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Assessment of need for community care

17

CASE STUDY

***R (on the application of Ireneschild) v Lambeth London Borough Council* (2007)**

Ms Ireneschild (Ms I) was disabled following a climbing accident. She needed help to stand and move around; she needed a wheelchair to get out; she was in constant pain and she was doubly incontinent. She lived with her two adult sons in a two-storey flat, which could only be accessed via a flight of stairs. She was worried about falling on the stairs, and by the risk to her sons of lifting her, and she wanted a toilet on the same level as the rest of her accommodation. She requested an assessment of her community care needs from the local authority. (The local authority was also her landlord, but the assessment was a social services assessment under community care law.) She claimed she should be given ground floor accommodation.

The social services department assessed her needs as 'substantial' but not 'critical' (these are levels of priority which we will encounter later). They took into account that she had not in fact fallen for eight years. They were not prepared to provide a ground floor flat, though the other elements of the care package were not disputed.

A High Court judge quashed that assessment: no reasonable social worker (in this case the OT and the housing department officer who had assessed her needs on the department's behalf) could have assessed Ms I as needing the present level of provision.

The sympathy of Hallett LJ in the Court of Appeal for the reality of the social worker's task will be worth remembering if you ever face criticism yourself:

> [The High Court judge had] found that in failing properly to assess the risks to the Respondent of falling and the risk to her sons of carrying her, the authority failed to follow the statutory guidance. He concluded that the assessment failed to address the impact of the accommodation on her independence. He described this as particularly surprising given the conclusions drawn by [the social worker] in his assessment.
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> 57. ...one must always bear in mind the context of an assessment of this kind. It is an assessment prepared by a social worker for his or her employers. It is not a final determination of a legal dispute by a lawyer which may be subjected to over zealous textual analysis. Courts must be wary, in my view, of expecting so much of hard pressed social workers that we risk taking them away, unnecessarily, from their front line duties.
>
> 58. ...I am satisfied that the assessment did adequately address the issue of independence and the risk to the carers. There was no failure to address essential questions which are required to be addressed under the guidance. At the risk of repeating myself: the assessment sets out over four paragraphs the detail of the [Ms I's] mobility inside and outside her home, including specifically going up and down the stairs, which on her own account she could

manage independently except on a bad day. On those occasions, she would obtain the assistance of her sons who are happy to continue helping her. The effect upon them was considered. The assessment did, therefore, address the degree to which [her] premises currently affect her autonomy and independence. The assessment recognised that 'ideally' [she] would be housed in accommodation without external steps or internal stairs. At the same time it recognised that this might take some time. The assessment also discounted (for practical reasons) the possibility of installing a stair-lift. As [the authority's barrister] argued, all these matters implied a recognition that the stairs posed some element of risk of falling. Thus, although the author may not have stated in terms the possible consequence to Ms Ireneschild of falling and hurting her arms, the risk of falls was undoubtedly uppermost in [the assessor's] mind. It would have been something of a statement of the obvious for her also to state that if Ms Ireneschild fell she could hurt herself and, if she hurt herself, it could significantly impair her independence and mobility.

59. [A senior member of the department] has accepted on behalf of the authority that for so long as Ms Ireneschild is housed in accommodation with stairs she is at risk of falling. But, the risk to Ms Ireneschild and her sons cannot be considered in isolation. Everything is relative. [She] said this:

> 'Essentially, the council has found that the Respondent is able to negotiate her way around the property and get into and out of it. The council accepts that there is a risk to the Respondent when using her staircases however it considers this risk to be a small and acceptable risk. There are numerous council service users who manage similar or greater risks in their homes and it is neither possible nor desirable for the council to avoid all risks of this nature.'

60. In the words of the [*Fair Access to Care Services: guidance on eligibility criteria for adult social care*] guidance [important statutory guidance which is discussed below], the risks in Ms Ireneschild's case were assessed as 'acceptable'. I understand why Ms Ireneschild may object to such an assessment. I have considerable sympathy for her and for her sons. They cope remarkably well with a very difficult situation. However, the fact that some may disagree with the result does not make the process unlawful.

OVERVIEW AND OBJECTIVES

Assessment of need is at the core of community care, and the service user is at the core of the process. In theory the idea is simple—find out by talking to the service user and their carers, doctor, etc., what their problems are and what help they need; compare those needs with your statutory powers and duties, in light of your departmental priorities, and decide which of these needs can be met. Of course, it is more complex than that because health, housing, financial, and emotional needs are connected to the social care needs; because the needs are already being met in whole or in part by a carer or out of the service user's own pocket; because other agencies, both statutory such as the NHS, and voluntary, are likely to be involved in meeting any need, as well as providing information for the assessment. Get it wrong, in the view of the service user or a family member, and complaints or litigation are possible. Get it right, and the process has only just started, as each case will need continual monitoring, interagency review, and re-assessment.

Understanding the basic framework will, we hope, be of assistance. That is the objective of this chapter. The framework which we want to explain to you is to be found in a combination of statutory requirements and government circulars, with a gloss provided by the courts.

The statutory framework—NHSCCA, s. 47

If you need to refresh your memory as to what the acronyms mean, see the previous chapter. On this occasion, however, we will give you it in full as one Act is at the core: National Health Service and Community Care Act. Assessment starts with s. 47, which sets out the statutory duties governing assessments and plans for the individual. This is worth quoting in full (with added emphasis):

> (1) Subject to subsections (5) and (6) below [not quoted—they allow you to meet needs without an assessment in order to deal with an emergency], where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority—
> (a) *shall carry out an assessment* of his needs for those services; and
> (b) having regard to the results of that assessment, *shall then decide whether his needs call for the provision by them of any such services.*

It is clear from the wording of s. 47 that an individual does not have to ask to be assessed; the local authority has to carry out an assessment of anyone who might be eligible for community care. The community care plan for the social services authority should already have identified, in broad terms, numbers and needs of people who might need the services.

Section 47(3) requires you, when assessing an individual, to notify the health authority or housing authority if you think that that agency may need to provide services. And s. 47(6) requires you, in urgent cases, to provide services first and to complete the assessment second.

Section 47 goes on to require an automatic assessment to take place of the needs of any persons who are disabled:

> (2) If at any time during the assessment of the needs of any person under subsection (1)(a) above it appears to a local authority that he is a disabled person, the authority—
> (a) *shall* proceed to make such a decision as to the services he requires as is mentioned in **section 4 of the Disabled Persons (Services, Consultation and Representation) Act 1986** without his requesting them to do so under that section; and
> (b) *shall* inform him that they will be doing so and of his rights under that section.

The cross reference in s. 47(2) to s. 4 of the DPSCRA 1986 is the beginning of a legislative paper chase. We will not do this on every occasion, but we are going to try following up the leads provided. In the process we will bring you into contact with the most important parts of the legislation, and illustrates some of the complexities of tracking down what powers and duties you have. We will **highlight in bold** the sections which require legislative surfing.

In s. 4 of the DPSCRA 1986, which s. 47 referred to, you find the following:

4 Services under s 2 of the 1970 Act: duty to consider needs of disabled persons

When requested to do so by—

(a) a disabled person,

(b) his authorised representative, or

(c) any person who provides care for him in the circumstances mentioned in **section 8**,

a local authority shall decide whether the needs of the disabled person call for the provision by the authority of any services in accordance with **section 2(1) of the 1970 Act** (provision of welfare services).

The 1970 Act referred to is the Chronically Sick and Disabled Persons Act (CSDPA). There is also a reference to s. 8 of the 1986 DPSCRA. The latter states:

8 Duty of local authority to take into account abilities of carer

(1) Where—

(a) a disabled person is living at home and receiving a substantial amount of care on a regular basis from another person (who is not a person employed to provide such care by any body in the exercise of its functions under any enactment), and

(b) it falls to a local authority to decide whether the disabled person's needs call for the provision by them of any services for him under any of the welfare enactments,

the local authority shall, in deciding that question, have regard to the ability of that other person to continue to provide such care on a regular basis.

(2) Where that other person is unable to communicate, or (as the case may be) be communicated with, orally or in writing (or in each of those ways) by reason of any mental or physical incapacity, the local authority shall provide such services as, in their opinion, are necessary to ensure that any such incapacity does not prevent the authority from being properly informed as to the ability of that person to continue to provide care as mentioned in subsection (1).

We still have to check s. 2 of the 1970 Act. Section 2 states:

2 Provision of welfare services

(1) Where a local authority having functions under **section 29 of the National Assistance Act 1948** are satisfied in the case of any person to whom that section applies who is ordinarily resident in their area that it is necessary in order to meet the needs of that person for that authority to make arrangements for all or any of the following matters, namely—

(a) the provision of practical assistance for that person in his home;

(b) the provision for that person of, or assistance to that person in obtaining, wireless, television, library or similar recreational facilities;

(c) the provision for that person of lectures, games, outings or other recreational facilities outside his home or assistance to that person in taking advantage of educational facilities available to him;

(d) the provision for that person of facilities for, or assistance in, travelling to and from his home for the purpose of participating in any services provided under arrangements made by the authority under the said section 29 or, with the approval of the authority, in any services provided otherwise than as aforesaid which are similar to services which could be provided under such arrangements;

(e) the provision of assistance for that person in arranging for the carrying out of any works of adaptation in his home or the provision of any additional facilities designed to secure his greater safety, comfort or convenience;
(f) facilitating the taking of holidays by that person, whether at holiday homes or otherwise and whether provided under arrangements made by the authority or otherwise;
(g) the provision of meals for that person whether in his home or elsewhere;
(h) the provision for that person of, or assistance to that person in obtaining, a telephone and any special equipment necessary to enable him to use a telephone,

then,...subject...to the provisions of **section 7(1) of the Local Authority Social Services Act 1970** (which requires local authorities in the exercise of certain functions, including functions under the said section 29, to act under the general guidance of the Secretary of State) and to the provisions of section 7A of that Act (which requires local authorities to exercise their social services functions in accordance with directions given by the Secretary of State), it shall be the duty of that authority to make those arrangements in exercise of their functions under the said section 29.

We do not need to take you through s. 7 of LASSA, since we covered that in Chapter 3. Though we have not quite finished surfing, we have reached our goal of finding what provision could be made on behalf of the people whose needs were being assessed under s. 47 NHSCCA, and this is s. 29 of the National Assistance Act. This section is the core of the post-war design of social care services for people not requiring residential care. A matching section is s. 21, dealing with residential care provision, which you will encounter in Chapter 18.

29 Welfare arrangements for blind, deaf, dumb and crippled persons, etc

(1) A local authority may, with the approval of the Secretary of State, and to such extent as he may direct in relation to persons ordinarily resident in the area of the local authority shall make arrangements for promoting the welfare of persons to whom this section applies, that is to say persons aged eighteen or over who are blind, deaf or dumb or who suffer from mental disorder of any description, and other persons aged eighteen or over who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.

(2), (3)...

(4) Without prejudice to the generality of the provisions of subsection (1) of this section, arrangements may be made thereunder—

(a) for informing persons to whom arrangements under that subsection relate of the services available for them thereunder;
(b) for giving such persons instruction in their own homes or elsewhere in methods of overcoming the effects of their disabilities;
(c) for providing workshops where such persons may be engaged (whether under a contract of service or otherwise) in suitable work, and hostels where persons engaged in the workshops, and other persons to whom arrangements under subsection (1) of this section relate and for whom work or training is being provided in pursuance of the **Disabled Persons (Employment) Act 1944 [or the Employment and Training Act 1973]** may live;

(d) for providing persons to whom arrangements under subsection (1) of this section relate with suitable work (whether under a contract of service or otherwise) in their own homes or elsewhere;

(e) for helping such persons in disposing of the produce of their work;

(f) for providing such persons with recreational facilities in their own homes or elsewhere;

(g) for compiling and maintaining classified registers of the persons to whom arrangements under subsection (1) of this section relate.

(4A) Where accommodation in a hostel is provided under paragraph (c) of subsection (4) of this section—

(a) if the hostel is managed by a local authority, **section 22 of this Act** shall apply as it applies where accommodation is provided under **section 21**;

(b) if the accommodation is provided in a hostel managed by a person other than a local authority under arrangements made with that person, **subsections (2) to (4A) of section 26** of this Act shall apply as they apply where accommodation is provided under arrangements made by virtue of that section; and

(c) sections **32 and 43** of this Act shall apply as they apply where accommodation is provided under **sections 21 to 26**;

and in this subsection references to 'accommodation' include references to board and other services, amenities and requisites provided in connection with the accommodation, except where in the opinion of the authority managing the premises or, in the case mentioned in paragraph (b) above, the authority making the arrangements their provision is unnecessary.

(5) ...

(6) Nothing in the foregoing provisions of this section shall authorise or require—

(a) the payment of money to persons to whom this section applies, other than persons for whom work is provided under arrangements made by virtue of paragraph (c) or paragraph (d) of subsection (4) of this section or who are engaged in work which they are enabled to perform in consequence of anything done in pursuance of arrangements made under this section; or

(b) the provision of any accommodation or services required to be provided under [the National Health Service Act 2006 or the National Health Service (Wales) Act 2006]...

(7) A person engaged in work in a workshop provided under paragraph (c) of subsection (4) of this section, or a person in receipt of a superannuation allowance granted on his retirement from engagement in any such workshop, shall be deemed for the purposes of this Act to continue to be ordinarily resident in the area in which he was ordinarily resident immediately before he [was accepted for work in that workshop; and for the purposes of this subsection a course of training in such a workshop shall be deemed to be work in that workshop].

We could—but will not as this legislative surfing could never end—now take you to the NHS legislation of 2006, which requires social services departments to respond to requests from the NHS to provide services, from the range of services they are required or permitted to provide, for NHS patients. If we had set out the whole of s. 47 NHSCCA, not just subsection (2), we would have set out on an additional trail looking at the obligation to consult the representatives of disabled persons under DPCRSA,

ss. 2 and 3. For present purposes, all we have space to say is that that obligation exists.

It is important to grasp what we have just covered, as it is at the core of community care assessment and provision. You must assess the needs for services of anyone who is classed under NAA, s. 29 as disabled. You must consult the disabled person's representative. You must take into account the capacity and needs of the carer of the disabled person. You must consider whether any of the services listed in s. 29 are required—help with overcoming disability in the home, workshops, etc. You must also consider the schemes which s. 29 enables the Government to publish, to see what other provision is available for the disabled person so you can assess their need for such services accordingly. We will consider such schemes in the next chapter.

We have taken you through this bit of legislation in full to show how you must assess needs for non-residential services for disabled persons. You also have powers and duties to provide residential accommodation for the disabled (see Chapter 18), to provide services for the sick, for mothers of young children, and for the old. Section 47 requires you to carry out an assessment of need as soon as you are aware that such a need may have arisen.

Case law on assessment—does it make the statutes easier to understand?

The *Barry* case will be considered in some detail below. We cite it here to illustrate that if the statute law is complex, often the case law is no better. The question was whether a social services department could reduce the assessed need for care services provided to Mr Barry, on the ground that the authority could not afford to maintain the high level of care they had previously provided. Mr Barry's challenge to the decision was finally decided in the House of Lords in *R v Gloucestershire County Council, ex parte Barry* (1997). Here is an extract from a key part of the judgment of Lord Nicholson:

> [N]either the fact that the section imposes the duty towards the individual, with the corresponding right in the individual to the enforcement of the duty, nor the fact that consideration of resources is not relevant to the question of whether the duty is to be performed or not, means that a consideration of resources may not be relevant to the earlier stages of the implementation of the section which lead up to the stage when satisfaction is achieved.

This is a key part of the judgment. But what does it mean? We think that Lord Nicholson is saying that:

(a) statute requires the council to make provision for Mr Barry;

(b) Mr Barry is entitled to ask the court to force the council to carry out its duty;

(c) the council cannot plead poverty as a way out of the duty; but

(d) the council's resources can be relevant in assessing what it can actually be required to do for Mr Barry.

We are reluctant to cast too much blame for the complexity of language and statute, since our own attempts to explain the provisions may, for you, be equally confusing.

We hope we have shown how s. 47 and the statutory requirement to carry out an assessment of an individual is at the core of community care assessment and of community care law. We will now try and explain the legal principles of the assessment itself. The *Barry* case, incidentally, is extremely important and is covered below.

The assessment process—needs come first

The assessment should be carried out by specialist social services staff, not by the service providers. The service user's needs for community care or residential provision are to be assessed in light of their need for any services which the local authority has a power or duty to provide. The assessment is not at this point an assessment of whether their needs can be met.

Government guidance on assessment is contained in circular LAC (2002)13, *Fair Access to Care Services* [*FACS*]. The assessor is charged, under this guidance, with one overarching task:

> councils should operate just one eligibility decision for all adults seeking social care support—namely, should people be helped or not?

The Department of Health's *Policy Guidance*, at para. 3.24, provides an important gloss on this by stating that 'service provision should, as far as possible, preserve or restore normal living'. The order of priorities in assessment of need is therefore in identifying what services will achieve:

(a) support so that the service user can live at home;

(b) a move to more suitable accommodation;

(c) a move to another household;

(d) a move to residential care;

(e) a move to a nursing home; or

(f) long-stay hospital care.

Circular LAC (92)12, *Housing and Community Care* (still current) requires the assessment to focus on the difficulties an individual is facing, and to take into account the following:

(a) capacity/incapacity;

(b) preferences and aspirations;

(c) the living situation;

(d) support from relatives and friends; and

(e) other sources of help.

Local authorities are democratically elected accountable public bodies. They set their own budgets and raise money from electors, who can remove councillors from office if they spend too much or too little on council services. Although there is much criticism

of 'post code lotteries' in health services, there is no expectation that provision of community care in Newcastle upon Tyne will match provision in Newcastle under Lyme or Newcastle, Shropshire. Minimum standards must be achieved, and assessed needs met where statute provides a duty to do so. This provides scope for significant variation in what the local authority sees as priority, and as we will see in the next chapter, budgets can be taken into account in deciding what services can be provided in meeting assessed need.

LAC (2002)13, *Fair access to care services: guidance on eligibility criteria for adult social care* is a core document, and makes this point clearly. This states:

> 42. [I]t is not the intention of the Department of Health that individuals with similar needs receive similar services up and down the country. This is because, although all councils should use the same eligibility framework to set their local criteria, the different budgetary decisions of individual councils will mean that some councils will be able to provide services to proportionately more adults seeking help than others. In addition, service provision is configured differently in different parts of the country. What is important is for people with similar needs to be assured of similar care outcomes, if they are eligible for help, irrespective of the services that are provided to meet eligible needs.
>
> When determining the most appropriate level of support to individuals with eligible needs, councils should ensure that resources are used cost-effectively with due regard to individuals' needs and agreed outcomes.
>
> 43. Once eligible needs are identified, councils should meet them. However, services may also be provided to meet some presenting needs as a consequence of, or to facilitate, eligible needs being met.
>
> 44. The determination of eligibility in individual cases should take account of the support from carers, family members, friends and neighbours which individuals can access to help them meet presenting needs.

Eligibility criteria

The assessment should look in particular at the autonomy of the service user, issues of health and safety, the ability to manage daily routines, their family life, and ability to engage with their community. The individual's needs for services should be categorized as being in one of four bands: critical, substantial, moderate, or low. Each need should be separately identified and categorized—it is the need, not the service user, which is critical, substantial, moderate or low.

But each social services authority establishes its own eligibility criteria. It is for the council then to determine whether the service must be provided—some councils will meet a given need when it is substantial, others only when it is critical. The circular permits this approach. But an authority must follow its own published criteria and must assess according to the priority criteria which we have reproduced in Box 17.1. The wording of each eligibility band should not be altered by local authorities—the discretion only lies in the decision as to what provision is appropriate for needs assessed within the different bands.

BOX 17.1 Extract from circular *FACS*

The eligibility framework is graded into four bands:

Critical—when

- life is, or will be, threatened; and/or
- significant health problems have developed or will develop; and/or
- there is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or
- serious abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out vital personal care or domestic routines; and/or
- vital involvement in work, education or learning cannot or will not be sustained; and/or
- vital social support systems and relationships cannot or will not be
- sustained; and/or
- vital family and other social roles and responsibilities cannot or will not be undertaken.

Substantial—when

- there is, or will be, only partial choice and control over the immediate environment; and/or
- abuse or neglect has occurred or will occur; and/or
- there is, or will be, an inability to carry out the majority of personal care or domestic routines; and/or
- involvement in many aspects of work, education or learning cannot or will not be sustained; and/or
- the majority of social support systems and relationships cannot or will not be sustained; and/or
- the majority of family and other social roles and responsibilities cannot or will not be undertaken.

Moderate—when

- there is, or will be, an inability to carry out several personal care or domestic routines; and/or
- involvement in several aspects of work, education or learning cannot or will not be sustained; and/or
- several social support systems and relationships cannot or will not be sustained; and/or
- several family and other social roles and responsibilities cannot or will no be undertaken.

Low—when

- there is, or will be, an inability to carry out one or two personal care or domestic routines; and/or
- involvement in one or two aspects of work, education or learning cannot or will not be sustained; and/or
- one or two social support systems and relationships cannot or will not be sustained; and/or
- one or two family and other social roles and responsibilities cannot or will not be undertaken.

17. In constructing and using their eligibility criteria, and also in determining eligibility for individuals, councils should prioritise needs that have immediate and longer-term critical consequences for independence ahead of needs with substantial consequences. Similarly, needs that have substantial consequences should be placed before needs with moderate consequences; and so on.

18. In setting their eligibility criteria councils should take account of their resources, local expectations, and local costs. Councils should take account of agreements with the NHS, including those covering transfers of care and hospital discharge. They should also take account of other agreements with other agencies, as well as other local and national factors.

19. Councils should review their eligibility criteria in line with their usual budget cycles. Such reviews may be brought forward if there are major or unexpected changes, including those with significant resource consequences.

20. Although final decisions remain with councils, they should consult service users, carers and appropriate local agencies and organisations about their eligibility criteria and how information about the criteria is presented and made available. Eligibility criteria should be published....

Assessment of a health, as opposed to a social care, need does not require the social services department to make provision—but the assessment should not have to be repeated, and the health authorities should have been involved in the assessment if there is any evidence of health problems.

The resources of the local authority

Once a need is assessed as existing, it must be met if the service is one of the obligatory services identified in the next chapter. But what is the relationship between the needs of the individual and the resources of the authority? Does a need diminish if the resource to meet it has reduced? Perhaps surprisingly, the answer to this question is yes, as is indicated in the case of *R v Gloucestershire County Council, ex parte Barry* (1997).

Mr Barry was 79 and severely disabled. He was assessed as requiring cleaning and laundry services; a schedule was worked out for what he would receive, and when, which seemed to work fine. But then the authority came under under financial pressure, and decided to reassess him. Not surprisingly, given the motivation to save money, it 'discovered' that what he really needed was reduced laundry services and, how fortunate!, no cleaning at all. But Mr Barry's health had not improved and from his perspective his needs remained the same, so how could the authority say he no longer needed the same services? He applied for judicial review. The Court of Appeal decided that under CSDPA, s. 2 (we saw above that, for a disabled person as defined under s. 21 NAA, the NHSCCA, s. 47 assessment is carried out with reference to this section), he should receive those services he was assessed as needing; resource problems did not change those needs.

The House of Lords—in a majority decision with some powerful dissenting judgments—overturned this decision. It ruled that the authority has a duty to provide only

what it can reasonably afford. You might think this is a separate question from assessment, and that it belongs in the next chapter of this book, on provision. We would be inclined to agree with you, but we would be wrong.

What the Lords were saying here was that you can work backwards from cost of provision and use the cost as a factor in assessing whether the provision is actually needed. In other words assessment is not separate from provision, and the s. 47 NHSCCA assessment, and any subsequent re-assessment, takes into account the service user's needs in the light of financial constraints. If the needs are expensive to meet, the assessment can in essence say that the service user only needs the amount of service which can be afforded.

But the Lords also said—prepare for mental gymnastics here—that once a need *is* assessed as existing, the authority *must* meet that need, even if it lacks resources. If you fall into the trap of saying a service user needs a service, and it falls into the list of those that must be provided in your local authority's priorities under *FACS*, identifying the lack of resources at this late stage is irrelevant. In *R v Sefton MBC, ex parte Help the Aged* (1997) the authority was ordered to provide residential accommodation to an elderly service user, because she had been assessed as needing it.

To make this proposition sound more reasonable from the local authority point of view, need is a flexible and subjective concept; it cannot be dissociated from the means by which it is to be met, taking into account the other pressures on a public authority's budget and looking at the individual's problems in a proportionate fashion. We think it would be honest, and accountable, to assess the service user's needs for, say, daily bathing regardless of the authority's financial position; the council is then free to choose whether it spends money on meeting that need and the voters are free to endorse or reject the approach chosen. It is a fudge to assess someone as not needing the full service on the grounds that there is insufficient money to pay for it. It also puts those carrying out assessments into a dishonest position, where they are under pressure to assess what can be paid for rather than what is needed.

Much will turn on the language used in the assessment. 'We can't meet your needs because we can't afford it' won't work if challenged in court. 'This is how we can meet your needs within the available resources' may work. *Barry* was decided before the Human Rights Act was in force. It also clashes, in our opinion, with a House of Lords decision on providing home education to a girl with ME. In *R v East Sussex County Council, ex parte Tandy* (1998), Lord Browne-Wilkinson stated:

> Parliament has chosen to impose a statutory duty, as opposed to a power, requiring the local authority to do certain things. In my judgment the court should be slow to downgrade such duties into what are, in effect, mere discretions....If Parliament wishes to reduce public expenditure on meeting the needs of sick children then it is up to Parliament so to provide.

Tandy related to a different statutory duty—provision of education, not care—so it can technically be distinguished from *Barry*. In spirit, however, *Barry* is open to question if *Tandy* is correct.

Following *Barry*, the Department of Health issued a Guidance Note (LASSA (97)13) telling local authorities not to use the judgment as an excuse to take decisions on

resource grounds only. The circular says that decisions must always be based on a needs assessment. We cannot agree that *Barry* allows you to do this without reference to the resources from which the needs will be met.

Since *Barry* the *FACS* circular has also been issued, which enables an authority to determine in advance which levels of eligibility they will normally meet. There is no higher band than critical, and if the social services department cannot meet critical need, its decision will be reviewable by a court. In every case below that level the department has discretion. Even it is has stated that it will not meet all needs assessed as substantial, it will have to consider each case individually and justify its decision. It cannot have a blanket policy never to meet substantial needs. If the authority cannot justify a decision not to meet substantial needs, the decision is open to challenge. Even need assessed as moderate must be considered on a case by case basis, with the decision justified rather than provision refused automatically. In all cases of refusal, *Barry* enables resources to be part of the overall consideration of what needs are met, and what needs cannot be.

Assessment of the carer

A press release from Help the Aged dated 24 October 2001 states: 'more than a million older carers are having to look after the sick without adequate support from health, social services or homecare agencies'. In attempting to tackle this issue the CRSA was strengthened by the CDCA in 2000. The authority must not only assess the needs of the person who is being cared for; it must assess the ability of any persons aged over 16 caring for that person. This assessment must be realistic and not turn a blind eye to the burden carers take on. The intention of the two Acts taken together is to ensure that the silent army of voluntary carers—including young children looking after sick parents—is monitored by the authority, and their efforts supplemented by care services to both service users; that is, the carer and the person being cared for. The right of the carer to their own life, particularly education and leisure opportunities, must also be considered in the assessment. Where this was good practice before, it is now a statutory requirement as a result of the Carers (Equal Opportunities) Act 2004. It is a statutory requirement to ask: what would the carer do if they did not have these caring responsibilities? What services will free up the carer to continue to have a reasonable caring/personal life balance?

The approach to working with the carer is summed up in the *Community Care Assessment Directions* LAC (2004)24:

> 2.—(1) In assessing the needs of a person under section 47(1) of the Act a local authority must comply with paragraphs (2) to (4).
>
> (2) The local authority must consult the person, consider whether the person has any carers and, where they think it appropriate, consult those carers.
>
> (3) The local authority must take all reasonable steps to reach agreement with the person and, where they think it appropriate, any carers of that person, on the community care services which they are considering providing to him to meet his needs.

(4) The local authority must provide information to the person and, where they think it appropriate, any carers of that person, about the amount of the payment (if any) which the person will be liable to make in respect of the community care services which they are considering providing to him.

Extracts from the guidance which accompanies these directions is set out in Box 17.2.

BOX 17.2 *The Community Care Assessment Directions*, LAC (2004) 24

2.1 The Community Care Assessment Directions do not change the requirements of best practice or the guidance available at **www.carers.gov.uk/carersdisabledchildact2000.htm** or **www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/SocialCare/SingleAssessmentProcess/fs/en**. The Directions, however, ensure that this existing practice and guidance on conducting care assessments and care planning is placed within a legal framework. For example when assessing older people the requirements of the Single Assessment Process and the National Service Framework should be observed and where necessary joint assessments involving health partners should be completed. Assessments for all adults with complex needs should take account of physical, cognitive, behavioural and social participation needs.

2.2 Full involvement of individuals and their carers in both assessment and care planning has long been recognized as good practice and the importance of doing so has been highlighted in previous guidance. Carers are entitled, under the Carers and Disabled Children Act 2000, to request an assessment of their needs in supporting the person they care for. It is, in any case, good practice that an assessment is offered to a carer who is going to be involved in providing part of the care package. The involvement of the carer in the assessment and care planning process ensures there is a realistic account taken of the care a carer is able to provide and that the caring relationship is sustainable. A carer's refusal of the offer of an assessment should not be used as a reason to exclude the carer from assisting with care planning.

2.3 There will be cases where the person whose care is being planned lacks the capacity to consent to the involvement of carers, or to the care plan itself. In these situations best practice suggests that the carers should be involved as much as possible, currently local authorities have a responsibility to make decisions in the best interests of the person being cared for.

2.4 If disagreements occur between the person and their carer these should be handled sensitively, safeguarding the best interests of the individual and the carer. In many cases it may be appropriate for a resolution to be sought through independent or statutory advocacy.

2.5 If it is felt to be inappropriate to involve the carer local authorities should retain a written account of why it was felt inappropriate. This should show that the carer's involvement has been actively considered and, if excluded from care planning, the reasons why. It is not enough to state that the reasons were considered, without recording those reasons.

2.6 Local authorities should continue to ensure that up to date and appropriate information on the range of support, entitlements and assistance available for carers is accessible in a variety of formats. This information should be offered to all carers, irrespective of whether the carer receives an assessment.

Assessment of older people

There is no particularly persuasive reason for assessing older people in a different manner from other service users. However, the framework for older people introduces the Single Assessment Process (SAP) which is described in further detail in Box 17.3. The principles behind the SAP are likely to be increasingly applicable for all assessments.

BOX 17.3 Single assessment process for older people, extract from *Introduction to the single assessment process* (DH guidance, Feb 2004)

The single assessment process for older people was introduced in the National Service Framework for Older People. *Detailed guidance was published in January 2002. The following extract covers the broad principles only.*

The purpose of the SAP is to ensure that older people receive appropriate, effective and timely responses to their health and social care needs, and that professional resources are used effectively. In pursuit of these aims, SAP should ensure that:

- Individuals are placed at the heart of assessment and care planning, and these processes are timely and in proportion to individuals' needs.
- Professionals are willing, able and confident to use their judgement.
- Care plans or statements of service delivery are routinely produced and service users receive a copy.
- Professionals contribute to assessments in the most effective way, and care co-ordinators are agreed in individual cases when necessary.
- Information is collected, stored and shared as effectively as possible and subject to consent.
- Professionals and agencies do not duplicate each other's assessments.

National Services Frameworks (NSF) and guidance for particular service users

There is a great deal of guidance on assessment and provision for different types of service user. You will get used to navigating the Department of Health web site for updates. What follows is merely intended to provide you with a flavour, so that you get to realize how much detail is available. We have chosen as our example of guidance the services for older people and, more briefly, services for mental health service users.

We have chosen these two areas because NSF guidance is available. NSFs are aimed principally at health services, but the necessary services are closely linked to, and often provided by, social services. The older people's NSF was published in 2001 and it has set standards which your assessment should take into account. We have reproduced these standards (but not the whole NSF) in Box 17.4, because they indicate the detailed

BOX 17.4 Standards from the NSF for older people

Standard 1: Rooting out age discrimination

NHS services will be provided, regardless of age, on the basis of clinical need alone. Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.

Standard 2: Person-centred care

NHS and social care services treat older people as individuals and enable them to make choices about their own care. This is achieved through the single assessment process, integrated commissioning arrangements and integrated provision of services, including community equipment and continence services.

Intermediate care: A new layer of care, between primary care and specialist services is being developed to help prevent unnecessary hospital admission, support early discharge and reduce or delay the need for long-term residential care. Older people will be the main but not exclusive beneficiaries of these services.

Standard 3: Intermediate care

Older people will have access to a new range of intermediate care services at home or in designated care settings, to promote their independence by providing enhanced services from the NHS and councils to prevent unnecessary hospital admission and effective rehabilitation services to enable early discharge from hospital and to prevent premature or unnecessary admission to long-term residential care.

Providing evidence-based specialist care: The UK has some of the best specialist services for older people in the world with a solid evidence-base for their effectiveness. Timely intervention by evidence-based services reduces long-term needs. But these services are not uniformly available and access to them can be haphazard.

Standard 4: General hospital care

Older people's care in hospital is delivered through appropriate specialist care and by hospital staff who have the right set of skills to meet their needs.

Standard 5: Stroke

The NHS will take action to prevent strokes, working in partnership with other agencies where appropriate. People who are thought to have had a stroke have access to diagnostic services, are treated appropriately by a specialist stroke service, and subsequently, with their carers, participate in a multidisciplinary programme of secondary prevention and rehabilitation.

Standard 6: Falls

The NHS, working in partnership with councils, takes action to prevent falls and reduce resultant fractures or other injuries in their populations of older people. Older people who have fallen receive effective treatment and rehabilitation and, with their carers, receive advice on prevention, through a specialised falls service.

Standard 7: Mental health in older people

Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and for their carers.

Promoting an active, healthy life: Older age is not always associated with an emphasis on health promotion. It should be. Older people wish to remain healthy, active and independent of the need for support from services and from their families. This NSF concludes with a strong emphasis on promoting the health and independence of those in older age.

Standard 8: The promotion of health and active life in older age

The health and well-being of older people is promoted through a coordinated programme of action led by the NHS with support from councils.

guidance which is increasingly available for assessments of particular service users. It is a requirement of LASSA, s. 7 that you adhere to this type of guidance.

The other NSF sets standards for assessment and service delivery in relation to services relating to mental health service users. Examples of the standards are that services available should be twenty-four hours, service users should have a full care plan provided, and there should be no discrimination against service users. More detail is found in Chapter 19.

There is also a large range of specific guidance for assessing service users' needs in addition to the NSF. An example, chosen purely for its illustrative value, is *Care management for older people with serious mental health problems* (DoH, 2002). Because it refers to the Care Programme Approach—a typical example of how much cross referencing is involved—we will also have to explain the CPA after this extract from the 2002 circular. The 2002 circular states:

> So that critical aspects of the Care Programme Approach (CPA) may be applied to individual older people with depression, dementia and other mental health problems, of sufficient complexity and severity for specialist mental health services to be involved, local NHS bodies and councils—when implementing and practicing the Single Assessment Process for Older People (SAP)—should :
>
> - Ensure that care pathways into specialist mental health services are agreed by agencies and understood by professionals, older people, their carers and families.
> - Ensure that individual older people, and professionals on their behalf, can access specialist mental health services and SAP 24 hours a day, seven days a week, and 365 days of the year.
> - Ensure that risk assessment explores not only the safety of the individual, but also the safety of others including carers, family, neighbours and professionals.
> - Ensure that the needs of carers and family members are given due consideration and, where appropriate, assessments under the Carers and Disabled Children Act 2000 are undertaken.

- Review the needs of older people, and any services they receive, on discharge from hospital. For the most severely mentally ill, care plans should be "followed up" with a week of discharge from hospital.
- In particular, ensure that the care plans of individuals at risk of suicide include more intensive provision for the first three months after discharge from hospital (or intervention at home), with specific follow-up in the first week.
- Ensure that individual care plans include contingencies for 'what to do in a crisis', and should include information sufficient to enable professionals to continue implementing the care plan in the interim.
- In addition, ensure that care plans record who the user is most responsive to, how to contact that person and previous strategies that have been successful in engaging with the service user if the user is difficult to engage.
- Ensure, subject to the Common Law Duty of Confidentiality and other legal / statutory requirements, that copies of service users' care plans are given to their GPs and other appropriate professionals.
- Ensure that when care plans are reviewed, individuals' status under the Mental Health Act 1983 are recorded and reviewed.
- Ensure that health and social care professionals involve the police, probation staff and other officers of the criminal justice system in individual cases as and when appropriate. Where an older person enters prison, community-based health and social care professionals should maintain contact with the individual and make plans for care on the person's release in collaboration with prison and probation staff as appropriate.
- Ensure that where it is appropriate for older people to move from CPA to SAP (or vice versa), such transitions are effectively managed with minimum or no disruption to the services that are provided.

The care programme approach (CPA) in mental health

It is not clear to us why the CPA has only been introduced to address community care needs relating to mental health. The CPA involves drawing up a single care programme as part of the assessment of the service user. The care programme is, in one sense, the most important outcome of the assessment process. The service user and their carers must have the fullest opportunity to play a part in the formulation of the care programme. The inputs expected of all agencies towards meeting the care needs of the service user should be recorded in a single care plan.

The CPA then requires the service user's needs to be graded at one of two levels:

Standard: They require support or intervention of one agency or discipline or require only low-key support from more than one agency or discipline; they are more able to self-manage their mental health problems; they have an active informal support network; they are more likely to maintain appropriate contact with services; and they pose little danger to themselves or others.

Enhanced: these service mental health service users have multiple care needs, including housing, employment etc, requiring inter-agency co-ordination; they are only willing to

co-operate with one professional or agency but have multiple care and support needs; they may be in contact with a number of agencies (including the criminal justice system); they are likely to require more frequent and intensive interventions, perhaps with medication management; they are more likely to have mental health problems co-existing with other problems such as substance misuse; they are more likely to be at risk of harming themselves or others; and they are more likely to disengage with services. (*Reviewing the Care Programme Approach 2006: A consultation document, Care Services Improvement Partnership,* DoH, 2006).

Assessment of the service user's resources occurs after assessment of need

Government guidance makes it clear that the individual service user's needs are to be assessed, and decisions made on how to address those needs, before looking at whether that service user can be called on to pay for or contribute towards any services. If the need is established it should be met. So far this is reasonably clear, but read in the context of LAC (92)12, a Department of Health circular, it is a little less clear: 'An authority may take into account the resources available when deciding how to respond to an individual's assessment'. This potentially allows the assessor to say that a need does not exist because the service user can pay to eliminate it.

Case law on assessment of need

Case law has established the following guidance. A department is obliged to *assess* the needs and the court can order you to carry out an assessment if you have not complied (*R v Sutton LBC, ex parte Tucker* (1996)).

It must assess those needs even if it already knows that it cannot afford to meet them (*R v Bristol City Council, ex parte Penfold* (1998)).

An inadequate assessment can be struck down by a court on judicial review. In *R v Birmingham City Council, ex parte Killigrew* (2000), the council had reassessed the service user as needing only six hours' daily care for her physical needs, where previously she required twelve. There was, it was held, no basis at all for this reduction. The reassessment was carried out without even looking at medical reports or consulting the service user's GP.

An assessment must be carried out in full: in *R (on the application of HP) v Islington LBC* (2004) the council had lawfully decided on the basis of psychiatric evidence that HP did not qualify for specialist community mental health services, but it was not entitled to refuse an assessment of his other needs.

Failure to assess cannot be used as an excuse not to make appropriate provision: *R (on the application of AA) v Lambeth LBC* (2001).

R (on the application of J) v Newham LBC (2001) confirms assessments must not be delayed. The court suggested 35 days would be too much delay.

Needs change. The extent to which re-assessment is required depends on the individual case. In *R (on the application of Heffernan) v Sheffield City Council* (2004) H's condition was deteriorating rapidly, and the court held the authority must assess his increasing needs. That did not mean that these had to be met. Collins J stated: 'I am bound to say that the amount of care [currently provided] is not at all generous. But it does not have to be: it must be adequate to meet the proper needs. The Claimant's condition is deteriorating and there must be regular reviews of his needs. He was saying he needs 27–30 hours as opposed to the 24½ provided, but more recently, and as a result of advice in particular from [a care consultant], the availability of care at all times is said to be needed.' The department therefore had to show that it had assessed his changing needs.

EXERCISE

Mrs Akuffo has recently been discharged from hospital where she was receiving treatment for bipolar disorder. She has chronic diabetes and severe arthritis and she has difficulty with stairs and much of her personal care. She has no income or savings. She has no home to return to as her tenancy was terminated by her private landlord shortly before her hospital admission, as she was said to have been shouting abusive comments to neighbours. How would you go about assessing her needs?

ONLINE RESOURCE CENTRE

For guidance on how to answer these exercises, visit the Online Resource Centre at: **www.oxfordtextbooks.co.uk/orc/brayne10e/.**

WHERE DO WE GO FROM HERE?

If anything can be simple in community care law, the next chapter is the nearest we will get to it. You cannot, in reality, assess a service user's needs without knowing what can be provided. But, apart from a discussion on direct payments as an alternative to the provision or purchase of services by the local authority, the next chapter requires little more than a listing of services which can, or services which must, be provided to those assessed as needing them.

ANNOTATED FURTHER READING

The circulars referred to in the text above, and the materials on community care law listed at the end of Chapter 17, are all we have been able to identify for further reading.

In particular you are advised to read *Fair Access to Care Services* LAC (2002)13 www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/LocalAuthorityCirculars/AllLocalAuthority/DH_4004734.