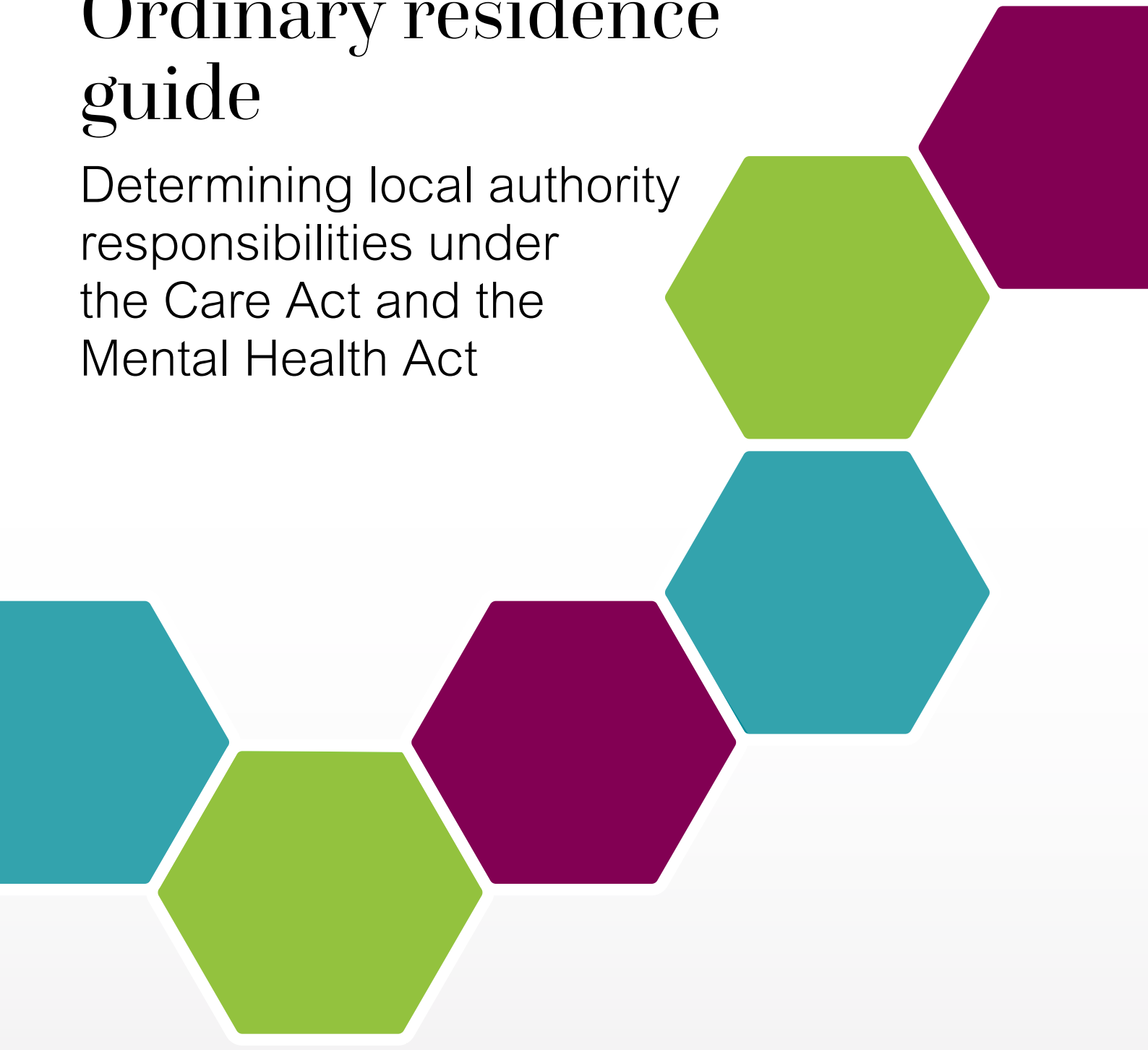
Local Government Association

directors of adass adult social services

Ordinary residence guide

Determining local authority responsibilities under the Care Act and the Mental Health Act



This guide is applicable to all adults whose care is commissioned in an area that is different from where they hold ordinary residence, including those whose services are governed by the Mental Health Act. It has been commissioned by the Transforming Care programme, which supports people with a learning disability, autism or both, and has been endorsed by the executive council of the Association of Directors of Adult Social Services in England (ADASS) for use with all adults.

This guide should not be taken as complete statement of the law or used as a substitute for getting legal advice about what to do in individual cases. It was written by Morag Duff, a former solicitor and independent health and social care consultant. She can be contacted at duffmorag@gmail.com in relation to the contents of this guide.

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Purpose of this guide

This guide has been created to support the ambitions of the Transforming Care programme to improve services and support for children, young people and adults with a learning disability, autism or both a learning disability and autism who may display behaviour that challenges, and significantly reduce the number of people in inpatient settings.

It is aimed at supporting partners to understand and apply the concepts of ordinary residence – in particular, recognising that many of the people supported have experienced complex care and support arrangements, over a number of years, in different geographical areas and where guidance and policy may have changed during this time.

These complexities can be challenging for partners in then determining the financial responsibilities for individuals, in particular on leaving inpatient settings where they may have been for significant lengths of time. Taking into account the experiences of and issues being raised by local authorities and Transforming Care Partnerships, this guide has been developed with the aim of supporting partners to minimise disputes and support collaborative local resolution.

In keeping with the principles of the Transforming Care programme, the wellbeing of individuals is paramount. Organisations should work together cooperatively and proactively, seeking to ensure that people moving between areas are provided with timely and effective support; they should ensure they are meeting the needs of the person and continuing with plans for individuals, regardless of uncertainties or disputes about funding arrangements. In these cases, the organisation currently meeting their needs should continue to do so on a 'without prejudice' basis, until the issue is resolved.

In line with current policy and good practice, the individual should always remain at the centre of the assessment and care and support planning process.

> "Children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, have the right to the same opportunities as anyone else to live satisfying and valued lives and to be treated with the same dignity and respect. They should have a home within their community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life."
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> **Vision statement, Transforming Care**

Section one: ordinary residence – the basic rules

About the concept of ordinary residence

Where an individual is 'ordinarily resident' determines which local authority is required to meet their eligible care and support needs under the Care Act. A local authority's duty to meet eligible needs also applies to those who are present in the area but are of no settled residence.[1]

The idea of ordinary residence is not new or unique to the Care Act, nor indeed its predecessor the National Assistance Act 1948. The concept is not defined in the Care Act, although chapter 19 and annex H of the Care and Support Statutory Guidance 2014 ('the statutory guidance') are dedicated to the subject and there is a significant body of legal case law and Secretary of State determinations that are relevant to this issue.

In the vast majority of cases it will be obvious where an individual is ordinarily resident – and consequently which local authority is responsible for meeting the eligible social care needs of that individual. The issue of where an individual is ordinarily resident will usually arise when a person is moving or has moved from one geographical area to another.

Where there is a dispute about which authority is responsible – due to disagreement over where the individual is ordinarily resident – the end point is resolution by the Secretary of State for Health.[2] Regulations[3] set out detailed guidance of the steps that a local authority must take in order to make such a referral. However, a formal referral to the Secretary of State should be the last resort.

Local authorities should make all efforts to resolve disputes locally wherever possible, including an early referral to in-house legal teams where differences of approach are identified.

The question of ordinary residence should be determined after a needs assessment has identified that the person has eligible needs[4] under the Care Act. Any disputes about ordinary residence must not adversely affect the meeting of the needs identified.[5] Therefore, one authority must accept responsibility on a provisional basis. This will be whichever authority is currently meeting the needs, or if none, where the individual is currently living, or if that is not clear where the individual is present.[6] See section four of this guide for more detail on disputes.

'Ordinary residence' is not defined within the legislation; therefore the words must be given their natural meaning within the legal context in which they appear.

The purpose of establishing ordinary residence is, at its root, about allocating legal and financial responsibility for an individual to a particular local authority. The development of the relevant legislation and any interpretation by the courts of that legislation support the basic principle that one local authority should not be able to 'export' responsibility for an individual by placing them in a different geographical/local authority area.

1 Care Act 2014 section 18(1)(a)
2 Care Act 2014 Section 40. However, it should be noted that the Secretary of State's determination can be challenged by way of judicial review proceedings.
3 Care and Support (Disputes about Ordinary Residence, etc.) Regulations 2014. An overview of these Regulations can be found at appendix C
4 Care Act 2014 Section 13 (3) (c)
5 Care and Support (Disputes about Ordinary Residence, etc.) Regulations 2014 Regulation 2(1)
6 Care and Support (Disputes about Ordinary Residence, etc.) Regulations 2014 Regulation 2(2)

Establishing ordinary residence for people with capacity

The statutory guidance advises that: "The concept of ordinary residence involves questions of both fact and degree. Factors such as time, intentions and continuity (each of which may be given different weight according to the context) have to be taken into account[7]." It will be seen that the range and importance of relevant factors can vary hugely in each individual case.

The approach to determining where an individual is ordinarily resident under the Care Act comes from the case of Shah[8], a case relating to entitlement to student grants. This approach applies to those people who have the mental capacity to decide where they want to live. There is a different approach for people who do not have the capacity to do so (see page 9 below).

In the case of Shah, Lord Scarman said: "Unless... it can be shown that the statutory framework or the legal context in which the words are used requires a different meaning, I unhesitatingly subscribe to the view that ordinarily resident refers to a man's abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or long duration."

Thus, determinations around ordinary residence often apply what is known as the 'Shah test' based on the origins of this case. There are both physical and mental aspects to the test which can essentially be reduced down to three elements, as follows.

Abode in a particular place

This is the physical element and is usually relatively straightforward to ascertain. A person's abode is simply where they live. The question 'Where do they normally eat and sleep?' will usually provide the answer to this element. This could be anything from a barn[9] to a house or flat, a hostel or residential accommodation. This is, of course, not an exhaustive list.

For the purposes of allocating responsibility for meeting eligible needs a person cannot be ordinarily resident in more than one place, so if an individual splits their time between two properties it would be necessary to look at all the facts to determine which one of those there is a stronger link to. Elements such as time spent at each address, GP registration, inclusion on the electoral register and looking at the extent of the individual's community ties in each area can assist in determining this.

The requirement of an element of physical presence means that a person cannot be ordinarily resident in a place where he does not yet live but which he intends to occupy at some stage in the future. Equally, simple ownership of property that is not occupied by that person has no bearing on ordinary residence.

Settled purpose

The person must be at their abode for a "settled purpose as part of the regular order of his life for the time being, whether of short or long duration."

Whilst there is a mental aspect to this element, the finding of a settled purpose is not contingent on the individual concerned having the mental capacity to form such an intention. This is because it is possible to objectively determine whether or not there is a settled purpose by looking at all the facts.

7 Care and Support Statutory Guidance 19.14

8 R v. Barnet London Borough Council ex parte Nilish Shah & others [1982] 2 AC 309

9 An example given by Lord Slynn in the case of Mohamed v. LB Hammersmith & Fulham [2001] UKHL 57

However, where the individual does have mental capacity in this regard, their known intentions can make a settled purpose easier to identify.

It is important to apply the 'settled purpose' test without artificial limitations in terms of duration of stay, as it is clear that the settled purpose – in the context of establishing ordinary residence – can be "of short or long duration". It is simply a question of whether the settled purpose is part of the regular order of the individual's life "for the time being".

From this perspective, settled purpose can be established at the instant of an individual's move to a new area, if that move is with the intention of remaining there permanently or for the foreseeable future. That is because the person will have a settled purpose from the moment they arrive. Thus, the physical presence that is required to establish settled purpose does not have to be of any specific length of time.

Example scenario

In a recent Secretary of State determination[10] it was decided that X was ordinarily resident in area A, after seven days of sleeping at her daughter's house in area A. X had moved out of a residential home in area B, where she had expressed a wish to move to area A to be nearer her family. Her settled purpose at her daughter's was to live in area A long-term, even though the address where she was staying was temporary.

The finding that there was a settled purpose in this case was due to the long-expressed and clearly articulated intention of X to move permanently to area A, coupled with the fact that she had unequivocally moved away from area B. The Secretary of State relied on the following excerpt from another ordinary residence case, Fox v. Stirk[11]: "Some assumption of permanence, some degree of continuity, some expectation of continuity, is a vital factor which turns simple occupation into residence."

If X had not known or been uncertain of where she intended to live, it would not have been possible to attribute a settled purpose to this otherwise temporary set-up and the outcome is likely to have been that she was of no settled residence.

In addition to physical presence, it is necessary that there is a sufficient degree of continuity to be described as settled, whether for a long or short duration. Examples given by the court in Shah[12] of valid reasons for a 'time-limited' choice of abode that could indicate a settled purpose are: education, business or professional, employment, health or family.

There is an important difference in approach where someone has made a clear decision to permanently move away from an area and the situation when someone is temporarily away from their place of residence when the need for support under the Care Act arises. If they are temporarily away, they will remain ordinarily resident in their own/originating area rather than acquiring ordinary residence in the area where they are staying. Therefore, an individual can be physically present in one area but not ordinarily resident there.

The approach to temporary presence in a particular place will vary depending on the individual circumstances. Temporary 'absence' from a place, for example a holiday or a stay in hospital, will not displace an individual's ordinary residence.[13] However, temporary 'presence' somewhere can – in limited situations, provided they have definitely moved away from another area – amount to ordinary residence.

10 OR determination 6 of 2016
11 Fox v. Stirk [1970] 2 QB 463
12 R v. Barnet London Borough Council ex parte Nilish Shah & others [1983] 2 AC 309
13 Fox v. Stirk [1970] 2 QB 463

The point to remember is that Shah established that the settled purpose could be of long or short duration, so the fact that an individual is only temporarily at an address is not a bar to them being ordinarily resident there.

If the purpose of the presence is not settled, the outcome will be that they are of no settled residence. In such a case, the duty to meet eligible needs would lie with the authority in whose area they are physically present.

It is of note that, prior to the Care Act, those of no settled residence had more restricted rights under the community care legislation and therefore a finding of no settled residence was undesirable and only ever concluded as a last resort. It remains to be seen whether this approach will relax with the greater rights conferred by the Care Act.

In practice, if there are live issues around the identification of a settled purpose, this will require a close examination of all the facts and often historical background. However, the likelihood will usually be that the greater the length of time that an individual has spent in a particular place, the easier it will be to demonstrate a settled purpose as a result of the increased level of continuity.

In summary then, an individual's intention is not required to establish a settled purpose, which can be determined from looking at all the circumstances. Whilst intention without physical presence will not result in ordinary residence, presence coupled with a clearly expressed intention will make it easier to demonstrate a settled purpose.

Voluntary adoption of the abode

This is the mental element of the test. The voluntary adoption or acceptance of a place of abode requires the individual to have the mental capacity to choose where to live. So if a person's abode has been enforced on them, for example as a result of a sentence of imprisonment, it has not been voluntarily adopted and the individual's presence there will not amount to ordinary residence.

On the other hand, the fact that an individual may not like where he is, or would prefer to be somewhere else, does not prevent that place from being where he is ordinarily resident for the time that he is there. "If a person, having no other accommodation takes his few belongings and moves to a barn for a period to work on a farm, that is where during that period he is normally resident, however much he might prefer some more permanent or better accommodation. In a sense it is 'shelter' but it is also where he resides."[14]

If an individual with capacity to make the decision goes along with the plans of others they will have voluntarily adopted the abode, even if it is the only place that was offered to the individual during the planning process.[15] However, if the place in question is one of a number of specified types of accommodation, the deeming provisions will apply. This is explored in more detail from page 10 below.

14 Mohamed v. LB Hammersmith & Fulham [2001] UKHL 57. Note this case was about 'normal' residence in a housing case, but the principle applies equally to the concept of 'ordinary residence.

15 Secretary of State determination 12 of 2015

Key point reminder!

The principle of informed choice by the individual, with the appropriate support and/or advocacy needed to ensure this, should be central to any decisions relating to the person's care and support arrangements. The starting assumption is that an individual is the expert in their own lives, and knows what they want to achieve with any health and social care support. Individuals should remain central to any planning processes and should be able to make informed choices about their preferred care and support arrangements, including location.

Establishing ordinary residence for people who lack capacity

As previously noted, a different approach must be used to establish ordinary residence under the Care Act for those individuals who do not have the mental capacity to voluntarily adopt a place of abode. The Cornwall case,[16] decided in 2015, changed the approach that had been used for some time. Whilst the case was decided on facts that pre-dated the Care Act 2014, the approach set out in the judgment applies equally to the current legislation.

It is important to note that all issues relating to mental capacity should be decided in line with the provisions of the Mental Capacity Act 2005. Under the legislation it must be assumed that adults have the capacity to make their own decisions – including in relation to their accommodation and care – unless it is established to the contrary. For the purposes of ordinary residence, the relevant decision is about where to live. Where a person is found to lack capacity for a specific decision, such as where to live, any decision must be made in the person's best interests – and involving the person as much as possible.

16 R (on the application of Cornwall Council) v. Secretary of State for Health & Somerset County Council [2015] UKSC 46

The Cornwall case

The Supreme Court in the Cornwall case clarified the application of what used to be known as the 'Vale approach', following on from the 1985 court case of the same name.[17] This 1985 case had been interpreted to advocate two alternative approaches, which will be referred to as 'Vale 1' and 'Vale 2'.

'Vale 1' was based on the following passage from the court judgment: "Where the subject is so mentally handicapped as to be totally dependent upon a parent or guardian, the concept of her having an independent ordinary residence of her own which she has adopted voluntarily and for which she has a settled purpose does not arise. She is in the same position as a small child. Her ordinary residence is that of her parents because it is her 'base'." This approach would only be appropriate in limited circumstances according to the ability of the individual to make their own choices and the extent to which they rely on their parents or carers. An example of a situation where it would not be appropriate is if there is no ongoing connection with the parents.

If 'Vale 1' was not suitable, the 'Vale 2' approach would be used, which involved simply using a modified version of the Shah test (set out above). That is: to look at all the circumstances to establish whether there is presence at an abode with a settled purpose, but without requiring the individual to have adopted the residence voluntarily.

In the Cornwall case, P was born in Wiltshire and placed by Wiltshire with foster parents in South Gloucestershire. P's parents subsequently moved to Cornwall and although P visited there, he had never actually lived there. The Secretary of State found that P was ordinarily resident in Cornwall because that was his 'base', as his parents lived there.

17 R. V. Waltham Forest LBC ex parte Vale (1985) The Times 25 February QBD

The High Court agreed. The Supreme Court, on the other hand, said that Cornwall could not have been his base because P had never resided there.

The Supreme Court observed (with hindsight) that it may have been unhelpful for the court in the Vale case to merge the Shah test with the idea of a 'base'. The Supreme Court analysed the use of the word 'base' in the original case that the court in Vale relied on[18] and confirmed that the idea of a 'base' was not intended to be separated from the need for physical residence of some kind. A base was somewhere from which an individual could come and go.

The Supreme Court went on to clarify that the two approaches in Vale were not separate legal tests: "Rather they were complementary, common-sense approaches to the application of the Shah test to a person unable to make decisions for herself; that is, to the single question whether her period of actual residence with her parents was sufficiently settled to amount to ordinary residence."[19]

The 'Cornwall' application of 'Vale' therefore requires there to have been some physical presence sufficiently settled to amount to residence at the 'base'. This means that where an individual's parent's move from area A to area B and the individual has never lived at B, it will not be his 'base'.

Going back to a general issue around determining ordinary residence for people who lack capacity, a common error in approach is to focus on whether there is a tenancy agreement or whether the individual had the capacity to sign one. This issue will not usually have any direct bearing on the question of where they are ordinarily resident. That is because the legality of any tenancy agreement cannot determine where someone is in fact residing at any particular time.

18 In re P (GE) (an infant) [1965] CH 568

19 R (on the application of Cornwall Council) v. Secretary of State for Health & Somerset County Council [2015] UKSC 46 paragraph 47 of judgment

The deeming provisions

As noted above, in the case of Shah, the definition of ordinarily resident has been described as referring to someone's 'abode' which they have 'voluntarily adopted' for 'settled purposes'.

The deeming provisions in section 39 of the Care Act[20] ensure that a local authority cannot 'export' its responsibilities under the Care Act by placing an individual in a different geographical area. That might happen where an individual chooses to go to a different area to be near family[21] or because there are no suitable local placements available and they are placed out of area. In such cases the legislation deems financial responsibility for care and support services to remain with the 'placing' local authority if a person has been placed out of area.

The deeming provisions require that certain types of accommodation (known as 'specified accommodation') be excluded from consideration when working out where someone is ordinarily resident. What that means in practical terms is that a person is 'deemed' or presumed to continue to be ordinarily resident in the area he was ordinarily resident in immediately prior to commencing living at the accommodation in question. Thus the responsibilities for that person remain with the 'placing' or originating local authority. This only applies in certain types of accommodation as set out in the regulations.[22]

These are:

- care home accommodation
- shared lives scheme accommodation
- supported living accommodation.

20 Care Act 2014 Section 39(1)

21 Care and Support and Aftercare (Choice of Accommodation) Regulations 2014

22 The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014

In simple terms then, if local authority A places an individual in a care home, shared lives scheme accommodation or supported living accommodation in local authority B, the responsibility for meeting eligible Care Act needs remains with local authority A – even though on a strict application of the Shah test, local authority B would be responsible. In this example, the individual is living in area B but is ordinarily resident in area A.

See appendix A for more detailed descriptions of the three types of specified accommodation detailed above.

What's new? Changes as a result of the Care Act

The deeming provisions are not new in concept but they were extended by the Care Act from residential accommodation (now called care home accommodation) to include shared lives schemes and supported living.

In relation to the two new types of accommodation (shared lives and supported living accommodation), the deeming provision will only apply for individuals who move into that type of accommodation after 31 March 2015.[23]

Example scenario

Mark lives with his parents at an address in the area of local authority A. He is ordinarily resident in area A. Mark's parents reach a point where they feel they can no longer provide the care and support that he needs in their own home. Local authority A assess Mark as having eligible care and support needs and, after consulting with him and his family, assess him as requiring supported accommodation. Local authority A places him into a supported accommodation scheme which provides extra care housing in area B, which all are agreed will best meet Marks's needs and is not too far from his parents.

The deeming provision means that although Mark is living in supported accommodation in area B, he is funded by local authority A and remains ordinarily resident in area A even though he is physically present in area B.

If Mark had moved to his new address in area B any time before 1 April 2015, the new deeming provision (which includes supported living accommodation) would not apply and he would have become ordinarily resident in area B at the time of moving.

Restrictions on the operation of the deeming provisions

The deeming provision for specified accommodation in section 39 of the Care Act only applies "where the adult has needs for care and support which can be met only" if the individual is living in a specified type of accommodation.

This must be determined by assessment and a care planning process involving the individual and their family (where relevant), and would include them exercising a choice as to the location of their preferred accommodation pursuant to the Choice of Accommodation Regulations. The statutory guidance advises that where the outcome of the care planning process is a decision to meet needs in one of the specified types of accommodation, it should be assumed (in the absence of any information to the contrary), that needs can only be met in that type of accommodation.[24] So, if an individual arranges their own support as a self-funder in such a type of accommodation, then it follows that the deeming provision will not apply. The rules relating to self-funders are less likely to impact on those individuals who fall within the scope of the Transforming Care programme, although there may be some exceptions. See appendix B for more information on how the deeming provisions apply to self-funders.

23 Care Act (Transitional Provisions) Order 2015

24 Care and Support Statutory Guidance 19.51

The deeming provision applies to people whose needs are met by the local authority through the provision of a direct payment, provided that the accommodation is accordance with what is specified in the care plan. This will usually be in relation to supported living arrangements where the direct payment will cover the care and support required (but not the cost of the accommodation). Direct payments are not currently available for long-term residential accommodation.

A local authority that fails to meet needs under the Care Act will not be allowed to rely on its failure to do so to avoid the responsibility that arises as a result of the deeming provision.[25] This is sometimes referred to as the 'Greenwich' rule from the name of the case which established this principle.

The deeming provision for NHS accommodation

The deeming provision in the Care Act also applies to exclude NHS accommodation, including hospital.[26] Therefore, as set out above, NHS accommodation should be excluded from consideration when working out where someone is ordinarily resident.

In addition to hospital, 'NHS accommodation' includes accommodation that is funded by the NHS, for example when an individual is in receipt of NHS continuing healthcare (CHC) funding within a care home setting. However despite the extension of the 'specified accommodation' deeming provision in the Care Act, the 'NHS accommodation' deeming provision does not apply to NHS-funded individuals within supported living or shared lives arrangements, as the accommodation in those situations would not usually be funded by the NHS. It only applies to NHS-funded individuals in care home settings and hospital.

In simple terms then, when a person is in NHS accommodation, they are treated as ordinarily resident in the area where they were living before they went into hospital or an NHS-funded care home placement for the purposes of Care Act needs and responsibilities.

Where an individual's accommodation is joint-funded by health and social care, the deeming provisions will apply, as set out above, as the social care part of the package is provided under the Care Act.

Hospital accommodation

Hospital accommodation has been included in the deeming provisions since 1990.[27] A person would never be ordinarily resident for the purpose of the Care Act within a hospital setting. In these instances, hospital provision is for a period of time for assessment and/or treatment, and the person remains ordinarily resident in the area in which they were ordinarily resident immediately before being admitted to hospital. This applies even if they move to a hospital in a different area and even if the stay in hospital is a lengthy one.

Non-hospital NHS accommodation

The deeming provision relating to non-hospital NHS accommodation is more recent and does not apply to anyone who was already in such accommodation prior to 19 April 2010.[28] In such a case, where the deeming provision does not apply, the starting point for consideration of ordinary residence is a presumption that the individual remains ordinarily resident where they were immediately before entering such accommodation, but this presumption can be displaced by looking at all the circumstances if it is appropriate to do so.

25 R (Greenwich LBC) v. Secretary of State for Health [2006] EWHC 2576

26 Care Act 2014 section 39(5)

27 NHS and Community Care Act 1990 amendment to National Assistance Act 1948

28 Care Act (Transitional Provisions) Order 2015 Regulation 6(2)(a)

Circumstances which might go to displace the starting presumption would include: a move to a particular area that occurred at the request of the individual concerned, clear community ties to the new area and a lack of community connections in the original area.

Section 117 accommodation

The final deeming provision in the Care Act relates to someone who is provided with accommodation as part of aftercare services under section 117 of the Mental Health Act. For the purposes of determining local authority responsibilities to meet needs under the Care Act, such a person is deemed to be ordinarily resident in the area of the local authority which has the duty to provide aftercare.[29] The reason for this deeming provision is to provide continuity of care by ensuring that the local authority meeting the aftercare needs will also meet any eligible needs which are not covered by the aftercare.

None of the deeming provisions within the Care Act apply to determining which local authority is responsible for providing aftercare under the Mental Health Act, which works differently. See section two ('leaving hospital') for more on section 117 of the Mental Health Act.

29 Care Act 2014 Section 39(4)

Section two: leaving hospital

Section one of this guide has looked at local authority responsibilities relating to ordinary residence under the Care Act.

This second section covers local authority responsibilities specifically relating to the discharge of individuals from hospital, both under the Care Act but also under the Mental Health Act in cases where section 117 aftercare arrangements apply. In relation to determining responsibilities under the Mental Health Act, the deeming provision set out in the Care Act does not apply.

Different rules apply to determine local authority responsibility depending on which statutory scheme applies (ie the Care Act or the Mental Health Act/section 117); this can cause confusion. Therefore it is important for practitioners to be clear about which statutory regime applies in any given situation.

Regardless of which statutory scheme applies, the underlying policy position in relation to hospital discharges and delays is that no one should remain in hospital longer than necessary. This is a key priority for the Transforming Care Programme, with the national service model setting out that "services should seek to minimise patients' length of stay… [and] outcomes should include recovery and return to the community at the earliest opportunity."[30]

Hospital discharges (not involving section 117 aftercare)

Acute hospitals

Where it is not likely to be safe to discharge an individual unless arrangements for meeting their care and support needs are in place, the NHS body must notify the local authority in whose area the patient is ordinarily resident of this. This will trigger a duty on the local authority to assess the individual for care and support needs, which if not carried out within a specified period carries a discretionary financial penalty.[31] Because of the deeming provision under the Care Act excluding any period of time spent in hospital, this will be the local authority in whose area the patient was ordinarily resident on admission to hospital, even if the individual's care and support arrangement/ accommodation is no longer available.

In simple terms then, if an individual is ordinarily resident in area A, and then admitted to a hospital, on discharge from hospital the local authority in area A has the duty to assess for and meet eligible care and support needs under the Care Act. Remember: someone can be ordinarily resident (for the purposes of the Care Act) in one area, but physically living somewhere else. For example, an individual could be placed by the local authority in area A into a supported living service in area B. Because of the deeming provisions, the person would still remain ordinarily resident in area A. Thus, in the scenario outlined, following discharge from hospital, area A would still remain responsible under the Care Act.

30 Supporting People with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition: www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

31 Care Act 2014 Section 74 and Schedule 3 and Care and Support (Discharge of Hospital Patients) Regulations 2014

Where the local authority disputes that the notice should have gone to them, they may notify the NHS body, who may reissue the notice. However if the NHS body does not agree to withdraw and reissue the notice, the local authority originally receiving the notice must proceed to assess and meet the needs until the dispute is resolved. Where there is disagreement as to which authority is responsible, it is crucial that the care planning process goes ahead and the individual's needs are met on a 'without prejudice' basis until any dispute is resolved.

Where the individual is of no settled residence, the notice should go to the local authority in whose area the hospital is situated. That will also be the authority responsible for meeting the individual's needs on discharge.

Continuing healthcare (CHC)

Where an individual is being discharged from hospital, potential eligibility for NHS continuing healthcare (CHC)[32] must always be considered, as this is a prerequisite to serving an assessment notice on any local authority. If there may be a need for CHC, a checklist must be completed. A checklist is the only screening tool that may be used. A positive checklist will trigger an entitlement to a full CHC assessment and this should usually take place outside an acute setting. If there is a positive checklist and the assessment is going to take place outside the hospital setting, the individual is entitled to NHS funding whilst waiting for a full assessment for CHC eligibility.[33]

If the individual is then discharged from hospital to a residential setting with NHS funding (awaiting their full CHC assessment) and it is later determined that the individual is not eligible for CHC, any eligible social care needs must be met by the local authority.

The local authority which would attend the multi-disciplinary CHC assessment and meet ongoing needs in the event of a not-eligible outcome would be the local authority where the individual was ordinarily resident at the point of admission to hospital, as set out above.

Section 117 aftercare (Mental Health Act)

As noted above, different rules apply for determining which local authority is responsible depending on whether a person's care and support is being provided under the Care Act or under the Mental Health Act. This will now be looked at in more detail.

Section 117 of the Mental Health Act imposes a joint duty on clinical commissioning groups (CCGs) (or local health boards in Wales) and local authorities to provide or arrange for the provision of aftercare services for individuals who have been detained under certain sections of the Mental Health Act that deal with compulsory treatment, and who then cease to be detained and subsequently leave hospital. The Act does not provide guidance on the apportionment of responsibility across health and social care partners, but local partner organisations are expected to have local policies in place clarifying respective section 117 responsibilities.[34]

The relevant sections where section 117 aftercare would apply are sections 3 (compulsory admission for treatment), 37 (court order for hospital admission or guardianship), 45a (higher court order for hospital admission), 47 (removal to hospital of person serving sentence of imprisonment) and 48 (removal to hospital of other prisoners in urgent need).

32 NHS continuing healthcare is a package of care provided by the NHS that meets assessed health and social care needs. It is not charged for and is available to those who have been assessed as having a primary health need.

33 National Framework for NHS continuing healthcare and NHS funded nursing Care (2012) DH paragraph 74

34 Circulars HSC 2000/003 and LAC (2000)3

This applies when the person is discharged onto a community treatment order, is a restricted patient on a conditional discharge and if the person remains in hospital for a period of time on a voluntary basis having been discharged from the above outlined sections.

'Aftercare services' covers both health and care and support needs and are defined[35] as having a dual purpose, namely to meet a need arising from or related to the person's mental disorder and to reduce the risk of a deterioration of the person's mental condition (and accordingly re-admission to hospital for treatment of that mental disorder).

The duty to provide aftercare services continues until the responsible aftercare organisations are satisfied that the person no longer needs any aftercare services for their mental disorder.

Determining the local authority responsible for aftercare provision under section 117 of the Mental Health Act 1985

The section 117 duty falls on the local authority where the patient was ordinarily resident immediately before being detained. As has already been stated, the deeming provisions within the Care Act do not apply to aftercare responsibility under the Mental Health Act, so the approach to be taken is simply to follow the three-stage Shah approach to identify where someone is ordinarily resident, modified where necessary for people who don't have the capacity to choose where they live, and taking into account all of the circumstances leading up to the compulsory detention.

It does not matter who is paying for care and support at the time of detention or which local authority employed any approved mental health professional (AMHP) who might have been involved in the detention.

Example scenario

Mary is living in a care home in area A funded by local authority A when she is detained under section 3 of the Mental Health Act. Discharge planning identifies a suitable care home in area B and Mary is discharged to that address. Aftercare provision is the responsibility of local authority A because that is where Mary was ordinarily resident at the point of detention.

After discharge, Mary remains at the care home in area B but three months later relapses and is admitted to hospital again under section 3. On discharge from this section 3, the responsibility to provide aftercare will now be on local authority B, because that is where Mary was ordinarily resident immediately before her second section 3 admission to hospital. Mary is no longer the responsibility of local authority A because the deeming provisions from the Care Act do not apply to responsibility for section 117 aftercare.

The responsibility for aftercare will be with B, where Mary was ordinarily resident at the point of detention, whether Mary is discharged to area A or B or a different area entirely.

If it cannot be established where the individual was ordinarily resident at the time of compulsory detention, it will be the local authority where that person is 'resident'.[36] It is unclear whether a different approach (i.e. use of the word 'resident' as opposed to ordinarily resident) is intended with this alternative wording.

35 Mental Health Act 1983 section 117 (6) (as amended by Care Act 2014 section 75)

36 Mental Health Act 1983 section 117(3) as amended by the Care Act (section 75)

The courts have expressed different views over the years, without coming to any clear conclusions as to whether adding an adjective (such as 'ordinary, 'usual', 'habitual' or 'normal') to the word 'residence' changes its meaning at all.

It is suggested that unless there are clear and cogent reasons to take a different approach, no difference in meaning should be inferred between 'resident' and 'ordinarily resident' in this context.

If residence (ordinary or otherwise) cannot be established, the outcome of the enquiry will be that the individual is of no settled residence. In such a case the duty to provide aftercare services will fall on the local authority to which a person is sent on discharge.

Where someone goes into hospital on a voluntary basis, they do not lose their residence. However, if during the voluntary admission the individual loses their previous accommodation, they no longer continue to be resident in that area. In such a case, if their presence in hospital is sufficiently settled they may acquire residence in hospital. If, having become resident as a voluntary patient in hospital, they are subsequently detained (for example) under section three, that will result in the authority responsible (for section 117 aftercare) being that where the hospital is situated,[37] as that is where they will be resident.

If the presence in hospital is not sufficiently settled (in accordance with the 'settled purpose' part of the test in Shah, discussed on page 6 above) to amount to residence they will be of no settled residence and the local authority responsible for aftercare will be of the area to which the individual is sent on discharge.

Example scenario

Nicola has been placed by local authority A (where she previously lived with her parents) in a supported living home under a tenancy agreement located in area B. Nicola is admitted to a hospital in area C on a voluntary/informal basis in relation to deteriorating mental health needs.

Whilst Nicola is in hospital, notice is served on the tenancy agreement and that address is therefore no longer available. Some time later Nicola is formally detained in hospital under section 3 of the Mental Health Act for treatment. She remains in hospital for several months before being ready for discharge. Discharge planning identifies a care home in area D that will best meet Nicola's needs.

The question arises as to which local authority is responsible for the section 117 aftercare. As the deeming provisions do not apply in cases relating to section 117 aftercare, local authority A is not responsible. As the supported living arrangement in area B was no longer available to Nicola at the time of her detention, she was not resident or ordinarily resident in area B. She has either become resident in hospital (in which case the duty to meet her aftercare needs will be the responsibility of local authority C) or is of no settled residence (in which case the duty to meet her aftercare needs will be the responsibility of local authority D).

Which one of those it is will depend on a close look at all the circumstances to determine whether there is a sufficiently settled intention to amount to residence in the hospital. Looking at the scenario in simple terms, the longer a person is in hospital before being compulsorily detained, the more likely it is that a settled intention will be inferred. So, if a person has been in hospital voluntarily for six months prior to compulsory detention, it is more likely that they will be resident there than if they were there for a week prior to compulsory detention.

37 This was the outcome in the case of R (Sunderland CC) v South Tyneside Council [2012] EWCA Civ 1232

Where a person has been in hospital voluntarily immediately prior to being detained, a detailed analysis of all the circumstances will be required to determine where, if anywhere, a person was resident at the point of detention. In such a case it will be sensible to seek early legal advice to enable the dispute to be quickly resolved.

Where any dispute arises over aftercare responsibility, one authority would have to take responsibility for care planning and provision on a 'without prejudice' basis, and if no services are currently being provided that will be the authority where the person is physically present. If there is disagreement as to aftercare responsibility this is likely to become apparent at the discharge planning stage, when the individual is still in hospital. Therefore it is possible that the local authority in whose area the hospital is situated will need to accept provisional responsibility, even if there are no other connections to that area.

Needs that are not part of the section 117 aftercare plan

Key point reminder!

Section 117 aftercare concerns needs arising from or relating to the person's mental disorder and hospital admission.

It is therefore important to recognise that an individual may have care and/or health needs that fall outside the scope of the section 117 aftercare plan. For example, this may relate to a physical disability or illness that has no direct bearing on the person's mental health.

It can therefore be the case that an individual may be section 117 eligible, as well as having additional care and support needs (that fall outside the section 117 plan) that will be met under the Care Act, subject to eligibility criteria being met.

In relation to any additional care and support needs that an individual may have (which are not part of their section 117 aftercare plan), section 39(4) of the Care Act provides that where an individual is being provided with accommodation under section 117 they are treated as being ordinarily resident, for the purposes of the Care Act, in the area of the local authority which has the duty to provide aftercare. So, the same local authority will be responsible.

If this deeming provision did not exist, it could result in different authorities meeting different kinds of needs, which could cause complexities in the delivery and monitoring of the individual's care and support package. If the person is not being provided with accommodation as part of their section 117 aftercare, the usual rules under the Care Act apply.

If there are additional health needs, the individual in receipt of aftercare may also have need for NHS funding for those health needs not related to their mental health.

Key point reminder!

For the purpose of the Care Act you can never acquire ordinary residence in hospital because of the deeming provision that excludes consideration of time spent in hospital.

As there is no equivalent deeming provision in the Mental Health Act, individuals can become resident in hospital for the purpose of determining aftercare responsibility, although this should happen only rarely.

Section three: miscellaneous provisions

Transitions from children's to adult social care – a new deeming provision?

On page 9, we considered the Cornwall case in the context of the issue of mental capacity and how it affects the evaluation of ordinary residence. The case was also relevant in setting out a new approach which applies an implied deeming provision to cases which involve a transition from children's to adult social care.

The previous interpretation of the law in such cases was where a child was placed out of area and then required assistance under the adult legislation, there was a presumption that the child remained ordinarily resident in the 'originating' local authority's area. That presumption could be rebutted by looking at all the circumstances of the case and in particular by strong community ties in the new area. However, the Supreme Court in the Cornwall case declared that "an authority should not be able to export its responsibility for providing the necessary accommodation by exporting the person who is in need of it"[38] and applied the deeming provision in the Children Act to the adult legislation, so that the original placing authority under the Children Act 1989 remained responsible. This extension of the deeming provision will apply to transitions that occur before and after the Care Act.

Other provisions of interest

People of no settled residence

What's new? Changes as a result of the Care Act

Changes to the law in the Care Act mean that, where previously there was only a power to accommodate people of no settled residence, now under section 18 there is a duty to meet an individual's eligible needs where they are present in the area even if they have no settled residence.

This means the individual has the same entitlement under the Care Act whether ordinarily resident or of no settled residence.

The courts' approach in the past was that it was undesirable for a finding of no settled residence and it should only be done as a last resort. This was because of the restricted rights enjoyed by those of no settled residence. However, the finding of no settled residence no longer results in limited rights, so it may be that this outcome becomes more common.

Prisoners

The local authority responsible for meeting the current needs of prisoners under the Care Act is the one in which the prison is situated.[39] For people leaving prison, the starting point is a presumption that they remain ordinarily resident in the area in which they were ordinarily resident before the start of their sentence,[40] but as always this presumption can be rebutted – for example by the wishes of the individual to move elsewhere or restrictions imposed on where they may live.

38 R (on the application of Cornwall Council) v. Secretary of State for Health & Somerset County Council [2015] UKSC 46 paragraph 54

39 Care Act 2014 section 74

40 Care and Support Statutory Guidance paragraph 17.48

Urgent need
The Care Act includes a power to provide for those in urgent need who are ordinarily resident in another area.[41] Annex H of the statutory guidance provides guidance and scenarios where this might arise.

Safeguarding enquiry
The new safeguarding enquiry duty on the local authority in section 42 of the Care Act arises in relation to adults in its area who may be experiencing or at risk of abuse or neglect, regardless of whether or not they are ordinarily resident there.

Deprivation of Liberty Safeguards
In relation to individuals without capacity, where a deprivation of liberty is likely to occur, the managing authority of the care home or hospital must request a standard authorisation for the deprivation of liberty from a supervisory body, namely a local authority. The supervisory body will be the local authority in whose area the individual is ordinarily resident, even if the person has been placed by the local authority or the CCG in a care home in a different area.

Where the individual is self-funding and has acquired ordinary residence in the area where the care home is situated, that authority will be the supervisory body.

Example scenario

Josephine is a self-funder who was living in area A is in hospital and will be moving to a different area (area B) on discharge. The authorisation will be sought from the authority where Josephine was ordinarily resident before admission to hospital (area A) – even though after discharge she will become ordinarily resident in area B. After Josephine has been discharged, the supervisory body responsibility will transfer to authority B, so any reviews should be undertaken by authority B.

If someone from area A is placed in a care home in area B as part of a CHC package, the deeming provision in section 39(5) will apply and local authority A is responsible for the authorisation, as they remain ordinarily resident in area A.

Where the individual is of no settled residence at the time of the authorisation, the local authority in whose area the care home or hospital is situated will be the supervisory body.

Annex H of the statutory guidance, in particular paragraphs 51 to 63, give additional guidance as to the approach to be taken.

Disputes relating to the supervisory body will be determined by the Secretary of State under the Mental Capacity Act.

41 Care Act 2014 Section 19(3)

Section four: disputes

Any dispute about where an adult is ordinarily resident for the purposes of part one of the Care Act, if it cannot be resolved locally, is to be determined by the Secretary of State or their appointed representative.

What's new? Changes as a result of the Care Act

The Secretary of State will also now determine disputes between local authorities about the authority responsible for aftercare under section 117 of the Mental Health Act 1983.

Prior to the Care Act there was no provision for this and any such disputes had to be decided by the courts.

It is vital that whenever a dispute arises over where an individual is ordinarily resident, local authorities do everything they can to resolve the matter internally and without delay. A referral to the Secretary of State should only be made if efforts to resolve the matter locally have been unsuccessful and should be made within four months of the dispute arising. It is a serious step which should not be taken without seeking legal advice. Appendix C sets out the steps that need to be taken if a formal referral is made.

Practitioners are advised that early identification of any potential dispute is key. It is vital that all parties to the potential dispute engage in a meaningful and ongoing dialogue that genuinely attempts to identify and quickly resolve the real issues between the authorities involved.

It is also of fundamental importance that one authority accepts provisional responsibility wherever there is a dispute, so that the assessment, care planning and implementation stages are not delayed. The individual should remain at the centre of the process and not experience any delays in the provision of care.

Appendix A

The deeming provisions – 'specified accommodation'

Further detail on the definition of each of the three different types of specified accommodation follows.

Care home accommodation

'Care home' means an establishment that provides accommodation, together with nursing or personal care,[42] which must of course be registered as such. It includes registered nursing homes. The old deeming provision within the National Assistance Act 1948 covered this type of accommodation.

Supported living accommodation

Whether an arrangement amounts to supported living for the purpose of the deeming provisions may be more difficult to identify in some cases. The regulations[43] and statutory guidance define supported accommodation in two alternative ways.

Firstly, "accommodation in premises which are specifically designed or adapted for occupation by adults with needs for care and support to enable them to live as independently as possible." The statutory guidance explains that means that the premises includes features which have been built in or changed in order to meet the needs of adults with care and support needs. This includes safety systems and features which enable accessibility and navigation around the accommodation and minimise the risk of harm, as appropriate to the individual.

The second type of supported accommodation that comes within the deeming provisions is accommodation which is provided in "premises which are intended for occupation by adults with needs for care and support...in circumstances in which personal care is available if required." In such a case the accommodation does not need to be specifically designed or adapted for such a purpose and the personal care provider does not need to be the same as the accommodation provider. Personal care is defined as physical assistance or prompting and supervision in connection with eating, drinking, toileting, washing or bathing, dressing, oral care or skin, hair and nail care.[44]

This wide definition is in line with current policy[45] about supported living and is not limited to formally recognised supported living schemes or de-registered care homes that have commenced operating as supported living arrangements, provided that it is established that the premises are 'intended for occupation' by adults with care and support needs. At the time of writing there are no published determinations where the outcome depends on the definition of supported living accommodation and it remains to be seen how this will be interpreted in practice. All determinations prior to the Care Act relate to situations where it was agreed by the parties to the dispute that the arrangements amounted to supported living.

42 The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014 Regulation 3 and the Care Standards Act 2000 Section 3

43 The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014 Regulation 4

44 The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014 Regulation 1(2)

45 See for example CQC guidance on regulated activities for providers of supported living and extra care housing, October 2015: "By supported living we mean schemes that provide personal care to people as part of the support that they need to live in their own homes. The personal care is provided under separate contractual arrangements to those for the person's housing. The accommodation is often shared, but can be single household."

It should be noted that the right to make a choice about preferred accommodation now also applies to supported living, which has a wide definition, and shared lives. Therefore an individual exercising these choices will result in a local authority retaining responsibility for meeting an individual's eligible needs in a broad range of situations.

Shared lives accommodation

This is accommodation which is provided together with care and support for an adult by a shared lives carer, approved by the scheme in the carer's home under the terms of an agreement between the carer, the adult and any local authority responsible for making the arrangement. The shared lives carer will normally be providing personal care but does not need to do so. Shared lives schemes are run by the local authority so it will be easy to identify if a particular arrangement amounts to shared lives accommodation.

Appendix B

Self-funders and owners of property

How does the deeming provision affect 'self-funders'?

This term 'self-funder' refers to an individual who is arranging and funding their own care. Usually this is because they are above the financial limit to qualify for assistance under the Care Act. Sometimes people choose, for their own reasons, to opt out of the system and make their own arrangements for care and support.

If a person arranges their own care and support and enters into a contract with the home in a new area, they will acquire ordinary residence in the new area. If their situation changes (most usually their financial situation), they should approach the area in which the care home is situated. This applies regardless of how close to the financial threshold they were when they moved.

If an individual would be self-funding on the basis of their financial circumstances but is unable to enter into a contract with the provider, the local authority must meet their needs and claim full reimbursement from the individual. This might happen if the individual does not have the mental capacity to contract with the provider and there is no one else who is able to do so on their behalf. In such circumstances the local authority is acting under part one of the Care Act and the deeming provision will apply if the accommodation is of a specified type.

Where the local authority is exercising a broader power or duty, for example the provision of information, advice and guidance, it will not be making arrangements and will not retain responsibility. This would apply even if practical assistance is given, provided it falls short of contracting with the provider.

12-week disregard

As a general rule (with some exceptions), the value of an individual's property will be taken into account in determining an individual's financial eligibility for assistance under the Care Act. The 12-week disregard is a mechanism that allows the value of a person's former residence to be temporarily ignored in calculating their available resources and therefore entitlement to assistance under the Care Act. Its purpose is to give the individual some time to decide how to proceed (sell, rent or deferred payments are the usual options). It is generally only available when an individual first enters a care home as a permanent resident or when another disregard becomes unavailable (for example a qualifying relative is no longer in the property).

During the disregard period, the authority in which the individual was ordinarily resident at the point of entitlement to the disregard will be the responsible authority. At the end of the 12 weeks the full value of the home is taken into account and the individual may become ordinarily resident in the new area if they are a self-funder who is contracting directly with the home or someone is doing so on their behalf. This is in line with the settled purpose test in Shah.

During the 12 weeks the relevant local authority is required to offer deferred payments if appropriate.

Deferred payment agreements

Where an individual owns property which they do not want to sell immediately, they may enter into an agreement with the local authority whereby the local authority pays for the care and support which is repaid at a later date and a charge is put on the individual's property to secure the debt. The local authority where the individual is ordinarily resident is responsible for offering and arranging the deferred payment agreement. Their responsibility will continue until the agreement is concluded, even if the individual moves to a different area during that time, as the deeming provision applies.

Example scenario

Thomas is ordinarily resident in the area of local authority A and chooses to have his needs met in a care home within the area of local authority B. Thomas owns his own property and the 12-week disregard applies; local authority A is responsible for meeting the needs during the 12 weeks that the property value is disregarded.

A deferred payment should be offered by local authority A during the 12-week disregard period. If Thomas accepts a deferred payment agreement then he will remain ordinarily resident in A whilst the agreement is in force because local authority A is contracting with the home. If Thomas declines the deferred payment scheme and contracts with the home himself, he will become ordinarily resident in local authority B.

Appendix C

Overview of the ordinary residence dispute regulations

The lead authority

Local authorities involved in a dispute about an individual's ordinary residence must not allow the existence of the dispute to prevent, delay, interrupt or otherwise adversely affect the meeting of the needs of the adult or carer to whom the dispute relates.

One authority must take responsibility for meeting the needs and must continue to do so until the dispute is resolved – that authority is called the 'lead authority' (which will have certain responsibilities if the case is referred to the Secretary of State).

The lead authority is determined at the date the dispute arises and will be the local authority:

- which is meeting the needs
- or in whose area the adult is living
- or in whose area the adult is present.

Steps to be taken prior to a dispute

As soon as possible after the dispute arises, the lead authority must:

- identify all the other authorities who may be concerned in the dispute and co-ordinate their discussions to try to resolve the dispute
- co-ordinate the attempts to resolve the dispute
- obtain and share all relevant information
- inform the adult about any progress in resolving the dispute
- refer the dispute to the Secretary of State if it cannot be resolved by them within four months of the dispute arising.

Each local authority must:

- nominate and provide the contact details of an individual who will be the point of contact
- take all reasonable steps to cooperate to try to resolve the dispute between themselves
- engage in constructive dialogue to ensure a speedy resolution
- comply without delay with reasonable requests for relevant information
- keep each other informed of any relevant developments.

Referring a dispute to the Secretary of State

The lead authority is responsible for providing:

- copies of all correspondence relating to the dispute
- statement of facts signed on behalf of each authority involved which includes the following information:
  - explanation of the nature of the dispute
  - chronology of events leading up to the referral (including the date on which the dispute arose)
  - details of the needs of the adult to whom the dispute relates
  - which authority has met the needs and how they have been met including under what statutory provision
  - details of the adult's current place of residence and any relevant former places of residence
  - where the issue of capacity is relevant:
    - statement that authorities agree the adult has or lacks capacity
    - any information relevant to the issue off capacity
  - any other steps (in relation to the adult) taken by the local authorities which may be relevant
  - what steps the local authorities have taken to resolve the dispute
  - any other relevant information.

Any legal arguments to be relied on must be submitted within 14 days of the date of referral.

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