest is difficult to manage for the named office holder in such circumstances (see the MCA Code for a brief reference). Use of the s2 LGA powers to provide financial assistance to enable an application by another person for deputyship, could avoid people with less than full capacity being left to unsupervised intervention of third parties in the management of their property and bank accounts, especially in cases where the authority has received cogent evidence of safeguarding risks.

Developing a resource allocation formula by means of an arbitrary approach, and then treating it as a definitive offering – risks being seen as a breach of the duty to meet individual needs, and to fund the package, corporately, in a needs-led way, if there is only one way of meeting need.

A resource allocation calculation based on the authority's total available spend, divided by the number of clients on the books; or one based only on what *other* people, who appear to be 'like' the client, needed to have spent on *them*, previously, will never constitute a proper discharge of the legal obligation to come up with services or the money to meet the needs of the assessed *individual*, lawfully. So there is little point in worrying too much about the finer points of the Resource Allocation methodology – it is only an indicative guideline - an accounting tool best seen as a means to ensure prudent financial management, and as a better basis for engagement with the clients, and as a rough tool to promote equality of opportunity.

Cutting a budget during the currency of a support plan, for an existing eligible client, without a lawful re-assessment of community care entitlement – this risks challenge as unlawful, according to decided case law, which has explored the absolute nature of the duty to meet the assessed needs in the support plan, pending re-assessment.

Altering the Resource Allocation formula by adjusting the points per question, or the pounds per point, so as to reduce expenditure on new clients coming into the system or existing clients on review – even if not risking challenge on the ground directly above, this risks being seen as a covert raising of the FACS threshold, without proper consultation and consideration of equalities and diversity obligations.

The current case law says that a current support plan, and by implication the funding for it, cannot be cut without a lawful re-assessment, and that any such re-assessment will need to articulate how the previously assessed eligible need has been resolved (unless the need for the re-assessment has been a raising of the FACS threshold). Altering the RA to reflect rationally and transparently evidenced inflationary or deflationary changes in the cost of services in order that the clients remain positively **able** to meet their needs may not require re-assessment; but altering

the RA, regardless of the absence of any change in assessed needs, would be more complex. When done in relation to new clients coming into the system for the first time, authorities should seek their lawyers' advice on their obligations, because different treatment of people with similar levels of need, according merely to the point at which they became social services clients, will be likely to attract political or press attention, even if not a legal challenge.

Treating a Direct Payment as something different to what used to be called, in the IB pilot era, an 'individual budget' – this risks confusion in relation to the nature of the payment being made. There is no new thing in the legal framework (other than a Direct Payment for a person lacking capacity, in force in November 2009) called a personal budget or an individual budget that is different from what we work with now.

The rules that apply to Direct Payments, will apply, as modified by any fresh guidance, or legislation, to any part of a personal budget taken as a Direct Payment. So there will still be monitoring, albeit proportionate to risk and amount, in accordance with CIPFA guidelines, and there will still be accountability for those who misuse the money or abuse a position of trust in relation to its management.

A personal budget is the sum of money that the authority is prepared to allocate to the person to have some form of control over; a Direct Payment is one way of taking control of a personal budget, and what is then bought is bought as a private purchaser, although the money was public money (and remains so for the purposes of recovery upon death, or mis-spending).

The alternative way of offering control is to require the authority to provide or arrange for community care services in the conventional way, albeit that good commissioning relationships may be used to encourage providers to allow the service users to have more and more say, within the contract framework, over who does what and *when*, exactly.

Another way is for a client to accept a Direct Payment, but then to appoint the local authority as his or her private purchasing agent, for the purposes of management of the Direct Payment. In this model, the LA is acting as a private purchaser, instead of a public authority, with all the pros and cons that this involves. Only a capacitated person or their lawfully authorised representative should be invited to take this decision because it involves the concept of agreement to authorise someone to act on one's own behalf, and has legal implications. Accessing volumised conventionally purchased 'public' community care services or equipment could enable the person to have a cheaper package than would be the case if the authority was buying services as a private client's agent.

A **well-being grant** under s2 Local Government Act 2000 is a different legal vehicle altogether and should not be confused with a personal budget or a Direct Payment for community care services. It is a form of financial assistance which can be given to an individual, so long as the authority believes it will inure to the benefit of the area, and so long as there is no other legislative bar in statute or regulations preventing the desired outcome. These grants cannot be made without regard to the authority's Sustainable Communities Strategy. They cannot be made if any existing enactment prohibits, restricts or limits the achieving of the desired outcome, and they do not, therefore, overcome difficulties with the existing legal framework, for clients who have actually been assessed as eligible for community care services.

Advice should be sought from one's legal team as to whether it could be said that the desired outcome is one which there is no power at all to achieve within the current framework, because it is strongly arguable that s2 can be used in such circumstances to supply the power. Advice has been obtained to this effect and can be requested from ADASS.

Encouraging the funding of things that are not even arguably within the social care legal framework – this risks being seen as the provision of public money to fund 'wants', instead of needs, or to fund things that the authority would not be able to buy, lawfully, and as such could be guaranteed to attract negative media attention, if not legal challenge.

Some of the clients within the pilot sites have benefited from a perceived freedom in what they could purchase that did not seem to exist within the Direct Payments schemes they had previously experienced. But Direct Payments are the legal basis for giving public money to community care clients, and the Direct Payment framework does relate back to the community care legal framework for service, in relation to the calculation of the amount that should be awarded, and the right to recover that which has not been used on services in the support plan. That underlying framework is flexible, but does inevitably have limits, borne of the fact that language has meaning; meaning which must, in our system, sometimes be interpreted by judges. For instance, it has been held that funding the suctioning of a tracheotomy tube could not ever be social care for a child in need; it is indubitably a *health* care service.

There is a duty to fund that which can feasibly **count as community care services**, out of social services' funds, and a corollary – **not funding that which could not feasibly be seen as coming within the statutory remit**. There is a good deal of flexibility in the current framework which enables a modern and appropriate interpretation of outmoded concepts and wording, in terms of the description of services. The inevitable limits to what can be provided by way of community care, are not such as to make it impossible to enable clients to achieve better outcomes.

Mainstream/universal services are not necessarily community care services **within a person's support plan**, for unmet need. So pulling these sorts of services into someone's assessment of need, as a means for helping them to help themselves meet their own needs, eligible or otherwise, does not mean that the community care legislation has been ignored. It just means that what would have otherwise have been a need, and maybe even an unmet need, has been met by recourse to services available to all, not just to those who are eligible for further provision, within their individual support plan, for meeting **unmet** need.

Giving clients Direct Payments with which to buy long term residential care – this is already unlawful under the current Direct Payments regulations and will continue so to be after November 2009. Using s2 of the Local Government Act 2000 to achieve something that is already prohibited by another Act or Regulations is also ineffective and illegal, by virtue of s3 LGA 2000.

A person in residential care may be given a personalised budget but the part for the care home fee must be left with the authority to spend as community care monies, and not as a Direct Payment. A person in permanent residential care cannot be charged under the Fairer Charging latest guidance to contributions, because that guidance only applies to non-residential community care services. A percentage of one's final resource allocation cannot be applied by way of a charge for residential care, because the residential care charging law framework does not work that way, and is not changing.

Treating people as eligible for ILF and benefits, even if they have not applied for these forms of financial assistance from the State - and thus regarding them only as eligible for the minimum LA contribution to a package to attract ILF – risks being seen as compelling people to apply for ILF and benefits in order to save money for social services departments, when there is no notional income rule in the charging framework for non-residential services.

A local authority's applying for ILF for a person lacking capacity without doing a best interests balance sheet consideration – this risks being seen as unlawful because the LA will be conflicted out of doing this by reason of the fact that it would be the main financial beneficiary of the receipt of ILF, and the client may in fact be worse off, because of the difference in the charging regimes of the ILF Trust and within social care.

Refusing to arrange for the provision of preventative services below the threshold on the basis that they are not ‘necessary’. This would be imprudent and could foreseeably lead to greater levels of critical need in any authority’s area.

Authorities worry about their FACS threshold, and what it would mean to provide services ‘below the line’. Preventative work – in the sense of universally available services to all, for people who would be well below the authority’s FACS threshold, **can already be arranged and funded under current community care legislation by local authorities, even when acting outside of assessed needs in individuals’ support plans.**

Authorities can choose to put funds into service level agreements for provision of services in the community, under s29 National Assistance Act, regardless of whether there is anyone assessed as needing them. Authorities can also - regardless of the level of assessed need in an area - also choose to grant-fund voluntary organisations under the Health Service and Public Health Act 1968 for the provision of services similar to the ones that authorities would otherwise make arrangements for. Doing so enables an authority to keep its FACS threshold higher than would otherwise be the case, because subject to the cost being nil or very low, it can legitimately point to the those services as rendering anything further for the individual as not ‘called for’ or ‘necessitated’ by way of unmet need.

Grant-funded organisations are the actual providers of services direct to the clients, and they make any charge they think fit, or that the grant conditions allow, direct to the client, which is not necessarily a Fairer Charging charge. ‘Social care’ types of services, provided by organisations who are contracted to provide them to the authority are, in the main, bound to be community care services, and can only be charged for in accordance with the Fairer Charging guidance and the legislation (regardless of who actually collects the charge).

Ignoring the notion of a duty of care to social care clients, if the budget is spent and the authority knows that the client is unable to meet their needs – this risks being seen as a breach of statutory duty to meet assessed need.

The agreement of a person to take a Direct Payment **discharges the authority from its duty of care in so far as actual service provision is concerned (see the current regulations)**, but not in relation to monitoring the success or otherwise of the plan to meet need. So the idea of a duty of care will be continue to be relevant to care managers, all safeguarding professionals, and to Mental Capacity Act leads within local authorities.

The Mental Capacity Act emphasises that people lacking capacity in relation to care and welfare and management of their affairs, have both rights and freedoms. These may be in civil law, or in Human Rights law, and these are relevant to all local authorities’ discharge of their community care functions.

As soon as an authority has reason to be concerned that the deployment method by which control has been taken over the person’s personal budget might not be working effectively to meet need, it has a duty to re-assess. In the context of a too-hastily spent budget, this would necessitate an investigation, at the very least, of the reasons why the money has been spent down. The situations in which an authority would be legally justified in walking away from a person faced with assessed eligible needs that can no longer be financed from their budget, would be very rare indeed, and legal advice specific to the situation should be sought. The more appropriate response would be to use the range of conditions provided for, in the new rules on Direct Payments, to tighten the authority’s supervision of the use of the money, or to withdraw the Direct Payment and revert to another deployment option for use of the personal budget.

Treating a person as entitled to demand to be financed through social care functions, in relation to any particular risk that they would like to be facilitated to take – this risks challenge as to lack of rigour in the spending of public money, and of ignoring the principles of the Mental Capacity Act. It could also feasibly (albeit exceptionally) lead to negligence actions or a Health & Safety investigation, or criticism from a coroner’s inquest.

As is clearly stated in the Department of Health paper on **Independence, Choice and Risk**, a capacitated person who takes an informed decision to do something that causes them harm, cannot expect to hold a local authority liable for the loss suffered.

But in addition, the paper mentions that an authority is not obliged to finance any particular risk that a capacitated person wants to take. It is entitled to take a view as to which risks it wishes to be associated with facilitating, because it is spending public money in the context of meeting assessed eligible needs, and not mere wants, nor aspirations. In deciding where the difference lies, it is bound by equalities duties to have regard to the need to promote equality, but is not under any duty to treat any particular lifestyle (or content of a lifestyle) as a mandatory comparator.

These legal principles need to be understood and are available to all in that DH discussion document.



Putting **People** First
Transforming Adult Social Care