INTRODUCTION TO COMMUNITY CARE

LEGISLATION

The legislation relating to community care in Northern Ireland is contained in a variety of Acts and Orders. Government guidance and directions are also highly significant. The following are some of the most important pieces of legislation:

Health and Personal Social Services (NI) Order 1972, as amended

Chronically Sick and Disabled Persons (NI) Act 1978

Disabled Persons (NI) Act 1989

Children (NI) Order 1995

Carers and Direct Payments (NI) Act 2002

Health and Social Care (Reform) Act (NI) 2009

INTRODUCTION

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There is no definition of the term community care in law but it has been loosely interpreted to mean the provision of both social and health care. Community care services can include such things as:

- support offered to a person at home;
- access to respite and day care;
- family placements;
- the provision of sheltered housing;
- placement in group homes and hostels or residential and nursing care homes;
- supported living placements.

In 1990, proposals for improving the management and delivery of community care services were set out in the government policy paper *People First: Community Care in Northern Ireland in the 1990*s. The fundamental principle is that a person who needs care and support should be encouraged and assisted in order to enable her/him to live, with as much independence as possible, in the community, as opposed to living in an institution.

Legislation, policy and guidance issued since 1990 have been geared towards achieving this aim. More people than ever before now reside in the community with the support of health and social services. In turn, this has led to an increase in the number of people seeking information and assistance on the provision of community care services and on their rights and entitlements to those services.

These notes set out the basic principles of community care law, including the rights and entitlements of a person to receive community care services and the remedies available to a dissatisfied service user.

1. THE LEGAL FRAMEWORK

Community care law in Northern Ireland is a combination of different statutes enacted during the last 40 years.

In addition to the main statutes governing service provision, there is a range of other legislation which may be relevant in different contexts such as regulations governing Attendance Allowance and Disability Living Allowance (DLA) and legislation governing the running of residential and nursing care homes, the provision of services to children etc.

Since devolution, the Department of Health, Social Services and Public Safety (DHSSPS) has assumed responsibility for health and personal social services issues. Community

care legislation in Northern Ireland was created by various sources and is to be found in:

- Acts passed by Parliament (primary legislation) or passed by the Northern Ireland Assembly, both in sections;
- Orders passed by the Secretary of State for Northern Ireland on authority delegated by Parliament, in articles;
- Regulations made by government ministers on authority delegated by Parliament, in paragraphs;
- Directions issued by government departments in accordance with primary legislation.

Public authorities are issued with guidance relating to policy and practice in various forms.

Guidance made explicitly under legislation is legally binding. The precise status and importance of other types of guidance, such as Codes of Practice and Circulars can be difficult to measure. In a 2010 Northern Ireland application for Judicial Review (*In The Matter of an Application for Judicial Review by Kathleen McClean,* the importance of such guidance was highlighted when the court found that a Health and Social Care Trust (HSCT) had, during the assessment of need process, acted unlawfully in two instances:

- by failing to apply '*correctly and properly'* guidance issued by the Department of Health and Social Services (Departmental Circular ECCU2/2008); and
- by taking into consideration the applicant's disability related benefits in contravention of a Departmental Directive entitled 'Provision of Community Care Services, Treatment of Attendance Allowance' (June 1999).

1.1 Health and Personal Social Services (NI) Order 1972

The Health and Personal Social Services (NI) Order 1972 (HPSS'72) as amended by the Health and Personal Social Services (NI) Order 1991 (HPSS'91), the Health and Personal Social Services (NI) Order 1994 (HPSS'94) and the Health and Social Care (Reform) Act (NI) 2009 (HSCR'09) is a key piece of legislation governing the provision of health and social care in Northern Ireland.

The order imposes a number of duties including:

- **Article 7 (1)**, a duty to make arrangements, to such extent as the DHSSPS considers necessary, for the prevention of illness and the care and after-care of a person suffering from illness;
- **Article 15 (1)**, a duty to make available advice, guidance and assistance, to such extent as the DHSSPS considers necessary, and to make such arrangements and provide or secure the provision of such facilities as it considers suitable and adequate in order for it to discharge its duty under Section 2(1)(b) of the HSCR'09;

- **Article 15 (4)**, a power to recover such charges (if any) as the DHSSPS considers appropriate, in respect of any assistance, help or facilities provided under Article 15;
- **Article 56**, a duty on the Regional Board to make arrangements for the provision of personal medical services.

1.2 The Health and Social Care (Reform) Act (NI) 2009

The Act came into operation in April 2009. It restructured the provision of health and social care (see below) and amended the HPSS'72 Order.

Section 2 sets out the overriding duty of the DHSSPS in relation to the Health and Social Care system in broadly the same way as Article 4 of the 1972 Order (now repealed). However, it goes further in detailing a number of specific areas where a statutory duty is being placed on the DHSSPS. Under Section 2, the DHSSPS has a duty to provide an integrated system of health and social care designed to improve the physical and mental health and social well being of people in Northern Ireland. Among other things, the DHSSPS also has a duty to develop policies to reduce health inequalities between the people in Northern Ireland.

- **Section 3** sets out the DHSSPS general power and sets out that it may provide or secure the provision of such health and social care as it considers appropriate to the discharge of its duty.
- **Section 21** places a duty on each HSCT to exercise its functions to improve the health and social well being of, and reduce health inequalities between, those for whom it provides or may provide health and social care.

1.3 Chronically Sick and Disabled Persons (NI) Act 1978

The Chronically Sick and Disabled Persons (NI) Act 1978 (CSDP'78) contains specific duties in relation to a person who is chronically sick or has a disability.

Sections 1 and 2 outline the duty to share information and make such arrangements as are necessary for the provision of social welfare services to meet the needs of any person coming within the definition of chronically sick and disabled.

- **Section 1 (1)** defines people covered by the Act as those persons who are *'blind, deaf or dumb, and other persons who are substantially handicapped by illness, injury or congenital deformity and whose handicap is of a permanent or lasting nature or are suffering from a mental disorder within the meaning of the Mental Health (NI) Order 1986'*;
- **Section 2** outlines the range of services which include:
  - ☐ practical assistance in the home;
  - ☐ the provision of or assistance in obtaining wireless, television, library or similar recreational features;

- ☐ the provision of lectures, games, outings or other recreational facilities or assistance in taking advantage of educational facilities available;
- ☐ travel arrangements for the purposes of participating in services;
- ☐ assisting in arrangements for the carrying out of any works of adaptation to the home;
- ☐ facilitating the taking of holidays;
- ☐ the provision of meals;
- ☐ the provision of, or assistance in, obtaining a telephone.

1.4 Disabled Persons (NI) Act 1989

Section 4 of the Disabled Persons (NI) Act 1989 (DP'89) creates a specific duty in relation to assessments of people who come within the definition of chronically sick or disabled. An assessment must be carried out when requested by a person with a disability, her/his authorized representative or her/his carer, in the context of the provision of services under Section 2 of the CSDP'78.

1.5 Mental Health (NI) Order 1986

The Mental Health Order 1986 (MHO'86) places a general duty on the Regional Health and Social Care Board and the Regional Agency for Public Health and Social Well-being to:

- promote mental health;
- secure the prevention of mental disorder;
- promote the treatment, welfare and care of persons suffering from mental disorder.

Also of note is Article 40, which imposes a specific duty on trusts in respect of applications for admissions and guardianships.

1.6 Children (NI) Order 1995

While all the above provisions apply equally to children and adults, the Children (NI) Order 1995 (CO'95) creates certain rights and duties specific to children, which may be relevant to the provision of community care services. Trusts are under a general duty, by virtue of Article 18 of this Order, to safeguard and promote the interests of children in need and, in furtherance of this duty, are empowered to provide a wide range of services.

The powers available to trusts in relation to the provision of services to children are almost unlimited and include assistance in kind or, in exceptional circumstances, in cash. It may therefore be possible in a family situation to access services under CO'95

in cases where a trust has failed to exercise its discretion to provide services under other general provisions.

As a result of the enactment of the Carers and Direct Payment Act (NI) 2002 (CDPA'02), new provisions have been inserted into CO'95. These are:

- a duty to assess the needs of child carers and carers of a child with a disability when requested and to consider what services to provide where appropriate;
- a provision for information to be made available to child carers and carers of a child with a disability regarding their right to an assessment of needs;
- a direct payments scheme.

1.7 Northern Ireland Act 1998

Section 75 of the Northern Ireland Act places a duty on public bodies to promote equality of opportunity between different groups of people including older people, people with disabilities and carers.

Public authorities are required to carry out equality impact assessments to ensure that they are acting in a way which is not in breach of their obligations under Section 75. If they find that they are acting in a way which adversely impacts on one of the groups defined under Section 75, they are obliged to consider how to rectify the problem. This is usually done by implementing equality schemes.

A person wishing to complain that a public authority has failed to carry out an equality impact assessment, has carried out the assessment inadequately (eg, has not considered relevant information) or has failed to implement an equality scheme, should first raise the matter with the public authority.

If the person is not satisfied with the response, s/he may then complain to the Equality Commission. The complaint must be sent to the Equality Commission during a period of twelve months from the date of which the complainant first knew of the matter alleged. The Equality Commission may then carry out an investigation and report on its findings. If the public authority fails to implement its recommendations within a reasonable time, the Equality Commission may refer the matter to the Secretary of State.

A person may also be able to challenge a public authority's failure to adhere to its duties under Section 75 in court.

Details for the Equality Commission are as follows:

ECNI, Equality House, 7-9 Shaftesbury Square, Belfast BT2 7DP

Telephone: 028 90 500 600
Textphone: 028 90 500 589
Enquiry Line: 028 90 890 890
Fax: 028 90 248 687
Email: information@equalityni.org

1.8 Human Rights Act 1998

In October 2000, the Human Rights Act (HRA) came into force in Northern Ireland. This Act seeks to protect people's human rights by giving further effect to the European Convention on Human Rights (ECHR). Under Section 6 of the HRA it is unlawful for a public authority (such as a trust) to act in a way which is incompatible with a ECHR right. Whilst it is largely concerned with prevention, it is important to note that the courts have also interpreted the HRA as placing a positive obligation on public authorities in certain cases.

The following articles are most likely to be of relevance to providers and users of community care services.

- **Article 3** prohibits the subjecting of a person to torture, inhuman or degrading treatment or punishment.

  A situation where a trust failed to provide services to meet an assessed need could lead to a person being left in a condition(s) amounting to inhuman or degrading treatment. However, the threshold for proving breach of this article is high. Caselaw has determined that the alleged inhuman or degrading treatment must reach a minimum level of severity to constitute a breach of Article 3.

- **Article 8(1)** provides that everyone has the right to respect for her/his private and family life and her/his home and correspondence.

  A lack of effective domiciliary care may be disruptive of family life, as could the placing of someone in residential care who wishes to remain at home.

- **Article 8(2)** sets out a number of grounds on which a public body may legitimately interfere with a person's right under Article 8(1). One of the grounds is that the interference is necessary in the interests of the economic wellbeing of the country. If a trust put this (or any of the other grounds listed in Article 8(2)) forward as an argument then the courts would have to decide whether or not the interference was justified.

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- **Article 14** deals with discrimination. This article cannot be argued on its own but must be used in conjunction with another article.

1.9 Carers and Direct Payments Act (NI) 2002

The Carers and Direct Payment Act (NI) 2002 (CDPA'02) received royal assent in May 2002 but not all of its provisions were brought into force. The Act gave new rights to carers and inserted paragraphs into the Children (NI) Order 1995. It also abolished all previous legislation on direct payments and introduced a new Direct Payments Scheme widening the availability of direct payments for people in Northern Ireland.

The CDPA'02 provides for direct payments to be available to:

- disabled people to whom Section 1(1) of the Chronically Sick and Disabled Persons (NI) Act 1978 applies, aged 16 or over;
- those assessed as needing services under the Health and Personal Social Services (NI) Order 1972;
- parents of disabled children;
- disabled parents;
- carers;
- sixteen and seventeen year old carers assessed for services under the Children Order 1995.

The CDPA'02 gives carers a statutory right to an assessment of need when requested. When such an assessment has been carried out, a trust must consider whether or not it should provide services to the carer.

The CDPA'02 also empowers trust to make direct payments to carers (including sixteen and seventeen year old carers) for the services that meet their own assessed needs.

In addition, when a trust carries out an assessment under HPSS'72 and the carer of the person whose needs have been assessed asks for a carer's assessment, the trust must take into account the results of the carer's assessment when deciding what services (if any) to provide for the person being cared for.

The CDPA'02 sets out that trust must take such steps as are reasonably practicable to ensure that information is available to carers regarding their right to assessments. Trusts must also advise any known carers of their right to an assessment.

The CDPA'02 provides that the Direct Payments scheme can only be put in place with the 'consent' of the person in receipt of services. People who do not have capacity to consent to this scheme cannot, therefore, avail of it directly. This gap in the legislation was highlighted in a recent Northern Ireland court decision *(Re PF and JF)*[1] *[2011].* The DHSSPS intends to make changes to the legislation to enable another person to receive direct payments on behalf of a person with eligible needs who lacks capacity to consent.[2] It has put interim measures in place to ensure that people without capacity are able to receive direct payments albeit through a different legal route. The interim measures are the subject of Guidance.[3]

1.10 Other legislation

Various other pieces of legislation govern matters relating to the provision of community care services but the majority of queries arise from the provision of, or failure to provide, community care services under the above legislation.

[1] [2011] NIBQ 2011. The full ruling can be accessed at www.courtsni.gov.uk
[2] Proposed changes to the CDPA 2002 are included within the provisions of the Mental Capacity Bill.
[3] Circular HSC (ECCU) 01/2012 'Direct Payments for Persons who lack Capacity to Consent'

It is hoped that the New Mental Capacity Act will be enacted before the end of 2015. The Act will introduce a single, statutory framework governing all situations where a decision needs to be made in relation to the care, treatment (for a physical or a mental health condition) or personal welfare, of a person aged 16 or over, who lacks capacity to make the decision for her/himself.

A Mental Capacity Bill has gone before an Ad Hoc Committee of the NI Assembly and is in the final stages of consultation at the time of writing.

2. HEALTH & SOCIAL SERVICES STRUCTURE

The provision of health and social care in Northern Ireland was restructured when the Health and Social Care (Reform) NI Act 2009 came into force in April 2009. It provides the legal framework within which the new health and social care structures operate.

The Health and Social Service Councils, Central Services Agency, Health and Social Services Boards and the Mental Health Commission were dissolved. Health and Social Services Trusts are now known as Health and Social Care Trusts (HSCTs).

The functions of the former Health and Social Services Boards have been transferred to the Regional Health and Social Care Board and the Regional Agency for Public Health and Social Well-being. The Regional Board has power to issue guidance to HSCTs as to how they carry out all their functions.

2.1 Health and Social Care Trusts

The five trusts in Northern Ireland - Belfast, Northern, Southern, South Eastern and Western - control their own budgets.

Trusts now manage staff and services at hospitals and other establishments which in the past were managed or provided by boards. Most of the key statutory functions of boards in relation to the provision of social services have been delegated to the trusts.

3. DUTIES AND POWERS

Legislation creates both duties and powers for trusts.

3.1 Duties

Duties are mandatory unless qualified and may be either general or specific.

3.1.1 Mandatory duties

A mandatory duty is usually signified by the use of the word '*shall*' in the legislation. If the duty is mandatory, a trust must discharge that duty. Failure to do so will permit a person to apply for judicial review of the action or inaction of the trust.

3.1.2 Qualified duties

A duty may be qualified. This is usually signified by the use of the words *'to such extent as is necessar*y' or *'so far as is reasonably practical'*. If such a qualification is used, it gives the trust a degree of interpretation in how it will discharge the duty. It may therefore be more difficult to successfully challenge a trust for its failure to discharge that duty.

When such a challenge is made, the court will decide whether or not something is necessary or reasonably practical. It is worth noting that the courts are reluctant to interfere with clinical decisions of doctors and other professionals and that often it is those persons who decide whether or not something is necessary or reasonably practical.

3.1.3 General or specific

A duty may also be either general or specific. A general duty is one which is owed to a group or class of people, as opposed to a specific duty, which is owed towards an individual. In general, it is more difficult for trusts to avoid a duty towards an individual and it is easier to bring a challenge against a trust which has failed to discharge such a duty.

3.2 Powers

Powers are discretionary. A discretionary power is often signaled by the use of the word '*may'* in the legislation. The full extent of the obligation on a trust in exercising a power will depend on the exact wording of the legislation and the individual circumstances of the case.

The exercise of a discretionary power may be challenged by way of judicial review. This would consider whether the decision of a HSCT was unreasonable, whether it was made for the wrong purposes, or whether all relevant considerations had been taken into account.

4. COMMUNITY CARE SERVICES

4.1 Range of services

The various Acts, Statutes and Orders discussed above place duties on trusts in relation to the provision of services to persons residing in their area.

Each person will have different requirements and will not necessarily require all the services which the trusts are under a duty to provide. However, as a result of their statutory and other obligations, it is expected that trusts will make the following range of services available to a person in need of community care services and her/his carers:

- domiciliary care/support services;
- home help services;
- day centre provision;
- respite care;
- aids and adaptations;
- community health services;
- residential and nursing care;
- supported living placements (which may be arranged and/or provided by a trust in conjunction with other public bodies such as NIHE);
- hospital discharge arrangements;
- meals on wheels services;
- assessment of care needs.

Note: Assessment may be regarded as a service in itself where a person with a disability, their authorized representative or a carer specifically requests it under DP'89 and CDPA'02.

4.2 Entitlement to services

A person who has health and/or social care needs which mean s/he cannot cope in one way or another with her/his own care is entitled to community care services. These needs may arise through illness or as a result of physical or mental disability, from a dependency which has developed over a length of time in institutional care or for some other reason which has led to an individual being otherwise vulnerable.

In planning for and providing services, trusts refer to individuals in terms of client groups, which is practical shorthand for social workers. This creates a difficulty in that most people do not think of themselves as carrying the label that trusts might place on them and may not therefore realise that they are entitled to a particular service. Furthermore, putting a person into a category may adversely affect the kind of treatment or services s/he receives. If a person has a range of needs but is treated mainly as coming within one of the client groups, s/he may not be considered eligible for services on offer to people in another client group.

It is essential to bear in mind that the defining factor, which determines a person's entitlement to community care services, is her/his individual and particular need for care and support.

5. ASSESSMENT OF NEED

5.1 Legislative basis for assessment

Assessment of need has a central role to play in the provision of community care. Correct assessment is crucial to the provision of appropriate care to meet a person's needs.

A recent Northern Ireland judicial review decision '*In the Matter of JR47 for Judicial Review [2013] NIQB*' clarified that Article 15 of the 1972 Order requires trusts to make individual assessment of needs in appropriate cases, extending the duty to any person within the knowledge of DHSSPS who might be seen to benefit from such enquiries. This means that anyone coming to the trust's attention who may benefit from services from the trust is entitled to an assessment of her/his needs. Section 4 of DP'89 sets out that a person with a disability who requests an assessment is entitled to be assessed for services under Section 2 of CSDP'78. In addition, under the Children Order as amended by the Children (Leaving Care) Act (Northern Ireland) 2002, trusts are now under a duty to assess and meet the care and support needs of young people leaving care until they are at least 21 years old.

Departmental Guidance, *People First, Care Management: Guidance on Assessment and the Provision of Community Care* (hereinafter referred to as the guidance) sets out that:

'From 1 April 1993… Health and Social Services Boards will be required to assess the care needs of any person who appears to them to be in need of community care services and to decide, in the light of that assessment, whether they should provide or arrange for the provision of any services.'

5.2 Triggering assessment

There are several ways in which a person's need for an assessment may be triggered. For example, a person may:

- apply for a place in residential accommodation or in a nursing home or for domiciliary care services;
- be referred by a general practitioner or a professional officer of the trust (including hospital staff);
- be referred by a voluntary organisation;
- be referred by an informal carer seeking assistance, by a relative or by some other person because of perceived unmet needs.

5.3 Type of assessment

Once it has been determined that a person requires an assessment, the decision must be made as to what level of assessment is required.

Some people will require a higher level of assessment than others. In some cases, a person's needs are readily apparent and an assessment can be carried out with relative ease to identify those needs. However, in certain cases a comprehensive multi-disciplinary assessment will be necessary to ensure that all the needs of the individual have been identified.

It is up to the trust, having regard to all the relevant factors, to determine what type of assessment a person requires and to arrange for the assessment. The only effective legislative description of what the assessment process should involve is contained in Section 3 of Part 11 of the DP'89 which details what a formal assessment should include. However, that Section of DP'89 has never been brought into force. The only other indication as to what the assessment process should include is to be found in the guidance. This sets out that *'the initial screening process, if necessary involving a home visit, should determine whether the comprehensive procedures ought to be called into play and, if they are to be used, which officer should co-ordinate the assessment.'*

The guidance also states that comprehensive assessment should include physical, mental and social functioning. It suggests that the areas to be covered include:

- physical health;
- mental health;
- capacity for the activities of daily living and self care;
- abilities and lifestyle;
- the contribution of informal carers;
- social network and support;
- housing;
- finance;
- environmental factors.

All appropriate agencies and professions involved with a person and her/his problems should be brought into the assessment procedure. These may include, for example, social workers, family members, physiotherapists, occupational therapists, speech therapists, dieticians, dentists, general medical practitioners, community psychiatric nursing staff, housing officers, social security officials, home care assistants and voluntary workers.

Assessment tools have been developed to create a framework for assessing the needs of certain client groups such as children. Additionally, the DHSSPS has developed a single tool (NISAT) for assessing the health and social care needs of people aged over 65.

NISAT aims to standardise and streamline assessment and care planning processes and therefore to simplify access to community care services for older people. The assessment consists of seven component parts, as follows:

1. contact screening;
2. care assessment;
3. complex assessment;
4. carer needs assessment;
5. specialist referral form;
6. specialist summary form;
7. GP report.

It is designed to capture information required for a holistic, person centered assessment of the older person.

In the McClean decision [see above page 7] which concerned the withdrawal of a cleaning service, the importance of carrying out an assessment of need, in line with the Departmental guidance, was highlighted. The court found that a trust had, during the assessment of need process, acted unlawfully in two instances:

- by failing to apply 'correctly and properly' guidance issued by the Department of Health and Social Services (Departmental Circular ECCU2/2008) (the Circular); and
- by taking into consideration the applicant's disability related benefits in contravention of a Departmental Directive entitled Provision of Community Care Services, Treatment of Attendance Allowance (June 1999) (the Directive).

The Circular requires an assessment to be 'thorough, accurate and up to date' and therefore re-assessment is an essential element in the process. The trust failed to carry out a review of an earlier assessment when it became clear that some of the relevant information in the assessment was inaccurate. For this reason, the assessment process was flawed.

In *McClean*, Mr Justice McCloskey stressed that a trust must make *'fully informed decisions'* by taking account of all material considerations and disregarding all immaterial considerations. He stated that proper consideration should be given to a service user's income *'…a simple exercise, falling far short of an accountancy audit is all that is required'*.

The Directive states that *'disability related benefits should not be taken into account'*, the trust should not therefore have taken into account the applicant's disability related benefits in considering her income and ability to pay privately for services.

5.4 Notification of outcome of assessment

Once the assessment process has been completed, the person and her/his carer should be informed of the result of the assessment and given the name of an individual to contact for any further discussion.

While there is nothing in legislation compelling trusts to provide written copies of assessments, paragraph 19 of the 2010 'Care Management, Provision of Services and Charging Guidance' requires that '*assessments should be written in plain language and should be shared with service users and carers as soon as possible*'. The guidance on carers' assessments goes further and states that *'the carer must always receive a copy of their assessment'* without any need for a trigger request.

The Data Protection Act gives a person the right of access to personal data held on her/him. Where this is denied, the person may appeal to either the Data Protection Commissioner or the courts. When a person requests a copy of the assessment, it should be provided within 40 days of the date of request.

The right under the Freedom of Information Act 2000 to make application for official information held by public bodies (the 'right to know') came into force in January 2005. For trust staff it means that, in effect, any information held about living individuals is potentially accessible under the Freedom of Information Act 2000.

In January 2012, the DHSSPSNI issued a revised Code of Practice on 'Protecting the Confidentiality of Service User Information'. It provides a reference point in all matters related to privacy and confidentiality for use by health and social care professionals and individuals who want to access their own personal data or that of a relative.

5.5 Failure to assess

Having considered the above duties, it should be apparent that it would be extremely difficult to meet a person's needs without having assessed her/him. As discussed, trusts have duties in legislation to assess the needs of chronically sick and/or disabled people; children leaving care and carers. In addition, following the judgment in the JR47 case, a trust must assess the needs of any person within its knowledge who would appear to benefit from such enquiries. In practice, assessments are carried out to establish what a person's needs are. Any refusal of a request for an assessment for services might give rise to litigation where a person is refused services or is dissatisfied with the level of services provided.

5.6 Housing assessments

The issue of assessing and meeting housing need for a person who is ill or has disabilities is complex. Both the Northern Ireland Housing Executive (NIHE) and trusts have duties in relation to housing.

5.6.1 Role of NIHE

NIHE is the statutory body responsible for providing public housing. It also has duties to those found to be homeless.

A person can be homeless if it is not reasonable for her/him to continue to occupy her/his current accommodation. This may be, for example, because of substantial disrepair, or perhaps because the house is not suitable for a person with a particular disability.

If the person is found to be unintentionally homeless and in priority need, NIHE is obliged to secure accommodation for her/him, usually after some time in temporary housing. Three reasonable offers of housing will be made but need not be in the person's area of choice.

NIHE has no statutory obligation to adapt the homes of its tenants to meet their need. It does have an obligation under the Housing (NI) Order 1992, Article 52, to operate a disabled facilities grant scheme which is open to tenants, landlords and owner occupiers. NIHE carries out assessments of need following recommendations from a trust. It then carries out a financial assessment as to the amount of grant aid to be offered.

In practice, NIHE is committed to carrying out adaptations recommended by trusts to its own homes, despite the lack of statutory obligation. Similarly, registered housing associations adapt their properties as they are able to access departmental funding on the basis of a social services recommendation.

5.6.2 Trust's role

Housing is one of the main areas which should be assessed as part of multi-disciplinary community care assessment. Under Articles 15 of HPSS'72, the trust must meet an assessed eligible social welfare need, including a need for residential or other accommodation.

There is also a duty to meet the needs of children for accommodation under the CO'95. This sits with the obligation to promote the upbringing of the child with her/his family. In order to establish this, it would be necessary for an assessment to be carried out.

Section 2(e) of the CSDP 1978 places a statutory duty on trusts to help arrange the carrying out of adaptations to the home, or to provide additional facilities designed to secure greater safety, comfort or convenience, where either is necessary to meet a person's housing needs. This is the basis for many community occupational therapy assessments.

Although NIHE has agreed to assess the need for and carry out adaptations to its properties which are occupied by people with disabilities, the only statutory obligation in this area remains with the trust. This means that if there is a failure by NIHE to assess or meet need correctly, the trust may be considered to have failed in its obligation to help with arranging the home adaptation.

5.7 Resources and assessment of need

There has been considerable litigation and legal debate on whether or not local authorities (equivalent to trusts) can take their own financial resources into account when assessing a person's needs. Two cases have gone as far as the House of Lords (now the Supreme Court) and they dictate the current state of the law on this issue.

5.7.1 R v Gloucestershire CC, ex-parte Barry [1997] 2 WLR 459 HL

This case concerned the obligations of social services under Section 2(1) of the Chronically Sick and Disabled Persons Act 1970 (CSDP'70) (which is equivalent to CSDP'78).

Mr Barry was a 79 year old man with a disability. He had been assessed by social services as needing home care assistance including cleaning and laundry services. Those services were initially provided to Mr Barry but were later withdrawn when the local authority had a shortage of funds. The authority wrote to around 1,500 people who were on the lowest priority level for the home care service, telling them that their service would be either reduced or withdrawn. Some of those people who were receiving their service under CSDP'70 sought a judicial review of the decision.

When the Court of Appeal heard this case, it held that the duty to assess a need for services provided under Section 2 of the CSDP'70 could not be connected to the financial position of the local authority.

The case then went to the House of Lords. The House of Lords held by a majority decision (3:2) that a local authority could take into account its own resources when assessing both the needs of a person with a disability and when deciding whether services (eg practical assistance in the home) had to be provided to meet that need. This meant that a local authority could, when its budget got tight, re-assess a person as having less need (because the council had less resources) by changing its eligibility criteria ie by raising the threshold required to be met for a need to be eligible for the provision of services . Then, even though her/his personal needs had not changed, the person may no longer be eligible for assistance and the service could be withdrawn or reduced.

The Court held that services could not, however, be withdrawn without a re-assessment of need.

Many argue that this case diluted the statutory duty owed to chronically sick and disabled persons under Section 2 of the CSDP'70 and changed it from a duty to a mere discretion. Until the case of *R v East Sussex CC, ex parte Tandy* (discussed below), the Barry case was the leading case governing when a local authority could take into account its own resources when making decisions about services provision. Although the Tandy case is the most recent in the area of resources, it was distinguished from the Barry case. This means that the Barry case is still the legal precedent in cases arising from the duty to meet need under Section 2 of the CSDP'70 (or the CSDP'78).

5.7.2 R v East Sussex CC, ex-parte Tandy [1998] 2 All ER 769 HL

In this case, a differently constituted House of Lords considered the duty of a local authority under the Education Acts of 1993 and 1996. It came to the conclusion that the resource arguments in the Barry case were largely restricted to cases concerning Section 2 CSDP'70.

Beth Tandy was a pupil in the local education authority's area. She suffered from ME and as a result was unable to attend school on a regular basis. She received five hours home tuition per week pursuant to Section 298 of the 1993 Education Act. The local authority then had a cash crisis as a result of which it resolved to cut its home education budget from £100,000 to £25,000 per year. Expressly taking this factor into account, the authority decided to cut Beth Tandy's home tuition to three hours per week. The House of Lords had to decide whether or not the local authority's resources were a relevant factor to take into account in deciding to cut her tuition.

In a unanimous judgement, the House of Lords held that the duty owed under the 1993 Education Act was a specific duty, owed to each child individually, and that there was nothing in Section 298 to indicate that local authorities could take their resources into account when deciding such matters.

The position as set out in the Barry case was considered by the High Court in Northern Ireland in the case of LW's (acting by her mother JB) Application [2010] NIQB 62 (LW's case).

LW was a 36 year old woman, who had sustained serious traumatic brain injuries and quadriplegia as a result of a road traffic accident 20 years earlier. It was asserted on her behalf that the trust had acted unlawfully in failing to provide adequate and suitable domiciliary care services in her home setting and had also acted unlawfully in failing to provide her with assessed residential care provision. The judgement given confirmed the position in the Barry case, ie that a trust can take into account budget factors when setting policy on care services and when determining which individual care needs it is necessary for the trust to meet.

However, when a trust decides that it is necessary to meet a need under Section 2 of the CSDP'78, then there is a clear legal duty on the trust to meet those needs regardless of budget constraints. In relation to other forms of assistance, such as a residential placement, the judge ruled that once a need of this nature is identified, the trust is under a duty to meet it. If the trust is unable to do so due to a lack of resources, then, as a minimum, it must make reasonable, sustained and conscientious efforts to discharge its statutory duty.

5.7.3 Commentary

Although there appears to be little difference between the Tandy case and the earlier Barry case, the judges distinguished the two cases. This was because the needs in CSDP'70 were judged not to be of the same magnitude as those under the Education Act.

Since the Tandy case, other cases have been decided on the grounds that, where a statutory duty is owed towards an individual, lack of available financial resources is not an excuse for failing to meet an identified need.

The present position is that (when making a decision whether to provide services under Section 2 CSDP'78) trusts can take their available resources into account during the assessment process when deciding whether need exists and when deciding whether it is necessary for the trust to provide a service to meet that need. However, once it has been decided that services are needed then they must be provided regardless of the availability or otherwise of resources. There may, however, sometimes be a delay in the trust arranging a service to meet an identified need. It is lawful for a trust to operate a policy whereby only critical and substantial needs are met immediately. Other needs may be placed on a register to be met at a later time. Any delay should be reasonable. Any risk to the service user as a result of a potential delay should be assessed.

It should also be noted that a trust is entitled to meet an identified need in the cheapest way possible. In a recent case heard by the European Court of Human Rights, the Court decided that a Local Authority's interference with the Applicant's Article 8 rights was not unlawful on the basis of lack of resources.

6. MEETING ASSESSED NEEDS

6.1 DUTY OR POWER TO MEET NEED?

Once it has been established that a person has needs, the next consideration is whether these will be met by the provision of a service.

It is necessary to check whether the trust is under a statutory duty to meet the need or whether it merely has a power to do so and may exercise its discretion in considering whether to provide the service.

6.1.1 Statutory duty

If there is a statutory duty, the trust cannot refuse to meet an assessed need on grounds of lack of resources. Trusts can only take their available resources into account during the assessment process when deciding whether a need exists (see 5.7.3).

6.1.2 Power

Where there is simply a power to provide a service, the trust is able to exercise its discretion. However, it must exercise its discretion properly. This means that, where a trust has a policy, it should comply with that policy and the policy must be fair, reasonable and non-discriminatory. It is also essential that the policy is not so rigid that

it does not take account of individual circumstances and there must be a genuine mechanism whereby consideration to exceptional cases can be given.

If it appears that there has been an abuse of discretion, a person who has been refused a service may be able to seek a judicial review of the trust's decision.

6.2 Waiting lists and delay in meeting assessed need

At times a trust will not refuse to provide the service but will operate a waiting list due to financial constraints. As noted, a trust must carry out a statutory duty. Where no time limit for doing so is set down in the legislation, the law implies that it should be carried out within a reasonable period of time. This allows someone who has been on a waiting list for a considerable amount of time to take court action to force the trust to provide the service.

The Scottish case of *McGregor v South Lanarkshire Council* involved a successful challenge to a waiting list for residential care funding. In consequence, prior to the decision in the Northern Ireland case of *Hanna v Craigavon and Banbridge HSST,* several waiting list cases in Northern Ireland had been settled before court action had been initiated. However, the High Court in the *Hanna* case found that the operation of a waiting list system for beds in residential accommodation (due to resources issues) was appropriate. With regard to the particular facts of the case, a delay of seven months in failing to ensure Ms Hanna's discharge from hospital to a residential home (when there was no medical reason for her to remain) was found not to be unreasonable.

In the LW case, Mr Justice McCloskey made reference to both *McGregor* and *Hanna* and in reaching his decision decided to follow the approach in the *McGregor* case. He found that, once a decision on what the authority considers *'necessary and suitable and adequate'* under Article 15 HPSS'72 in respect of meeting need has been made, the discretion is exhausted and a duty of provision arises. In making the assessment in each individual case, the authority can properly take into account factors such as available resources and the demands on its budget. However, when the assessment is completed (ie an eligible need for a service has been identified) that discretion is supplanted by duty and resources cannot play a part. In effect, the decision in *Hanna* was overruled by that in *LW.*

Assessment of risk is paramount. It is therefore imperative that the risk to not having the service right away is identified and forms the basis of the decision to place that person on a waiting list and not the type of service required. The importance of carrying out risk assessments was highlighted by Mr Justice McCloskey in the *McClean* decision.

A person who has been placed on a waiting list for a service and who feels that there has been excessive delay can also make a complaint to the Ombudsman on the grounds of maladministration. This has already happened on numerous occasions in England.

6.3 Wishes of the individual

Sometimes the situation will arise where a trust wishes to meet an assessed need by providing a particular service and the person in need wants a different service to be provided. In those circumstances, it is important to check that both services actually meet the person's need. Consideration can be given to whether the service suggested meets a person's particular psychological or cultural needs.

If only one of the services meets those needs, the person should draw this to the attention of the trust. If, however, the services are equally suitable in terms of meeting needs, the trust may take into account its resources at this stage. It can therefore make 'best value' decisions having regard to the fact that one option is more cost-effective in deciding which service to offer This was established in *R v Lancashire CC ex. p. Ingham [1995].*

7. CARE MANAGEMENT

7.1 Care packages

Once a comprehensive individual assessment has been completed and a decision has been taken that publicly funded care can and should be arranged, it is the responsibility of the trust to design appropriate care arrangements. This must be done in consultation with the person, her/his informal carers, and all the care professionals involved.

The guidance stresses that care arrangements should begin with the needs and wishes of the person and her/his carers. Trust staff should, as far as possible, aim to provide or arrange the provision of services which will meet those particular needs and wishes.

7.2 Management and monitoring

It was recognised in *People First* that a person's care needs may change over time and must be monitored. It is therefore recommended that a single professional worker should be assigned as a personal contact to each individual.

The main contact for the person is the care manager. The care manager takes responsibility for designing and assembling a package of services tailored to the person's needs and for ensuring that the services are effectively coordinated, delivered and monitored.

8. THE ROLE OF CARERS

Approximately 6.5 million people in the UK are carers and it is estimated that approximately 214,000 people in Northern Ireland are carers (www.carersuk.org). The

CDPA'02 is the first piece of legislation in Northern Ireland dealing with carers rights. It defines a carer as someone who provides or intends to provide a substantial amount of care on a regular basis.

Sections 1, 4 and 5 of CDPA'02 give carers, child carers and carers of a child with a disability, the right to an assessment when requested.

Once a carer's assessment has been carried out, the authority must consider what services if any can be provided to the carer or the person being cared for. The authority may charge for the services provided. As stated earlier, the Act also empowers trusts to make direct payments to carers (including sixteen and seventeen year old carers) for the services that meet their own assessed need.

The CDPA'02 sets out that an authority shall take such steps as are reasonably practicable to make information available to carers concerning their right to an assessment.

9. CHARGING FOR DOMICILIARY SERVICES

Once a person has been assessed as requiring domiciliary care services, the trust must exercise its discretion in deciding whether or not to charge for those services.

9.1 Legislative basis

Trusts have discretion to charge for domiciliary services. Article 15 (4) of HPSS'72 allows social services to recover any charges the trust considers appropriate in respect of any services provided under Article 15.

Similar discretionary powers to charge for services are written into other provisions in HPSS'72, eg Articles 7 and 8, which are provisions in relation to the prevention of illness, care and after-care, and the care of mothers and young children respectively.

Other than those general provisions, there is no specific legislation regulating the imposition of charges for domiciliary services. This, coupled with the lack of a clear policy statement or any comprehensive guidance on charging, has resulted in inconsistencies in the manner in which trusts throughout Northern Ireland approach charging for such services.

9.2 General principle

As a general principle, there should be no consideration in the financial assessment of income and capital of anyone but the person in need and her/his spouse or civil partner.

9.3 Charging

Historically, domiciliary care services have attracted a relatively low level of charges or have been provided free of charge. However, there are some notable exceptions, among which is the home help service.

9.3.1 Home help scheme

A means-tested charge has been applied to the home help service for many years, in line with the DHSSPS policy as set out in Circular HSS(SS)1/80.

This model home help scheme outlines the criteria for assessment and charging of individuals aged under 75. People over 75 are not charged.

The circular is regularly amended to take account of increases in social security benefits which are applied when assessing a person's ability to pay for the service.

A trust must have regard to this guidance when carrying out a financial assessment. An attempt by a trust to apply a charging policy which is inconsistent with the guidance may be challenged by judicial review.

9.3.2 Meals

A standard subsidised charge, ie not subject to a means test, has been levied for many years for meals provided at day centres. This is set and reviewed annually by the DHSSPS. Charges for the meals-on-wheels service have followed a similar pattern.

10. CHARGING FOR RESIDENTIAL CARE

Trusts have a duty to charge for residential services. Article 99 of HPSS'72 provides for charging for accommodation in board and trust managed homes. Article 36 of HPSS'72 makes provision for charging for accommodation in voluntary or private homes.

In both situations, a financial assessment must be carried out in accordance with the Health and Personal Social Services (Assessment of Resources) Regulations 1993 (HPSS'93 Regs) (as amended) to ascertain the person's ability to pay.

Where an individual is placed in residential care on a temporary basis (as defined) then for the first eight weeks of her/his stay, the trust can choose to conduct a financial assessment or can levy a charge which it believes would reasonable for the person to pay. Most trusts levy a standard charge for temporary respite breaks in residential care for the first eight weeks. From the beginning of the ninth week, trusts must conduct a financial assessment in accordance with HPSS'93.

Guidance on charging is contained in the *Charging for Residential Accommodation Guide* (CRAG). This is issued by the DHSSPS and regularly updated.

When a person is assessed as requiring permanent nursing or residential care (or where they are assessed as needing a period of residential care exceeding eight

weeks), the trust will undertake a financial assessment to see whether or not s/he can pay, or requires assistance paying the residential care fees. First, the trust will look at the person's capital, and then, if s/he has less than the capital limit, it will look at their income.

The capital and income rules which trusts must follow in conducting a financial assessment for a person entering residential care are similar to those used to determine entitlement to Pension Credit (PC) or Income Support, although there are some significant differences.

10.1 Capital rules

10.1.1 Financial limits

In order to get help from a trust with care fees, a person must not have capital in excess of specified limits. Those limits are set down in the HPSS'93 Regs as amended. Trusts are not entitled to substitute their own scale for judging a person's ability to pay.

This was confirmed in *R v Sefton MBC ex parte Help the Aged*. In this case, the local authority's policy of waiting until people had only £1,500 left before providing financial assistance was held to be unlawful.

The current capital limits are as follows.

- Capital of £14,250 or less is ignored. This means that the person is not expected to use any of this money to fund her/his care.
- A person who has capital of between £14,250.01 and £23,250 will have an assumed income from the capital. Each £250 or part thereof between £14,250.01 and £23,250 is assumed to generate an income of £1 per week. The assumed income is then taken into account in the assessment of income.
- A person in or about to enter residential care who has capital of over £23,250 is expected to fund the full cost of her/his care from her/his own resources.

10.1.2 What counts as capital?

Capital can take many forms and the legislation and regulations give no useful definition of what it includes. However, CRAG does provide examples of different types of capital a resident may have and how this capital is to be treated for the purposes of her/his financial assessment.

Capital includes a person's home and any land or property owned by her/him although there are circumstances where the value of a home can be ignored. These are discussed below.

Capital can be distinguished from income because a capital payment is made without being tied to a period and is not intended to form part of a series of payments.

Savings count as capital. This includes money in a bank or building society, cash at home, shares and unit trusts. Fixed term investments are taken into account unless the money is unobtainable. An investment which can be realised before the end of a term, albeit with a loss of interest, is taken into account (eg a Tessa).

Money or other assets held on trust are taken into account in certain circumstances. For more details on this see *Law Centre (NI) Encyclopedia of Social Welfare Rights, B.2 Financing Residential Care*.

10.1.3 When is the value of a person's home ignored?

Often one of the major concerns for a person entering residential care is whether or not her/his home will have to be sold. The term home includes the garage, garden and outbuildings, together with any land or other premises which are not occupied, but which it is unreasonable to sell separately.

When a person enters residential care permanently, the value of her/his home is disregarded for up to twelve weeks. After that, how the property is treated depends on who is still in occupation.

The value of the home is ignored if any of the following still lives there:

- a partner, former partner or civil partner (except where the resident is estranged from the partner, former partner or civil partner);
- a lone parent who is the resident's estranged or divorced partner;
- a relative or a member of the resident's family who is aged 60 or over;
- a relative or member of the resident's family who is incapacitated;
- a relative or a member of the resident's family who is a child under sixteen whom the resident is liable to maintain.

The trust also has a general discretion to ignore the value of the premises occupied by any third party where this would be reasonable in the circumstances.

The discretion to ignore the value of the home where a person goes into residential care permanently and the home is occupied by a third party is a far wider power than that contained within PC or Income Support regulations. It may be exercised, for example, where a long-standing carer or family member under 60 continues to live in the person's property after her/his admission to care. It is important therefore to provide reasons why the home should be disregarded and to ask the trust to exercise its discretion on this basis.

10.1.4 When is other capital ignored?

In certain circumstances, other capital can be ignored. These include:

- tax rebates;
- Social Fund payment;
- the surrender value of life assurance;

- endowment policies or annuities; and
- personal possessions.

However, where personal possessions are bought in order to enable a person to claim or increase her/his entitlement to assistance with care fees, the value of those is taken into account.

An interest in property which a person will or may possess in the future, but does not possess at the time of assessment, is generally ignored as capital. However, this does not apply where the future interest is in land or premises for which a person has been granted a lease, tenancy, sub-lease or sub-tenancy.

10.1.5 Valuation of capital

The value of capital is based on its current market value or surrender value. Ten per cent is deducted from this for expenses attributable to sale. The amount of any charge secured on the asset (eg an outstanding mortgage) is also deducted.

Where more than one person has an interest in a capital asset other than land, each person will be deemed to have an equal share of the asset until the asset is sold and each person possesses her/his actual share.

Where the asset which is jointly owned is land, the value of a person's share is the price her/his interest would realise if sold to a willing buyer, minus ten per cent and the amount of any charge secured solely on the person's share. The resulting value could easily be minimal, as there may be few willing buyers for a part share in a house.

10.1.6 Disposal of capital, notional capital

Regulation 25 of the HPSS'93 Regs provides that a person may be treated as possessing actual capital of which s/he has deprived her/himself for the purpose of decreasing the amount that s/he may be liable to pay for residential care. (For exceptions to this see *Law Centre (NI) Encyclopedia of Social Welfare Rights, B.2, Financing Residential Care.)*

It is important to note that trusts have discretion as to whether or not to assume notional capital and accordingly they should have regard to all relevant factors. Trusts cannot take account of irrelevant factors and could be challenged if they act irrationally in making their decision. The key question for trusts to consider is motive: what has been the reason behind the person's decision to get rid of an asset?

There may be more than one purpose for disposing of a capital asset, only one of which is to avoid a charge for accommodation. CRAG explains that avoiding the charge need not be the resident's main motive but it must be a significant one.

Pragmatically, the earlier the transfer the lower the risk. CRAG also explains that it would be unreasonable to decide that a person had disposed of an asset in order to reduce her/his charge for accommodation when the disposal took place at a time when s/he was fit and healthy and could not have foreseen the need for a move to

residential accommodation. Nonetheless, the legal test is one of purpose of transferring property or other assets and not timing.

Where it is held that a person has deliberately transferred an asset to a third party in the six months prior to going into care, or after going into care, the trust has the power to seek recovery of accommodation costs from the third party. If an asset is transferred to more than one person, then each person is liable for charges up to the value of her/his share of the transferred asset. If assets are deliberately transferred more than six months before going into care, the trust still has discretion to treat the resident as possessing that asset and to seek recovery of charges from her/him.

10.1.7 Relevant case law

Two decisions are worthy of note.

In the case of *Yule v South Lanarkshire Council*, (1999 2 CCLR 395), the Scottish Court of Session held that the true purpose of any transfer of property could be determined without a specific finding having to be reached concerning the state of knowledge or intention of the resident.

In the case of *Robertson v Fife Council*, (2000 SLT 1226), the court refused to find it unreasonable of the council to hold that a woman who had transferred her home to her children two and a half years before entering residential care had deprived herself of capital for the purpose of reducing liability for care fees. The council was accordingly entitled to treat the woman as having notional capital from which she could pay the fees.

10.2 Income rules

Once it has been established that a person is not disqualified from financial assistance by virtue of the amount of capital which s/he has, the trust will consider her/his income. In order to do this, the trust must ascertain what the cost of the accommodation will be and also the level of income which the person will have when in care. The trust will take into account almost all income except an allowance for personal expenses of £24.90.

There are, however, two important exceptions, Attendance Allowance and DLA (care component). These benefits are payable for only four weeks to people who enter residential accommodation on a permanent basis and who are not fully self-funding. Although these benefits are ignored for the purposes of PC and Income Support calculations, they are taken into account when assessing entitlement to trust assistance. The exception is where a person is only entering care on a temporary basis, in which case Attendance Allowance or DLA (care component) is disregarded.

10.3 Preferred accommodation

Guidance issued by the HSSE makes it clear that a trust must arrange to provide care in a person's preferred accommodation:

- subject to the accommodation being available and suitable to her/his needs; and
- provided that it does not cost more than the trust would usually expect to pay for care for someone with such needs.

Where a person is unable to make a choice because they lack sufficient mental capacity to make her/his own decision, then the wishes of the carer/family members should be taken into account and any decision made must be in her/his best interests

Guidance sets out that the cost test is not whether a cheaper option is available but what a trust would normally pay to meet a person's needs by the provision of residential care.

If a person chooses a more expensive option, the placement may be arranged by the trust providing a third party (eg a family member or friend) is prepared to meet the difference. In such cases, the trust should normally pay the full charge and recover the extra cost from the third party (a third party top up), unless the third party is willing to pay the third party top up directly to the nursing or residential care home.

Third party top-ups should only be happening where the third party has agreed to pay the additional amount in order that the person entering care can enter a particular home which is more expensive than the trust considers reasonable. Trusts should also ensure that the third party is in a financial position to continue to pay the third party top up whilst the resident remains in the residential/nursing home

If the trust has placed an unreasonable restriction on the amount which it considered reasonable, or if the person's needs can only be met by being placed in a particular home, a request for a third party top-up payment may be improper and may be open to legal challenge. In these circumstances, legal advice should be sought as soon as possible. The Law Centre's Community Care Legal Advice Service can advise in such cases.

10.4 Care Management, Provision of Services and Charging ECCU 1/2010

This guidance states that a trust's decision to enter into a third party agreement about more expensive accommodation must be informed by a risk assessment of the third party's commitment and capacity to sustain an agreement.

Trusts must ensure that all additional payments are as a result of an informed choice, and that the rationale for the additional payments is fully transparent, for example, the rationale could be an optional additional service or an experience-based preference on the part of the service user.

10.5 Liable relatives

During the financial assessment, only the income and capital of the person in residential care are taken into account. However, once that assessment has been carried out, if the trust is unable to recover the full cost of the care from her/him, then it can look to see if there are any liable relatives from whom it could recover the outstanding costs.

Trusts are able to claim payment from liable relatives under Article 100 of HPSS'72. This power is based on the legal principle that spouses and civil partners are liable to maintain one another and parents are liable for their children's maintenance. However, other relatives, such as children of elderly parents or cohabitees, have no legal liability to fund care or to provide financial assistance.

When it is evident that the liable relative is not in a position to make a contribution, eg where the liable relative is in receipt of Pension Credit or Income Support, the trust need not pursue the matter. However, where a trust believes that a spouse or a parent of a child should contribute to the cost of care and that contribution is not forthcoming, the trust may take court proceedings to recover the amount of the contribution.

Heath and social care trusts do not generally apply the liable relatives rule in practice.

10.6 Case law re charging for long-term care

In *R v North and East Devon Health Authority ex parte Pamela Coughlan and Secretary of State for Health and Royal College of Nursing*, the central issue was whether the National Health Service (NHS) or social services is responsible for long term care.

This case, decided by the Court of Appeal in England and Wales on 16 July 1999, raised several important issues.

The most important point stated by the court is that, where a person's needs are primarily health care needs, the NHS must fund the entire cost of a placement in a nursing home. The court did not go as far as to say that all nursing care is the responsibility of the NHS. However, it did say that social services departments are only legally permitted to purchase nursing care when it is ancillary or incidental to the nursing home placement.

Whether a person's needs are primarily for health care depends on the quality and quantity of nursing care required. Pamela Coughlan's needs included help with feeding, transfers from bed to wheelchair, a pressure sore mattress, occasional suppositories and intermittent catheterisation.

Following this decision, the DHSSPS said it would issue guidance in this area. To date, this has not been done and the part implementation of the proposals put forward by the Royal Commission on long term care has somewhat sidelined this case.

It may still be possible for a person to mount a Coughlan type challenge before the courts, but the differences in community care law in England and Northern Ireland may mean that such a challenge could fail before the Northern Ireland courts.

11. DIRECT PAYMENTS

The purpose of direct payments is to enable people to have more control over the services they require and the way in which those services are delivered.

11.1 Eligible persons where an eligible need has been identified

Trusts are under a duty to make direct payments if requested provided that the person requesting the direct payment is eligible and provided that certain criteria are met. Certain people cannot receive direct payments, such as those who have a mental illness and are still subject to conditions under the MHO'86 and those who are subject to certain criminal justice measures.

Direct payments are governed by the Carers and Direct Payments (NI) Act 2002 and The Personal Social Services and Children's Services (Direct Payments) Regulations (NI) 2004. Guidance is also in place.

Currently, service users who are unable to 'consent' to the Direct Payments Scheme (due to lack of capacity) cannot benefit from the scheme unless an 'authorised person' is appointed by the Office of Care and Protection to receive and manage the direct payments on their behalf. This places a considerable number of service users and their carers under a disadvantage in respect of choice for service provision. The recent judicial review judgement *PF and JF's Application for Judicial Review [2013]* highlighted this restriction in the legislation.

Following the *PF and JF* judgement the DHSSPSNI issued Guidance, '*Direct payments for Persons who lack Capacity to Consent*', which states that the legislation will be amended to enable another person to receive direct payments on behalf of a person with eligible needs who lacks capacity to consent to the receipt of payments. It is intended these changes will be implemented when new mental health and mental capacity legislation is introduced in Northern Ireland within the next couple of years. Interim arrangements have been put in place under this Directive. The Law Centre's community care legal advice service can give advice and assistance.

A person to whom direct payments are made must be willing and able to manage them alone or with assistance. S/he must retain control of the arrangements. S/he remains accountable for the way in which the money is used.

However, where a person is in receipt of a direct payment and ceases to be capable of managing the payment, the trust may continue to make the payment provided another person is prepared to accept and manage the payment on the incapable person's behalf.

In addition, direct payments can be used to support the carer in her/his caring role or help maintain the carer's own health and well being.

Direct payments are not usually treated as taxable income and will not usually affect social security benefits or Independent Living Fund grants (see 12.2).

11.2 Use of payments

Direct payments cannot ordinarily be used to employ certain relatives to provide care where they are living in the same household as the direct payments' recipient. However, where the trust considers that it is in the best interests of the person being cared for, direct payments can be used to pay for services from a spouse or partner or a close relative living in the same household.

These restrictions are not intended to prohibit a person from employing a live-in personal assistant (provided such a person is not someone who would be automatically excluded by the regulations*).*

The Court of Appeal in England and Wales has held that direct payments will count as income of a couple for Income Support purposes, if a disabled person 'employs' her/his partner as the carer, but will not count if a third party is employed (*Casewell v Secretary of State for Work and Pensions, 2008*).

11.3 Type of service

Where a direct payment is requested by a person with social care needs, trusts are only permitted to make direct payments in respect of the personal social services which that person has been assessed as needing. They cannot make direct payments in lieu of health services, including some community services such as community nursing or services provided by medical staff.

11.4 Summary

The Direct Payments Scheme aims to give the user greater control and independence. Although this is accompanied by increased responsibilities, the guidance issued by the DHSSPS emphasises the need for a person availing of the direct payments scheme to have access to support services and practical assistance.

The Centre for Independent Living provides a range of services for people using and considering Direct Payments. The centre works to promote the principles of independent living (phone number: 028 9064 8546).

Anyone who is dissatisfied with any aspect of the direct payments scheme, including being refused a payment, should use the trust complaints procedure in the first instance.

12. MANAGING FINANCIAL AFFAIRS

When a person is incapable for whatever reason of managing her/his own financial affairs, the law permits the appointment of another person to take charge of these. This can be done in a variety of ways. The particular circumstances of a given case will dictate which type of intervention is necessary and/or available.

The following are some of the most common types of appointment:

- appointee, for social security benefits;
- agent, for social security benefits;
- power of attorney;
- enduring power of attorney;
- controller.

12.1 Appointee

Regulation 33 of the Social Security (Claims and Payments) (NI) Regulations 1987 provides that the DHSSPS can authorise an appointee to act on behalf of a person who cannot claim for her/himself because of mental incapacity, for example if s/he is mentally ill or suffering from senility. This provision does not apply to a person who, despite a physical disability, can understand and control her/his own affairs. For an appointee to be authorised, an application must first be made in writing to the social security office of the person claiming. A social security officer should interview the person claiming to check that the appointment is needed. Medical evidence may be sought if the officer has doubts about the incapacity or if the person claiming is not in hospital.

12.2 Agent

An agent can be appointed where a person does understand her/his own affairs, but for example has a mobility problem which causes difficulty in dealing with matters such as claiming benefit. Agency is a general legal concept which allows a person (the principal) to appoint someone else (the agent) to act on her/his behalf in certain matters. It is important that the person has sufficient mental capacity to give the agent instructions.

As regards social security benefits, an agent can be appointed by the person claiming or in certain circumstances by the DHSSPS if it is satisfied that an appointment would be beneficial.

12.3 Power of attorney

A person who is physically incapable of managing her/his financial affairs may appoint someone to act for her/him by giving that person a power of attorney. This is a legal document which states that the donee/appointee (the person with the power) is acting on the instructions of the donor (the person giving the power*).* A power of attorney may be limited to the performance of a specific act on the donor's behalf eg the sale of a property, or it may be a general power, eg to act on the donor's behalf in all matters whilst s/he is out of the country.

By law, a power of attorney lapses if the donor becomes mentally incapable of giving instructions unless s/he has made an enduring power of attorney (see 13.4*).*

It should be noted that the existence of a power of attorney does not mean that the donor cannot act on her/his own behalf.

12.4 Enduring power of attorney

An enduring power of attorney allows a donor to appoint one or more persons to act for her/him, should s/he become incapable of managing her/his affairs in the future. Such a power can only be granted by the donor whilst s/he is capable of understanding the nature and effect of creating such a power.

Unlike a power of attorney, an enduring power of attorney continues to be valid after the donor ceases to be capable.

12.5 Controller

When a person becomes unable to look after her/his property and affairs by reason of a mental disorder, the law provides for the appointment of a controller. This is important where an enduring power of attorney has not been created or the extent of the powers given in such a document is not sufficient.

The legislation dealing with the appointment of a controller is the MHO'86, Part VIII. The Order places the responsibility for managing the financial affairs of patients, ie those with insufficient mental capacity to manage their own affairs, on the High Court in Northern Ireland. Within the High Court system, it is the Office of Care and Protection which deals with the appointment of controllers and the management of patients' financial affairs.

The Regional Board, HSCTs, the Regional Quality Improvement Authority (RQIA) and any person running a nursing home, a home for persons in need or a private hospital are under a legal duty to notify the Office of Care and Protection if they are satisfied that:

- a person for whom they have responsibility (or, in the case of the Mental Health Commission, of whom they have knowledge) is incapable of managing her/his property or affairs;
- involvement of the court in managing that person's affairs is appropriate; and
- no-one else has taken steps to notify the Office of Care and Protection.

This duty is contained in Article 107 of the MHO'86. Such notification must be made within fourteen days of the body or person becoming so aware.

An application for the appointment of a controller to deal with the day-to-day management of a person's financial affairs must be made in writing to the Office of Care and Protection in Belfast. Forms can be obtained by phoning the Office on 028 9072 4733. Where there is no one suitable to make the application, the Office can

direct an officer of the court or the official solicitor to make the application. In urgent cases, the requirement to apply in writing can be waived.

12.6 Other powers and duties

It should also be noted that a trust has powers in relation to the property and affairs of a person in a hospital or other accommodation managed by the trust. Under Article 116(1) of the Mental Health Order 1986 where it appears to a board that any patient in a hospital or in any accommodation managed by it is incapable, by reason of mental disorder, of managing and administering her/his property and affairs, the board may receive and hold money and valuables on behalf of that patient.

The law surrounding guardianship is too complex to be dealt with here but has simply been mentioned to avoid confusion.

The role of the guardian appointed under the Mental Health Order 1986 should not be confused with the above.

13. REMEDIES

A person who is dissatisfied with the service s/he is receiving from a trust has a number of remedies available to her/him. The particular circumstances of the case will dictate which remedy is the most appropriate. In certain cases more than one remedy may be pursued.

The most commonly used remedies are:

- social services internal complaints procedures;
- Patient and Client Council;
- Ombudsman;
- judicial review.

13.1 Social services complaints procedure

The procedure for complaints in relation to Health and Social Care provision in Northern Ireland has recently been reviewed and is set out in the Health and Social Care Directions (Northern Ireland) 2009 and the Directions to the Health and Social Care Board on Procedures for FPS Complaints (Northern Ireland) 2009 (the Directions).

The legislation is complemented by DHSSPS Guidance on the implementation of the procedures, *'Complaints in Health and Social Care - Standards and Guidelines for Resolution and Learning'* (the Guidance), which sets out minimum standards which must be met.

The legislation allows each trust to make its own arrangements for dealing with complaints. However, those arrangements must be in accordance with the provisions of the Directions, must be set out in writing and should be in the spirit of the Guidance.

13.1.1 Time limits

A complaint should generally be made within six months of the date the matter occurred or within six months of the date the matter came to the complainant's notice, and normally no longer than twelve months of the matter occurring.

13.1.2 How to complain

A complaint may be made orally or in writing. There is no requirement for a complaint to be made in writing initially but it is desirable to do this whenever possible as it will ensure that the result of the initial investigation will be communicated to the complainant in writing.

13.1.3 Procedure

New arrangements were put in place for the complaints process in April 2009 which focus on local resolution of a complaint and remove the stage of independent review. This single tier process aims to provide effective resolution of the complaint.

The complaint must be acknowledged within two to three working days of receipt. If the complaint is about a hospital or community service, a full response should be received by the complainant within 20 working days. However, some complaints will take longer to resolve than others and if it becomes clear that the trust will be unable to respond within the timescale above, then the complainant should be informed of the reason why.

13.1.4 Problems

The lack of any statutory time limits on the various stages of the procedure is one problem with the social services complaints procedure. Depending on the nature of the complaint, this could potentially limit the effectiveness of the procedure as a remedy for many people. For example, in many cases where a person's complaint is about the withdrawal of an essential service, an urgent response may be required.

In such cases, if, following the initial complaint, no offer is made by the trust to retain or reinstate a service pending the outcome of the complaints procedure, it may be appropriate to consider other potential remedies.

Law Centre (NI) can advise on the alternative options and the potential implications of initiating any legal action prior to the completion of the internal complaints procedure.

13.2 The Patient and Client Council

The Patient and Client Council represents the interests of the public in health and social care.

The Council must promote the involvement of the public in the provision of health and social care. Its advocacy and advice services are available to people who are making or intending to make a complaint relating to health and social care.

13.3 The Ombudsman

13.3.1 Background

The Ombudsman is the common name for two offices:

- the Assembly Ombudsman for Northern Ireland; and
- the Northern Ireland Commissioner for Complaints.

The Ombudsman provides a free and confidential service to people who complain that they have suffered injustice due to maladministration of government departments and public bodies in Northern Ireland. The bodies which the Ombudsman can investigate are specified in the legislation. They include all local councils, education and library boards and trusts, as well as all government departments and their agencies.

13.3.2 Maladministration and substantive personal injustice

The term maladministration is not defined in the legislation but it is generally taken to mean poor administration or the wrong application of rules. Some examples which the Ombudsman may regard as maladministration include:

- avoidable delay;
- faulty procedures or failing to follow correct procedures; and
- failure to advise a person as to her/his rights of appeal.

For the Ombudsman to investigate the complaint, there must have been substantive personal injustice caused to the complainant as well as maladministration by the organisation. Examples of such injustice might include where a person has been subjected to continued suffering by being placed on a waiting list for an exorbitant length of time or where hurt and distress have been caused to a person by the failure of an organisation to respond to a complaint.

13.3.3 Bars to investigation

In some circumstances, the Ombudsman cannot investigate a complaint, for example, if:

- the action complained of took place more than twelve months ago; or
- there is a right of appeal to a tribunal; or

- there is a remedy through the court system.

It is important to remember that a number of decisions taken by government and public bodies are discretionary, ie the decision maker can exercise its discretion without having to satisfy any stated conditions. The Ombudsman can only investigate such a decision if there is evidence that there has been maladministration in the way the decision is made or if the decision is so unreasonable that no reasonable person would have made it.

Before the Ombudsman agrees to investigate a complaint, the matter will usually have to have been taken up with the organisation concerned via its internal complaints procedure. However, this will not always be necessary, for example, if it would be inappropriate to use the internal complaints procedure because the person who would be investigating the complaint is the person complained about. Another example would be where the delay involved in using the complaints procedure would cause further hardship or suffering to the individual. In those circumstances, the Ombudsman may be prepared to accept a complaint directly.

13.3.4 Making a complaint

A complaint can be made either by writing a letter to the Ombudsman or by using the Ombudsman's complaint form.

13.3.5 Procedure

When the Ombudsman receives a complaint in writing, it is firstly checked to ensure that it meets the necessary criteria for investigation by the Ombudsman. This is stage one, the initial sift.

If the complaint satisfies the criteria, it is referred to stage two, preliminary investigation or screening. The purpose of stage two is to determine whether there is evidence of maladministration and whether this has caused injustice to the person making the complaint. At this stage, the Ombudsman sends a summary of the complaint to the organisation concerned, and asks for its comments and copies of all relevant papers. If it is considered necessary, the Ombudsman may arrange for an investigating officer to speak to the organisation and/or the complainant.

Where there is evidence both of maladministration and substantive personal injustice, the complaint will then be referred to stage three, formal investigation. This is a long detailed process which can take several months. It involves interviewing the complainant and the relevant officials and inspecting all the relevant documentary evidence.

At the end of the investigation, the Ombudsman will prepare a draft report which contains the facts of the case and the likely findings. The case is then reviewed with the complainant. The organisation involved is also given an opportunity to comment on the accuracy of the facts reported, the likely findings and any redress which the Ombudsman proposes to recommend.

Following receipt of those comments, the Ombudsman then issues her/his final report to the complainant (or MLA if the complaint was sponsored by an MLA) and to the organisation concerned. The Ombudsman's target for completion of this stage of the process is twelve months from the date of receipt of the complaint.

Note: Even when the Ombudsman has decided to investigate, it does not compel the organisation to stop any action it may be taking in relation to the matters under investigation, nor does it prevent the organisation from dealing with any other aspect of the complainant's affairs.

13.3.6 After investigation

Following an investigation, the Ombudsman may conclude that:

- the complaint was wholly justified;
- the complaint was partly justified; or
- the complaint was not justified.

If it is found that the complaint is justified, the Ombudsman can recommend that the body complained about should provide a remedy. The Ombudsman has no power to enforce the recommendations made but, in practice, the bodies almost always accept the recommendations.

Where a recommendation is made under the Commissioner for Complaints legislation, the person complaining may seek the support of the courts if a public body fails to provide the recommended remedy. It is not the Ombudsman's role to obtain compensation for individuals.

However, if it is decided that the person has suffered because of something an organisation has done wrong, the Ombudsman will try to get the organisation to put her/him in the position s/he would have been in if s/he had been treated fairly in the first place. This may involve the recommendation of a consolatory payment, but often the Ombudsman may consider that an apology is sufficient. Often, the Ombudsman will also tell the organisation to improve its procedures so that no one else suffers in the same way.

To quote from the Ombudsman's report: *'It would be of value if public sector bodies whether central or local could emphasize to staff that complaints are of the same genre as compliments and in pursuing remedies it is possible to alter a feeling of dissatisfaction and/or injustice to a position where an individual citizen will appreciate the efforts made to put matters right.'*

13.4 Judicial review

Judicial review is the main legal procedure by which people with a sufficient interest can challenge decisions made by public bodies. It is not a method by which to appeal the merits of a decision but serves only as a means of scrutinising the legality of the decision making process. The main concern of the court in judicial review proceedings

is to ascertain whether a correct legal basis has been used to reach the decision. The court will examine whether authorities have acted unreasonably, illegally or unfairly.

Generally, before a judicial review can take place, all other rights of appeal must have been exhausted. This includes for example the use of any internal complaints procedure, unless it can be shown that the procedure is inappropriate to deal with the problem, eg where the delay in using the complaints procedure may make it impractical. In such circumstances, an application for judicial review can be made very speedily to obtain an urgent order (an interim injunction) to preserve a situation for more detailed consideration at a later date.

13.4.1 Public body exercising public function

A judicial review can only be taken if a public body made the decision being challenged. Key factors that are taken into account in determining whether a body is susceptible to judicial review are whether the body has any statutory powers and whether its functions involve a sufficient public element. Health and social services boards and trusts are considered to come within this category and have been the subject of judicial review.

It is not enough, however, that the intended subject of the judicial review (the respondent) is a public body. Only decisions taken by such a body in the exercise of its public functions may be challenged by way of judicial review. Where, for example, an individual is in a contractual relationship with a public body, it may well be that its actions in relation to that person come within private law. In that case, the appropriate remedy would be to sue for damages in a civil court or tribunal.

13.4.2 Applicants

Only a person or body with 'a sufficient interest in the matter to which the application relates can apply for leave for judicial review' (Order 53). The legal term for this is locus standi, or standing. In order to have standing, the person applying must be affected by the decision or have a remit or interest making the decision particularly relevant to her/him.

Note, however, that if a person wishes to take judicial review proceedings based on a breach of the Human Rights Act 1998 (HRA'98) then s/he must meet the definition of a victim as set out in the Act, which is narrower than the test contained in Order 53. In certain circumstances, some groups or organisations can also apply for judicial review provided the matter falls within their terms of reference or remit.

13.4.3 Grounds for judicial review

The grounds on which an application for judicial review may be made are not defined in any piece of law. This leaves it open to imaginative lawyers and advisers to argue in various ways that a decision of a public body has been unfair. However, previous court cases have defined and developed some common grounds for judicial review. These

grounds, set out by Lord Diplock in the case of *Council of Civil Service Unions v Minister for the Civil Service [1985],* are examined below.

■ Illegality

This ground is established where:

- ☐ the public body has exceeded its powers, ie acted ultra vires (beyond powers);
- ☐ there has been an error in law, ie the law has been applied and/or interpreted incorrectly;
- ☐ there has been an error of fact, ie the decision has been based on an incorrect fact;
- ☐ there has been improper exercise of discretion, eg where a blanket policy has been applied in circumstances where the body should have been exercising its discretion;
- ☐ there has been unlawful delegation;
- ☐ there has been a failure to take into account relevant factors in making a decision; or
- ☐ a body has acted in contravention of the Human Rights Act 1998.

■ Irrationality

This can be very difficult to distinguish from a decision with which the applicant disagrees. The courts have established that judicial review will not interfere with a reasonable decision even if the court feels it may have taken a different decision in the circumstances. In order for judicial review to succeed, the decision must be *'so unreasonable that no reasonable authority could ever have come to it'*. This principle, often called 'Wednesbury unreasonableness' was established in the case of *Associated Provincial Pictures Ltd v Wednesbury Corporation [1948]*.

Where the judicial review is based on HRA'98 or European Community Law, the test of reasonableness is replaced by one of proportionality. The intensity of review is somewhat greater under the proportionality approach. The doctrine of proportionality may require the court to assess the balance which the decision maker has struck, not merely whether it is within the range of rational or reasonable decisions. The proportionality test may go further than the traditional grounds of review inasmuch as it may require attention to be directed to the relative weight accorded to interests and considerations.

■ Procedural impropriety

This ground is established if it is shown that the process for reaching the decision has been flawed in some way. This might be where, for example, a decision has been reached without following procedures laid down in legislation or in guidance. Another example is a failure to observe the basic rules of natural justice (often called fairness) as defined by the courts.

- Substantive legitimate expectation

A new ground for challenging judicial review is currently developing and may be used in certain circumstances in the future. It is known as substantive legitimate expectation. It could be used where the board or trust led someone to believe that it would act in a certain way and then failed to do so, without good reason and to the detriment of the person who had the legitimate expectation. This ground was established in *R v North and East Devon Health Authority ex parte Pamela Coughlan and Secretary of State for Health and Royal College of Nursing [1999].* In this case, the decision of a local authority to close a home which had been earlier promised by the authority to be 'a home for life for Ms Coughlan' was held by the Court of Appeal in Great Britain to be a breach of her substantive legitimate expectation.

Applications for judicial review frequently overlap between the above grounds. The statements on which the case is based will usually cite more than one of them.

13.4.4 Time limits

Order 53 of the Rules of the Supreme Court specifies that *'an application for leave to apply for judicial review shall be made promptly and in any event within three months from the date when the grounds for the application first arose unless the court considers that there is good reason for extending the period within which the application shall be made.'*

In view of the time which legal aid applications and preparation of documents can take, this time limit means that advisers should contact solicitors immediately if they become aware of a potential judicial review issue.

13.4.5 Orders of the court

All remedies under judicial review are discretionary. A court is not obliged to make an order, even where grounds for judicial review are established.

In the event that it does wish to make an order, the orders available to a court are:

- certiorari - to quash or strike out a decision;
- mandamus - compelling an action;
- prohibition - preventing an action;
- declaration - making a finding;
- injunction - requiring or preventing an action.

Damages can be sought in judicial review but are in practice extremely rare. A successful judicial review will usually result in the decision being quashed and either replaced by a finding of the court or, more often, an order of mandamus requiring the public body to take the decision again following correct procedure. Unfortunately, this means that the respondent may be able to take the same decision, correcting the procedural impropriety, with the result that the person applying gains little from the whole procedure.

Applications for declarations alone are unlikely to succeed since the courts have stated their reluctance to make findings which are of no practical or meaningful effect.

Court orders at the end of judicial review will also refer to costs. A legally aided person who is unsuccessful will usually have her/his costs paid by the legal aid fund. S/he will not have to pay the costs of the respondent unless s/he has behaved in a frivolous, vexatious or malicious manner. Where the person applying is successful, the costs can be awarded against the respondent and any contribution which the person applying had to make towards legal aid will be refunded.

Many cases are settled or agreed between the applicant and the respondent (the parties) prior to the judge hearing the case in full. In cases which are settled, the parties can agree to any terms. They are not limited to the categories of court orders.

14. FURTHER INFORMATION

Government guidance

People First: Community Care in Northern Ireland in the 1990's, DHSSPS.

Charging for Residential Accommodation Guidance, DHSSPS, guidance available from DHSSPS, Castle Buildings, Stormont, BT4 3SF and at:
http://www.dhsspsni.gov.uk/charging-for-residential-accommodation-guide-2014.pdf

Direct Payments: Legislation and Guidance for Boards and Trusts April 2004, available from DHSSPS.

Carers Assessment and Information Guidance, DHSSPS, 2005 - available from DHSSPS website.

Law reports

Community Care Law Reports, published by Legal Action Group quarterly, 1997 onwards.

Textbooks

There are no textbooks specifically dealing with Northern Ireland community care law but the following texts may be of general assistance.

Community Care and the Law, Luke Clements and Pauline Thompson, published by Legal Action Group, Fifth Edition, 2011.

Other

Challenging Community Care Decisions in Northern Ireland, Public Law Project, London, 2005. Available in the Law Centre Library.

Welfare Benefits and Tax Credits Handbook, 2016-2017, available from CPAG, 94 White Lion Street, London, N1 9PF, £61.00

Paying for Care Handbook, 6th Edition, 2009, available from CPAG, 44 White Lion Street, London, N1 9PF.

Community Care Practice and the Law, 4th Edition, 2009, Michael Mandelstam.