

The Law Commission
Consultation Paper No 192

ADULT SOCIAL CARE

A Consultation Paper

THE LAW COMMISSION – HOW WE CONSULT

About the Law Commission: The Law Commission was set up by section 1 of the Law Commissions Act 1965 for the purpose of promoting the reform of the law.

The Law Commissioners are: The Rt Hon Lord Justice Munby (*Chairman*), Professor Elizabeth Cooke, Mr David Hertzell, Professor Jeremy Horder and Frances Patterson QC.

The Chief Executive is Mr Mark Ormerod CB.

Topic of this consultation: This consultation paper reviews the law relating to adult social care in England and Wales and makes recommendations for its reform.

Scope of this consultation: The purpose of this consultation is to generate responses to our provisional proposals and questions with a view to making recommendations for reform.

Geographical scope: The contents of this consultation paper refer to the law of England and Wales.

Impact assessment: The core impact assessment analysis for our proposed reforms is provided in Appendix A. The draft full impact assessment will be available on http://www.lawcom.gov.uk/adult_social_care.htm.

Previous engagement

- On 26 November 2008 we published a scoping report setting out the scope of the project. It was published for information purposes only and no responses from interested parties were sought.
- We have met with Department of Health and Welsh Assembly Government officials and a number of stakeholders and other experts in the field of adult social care.

Duration of the consultation: We invite responses before 1 July 2010.

How to respond

Please send your responses either –

By email to: adultsocialcare@lawcommission.gsi.gov.uk OR

By post to: Amanda Walker, Law Commission, Steel House, 11 Tothill Street, London SW1H 9LJ
Tel: 020-3334-0264 / Fax: 020-3334-0201

If you send your comments by post, it would be helpful if, whenever possible, you could send them to us electronically as well (for example, on CD or by email to the above address, in any commonly used format).

After the consultation: We will review our proposals in the light of the responses to the consultation paper and will publish our final recommendations in 2011.

Code of Practice: We are a signatory to the Government's Code of Practice on Consultation and carry out our consultations in accordance with the Code criteria (set out on the next page).

Freedom of information: We will treat all responses as public documents in accordance with the Freedom of Information Act and we may attribute comments and include a list of all respondents' names in any final report we publish. If you wish to submit a confidential response, you should contact us before sending the response. PLEASE NOTE – We will disregard automatic confidentiality statements generated by an IT system.

Availability of this consultation paper: You can view/download it free of charge on our website at: <http://www.lawcom.gov.uk/docs/cp192.pdf>. The consultation paper is also available in Welsh and in large print format.

A summary of the consultation paper is also available on the website, as well as an outline of our proposed adult social care statute. These documents are available in Welsh, large print, easy read and audio formats. See http://www.lawcom.gov.uk/adult_social_care.htm.

CODE OF PRACTICE ON CONSULTATION

○ THE SEVEN CONSULTATION CRITERIA

Criterion 1: When to consult

Formal consultation should take place at a stage when there is scope to influence the policy outcome.

Criterion 2: Duration of consultation exercise

Consultations should normally last for at least 12 weeks with consideration given to longer timescales where feasible and sensible

Criterion 3: Clarity and scope of impact

Consultation documents should be clear about the consultation process, what is being proposed, the scope to influence and the expected costs and benefits of the proposals.

Criterion 4: Accessibility of consultation exercises

Consultation exercises should be designed to be accessible to, and clearly targeted at, those people the exercise is intended to reach.

Criterion 5: The burden of consultation

Keeping the burden of consultation to a minimum is essential if consultations are to be effective and if consultees' buy-in to the process is to be obtained.

Criterion 6: Responsiveness of consultation exercises

Consultation responses should be analysed carefully and clear feedback should be provided to participants following the consultation.

Criterion 7: Capacity to consult

Officials running consultations should seek guidance in how to run an effective consultation exercise and share what they have learned from the experience.

○ CONSULTATION CO-ORDINATOR

The Law Commission's Consultation Co-ordinator is Phil Hodgson.

- You are invited to send comments to the Consultation Co-ordinator about the extent to which the criteria have been observed and any ways of improving the consultation process.

- **Contact:** Phil Hodgson, Consultation Co-ordinator, Law Commission, Steel House, 11 Tothill Street, London SW1H 9LJ – Email: phil.hodgson@lawcommission.gsi.gov.uk

Full details of the Government's Code of Practice on Consultation are available on the BERR website at <http://www.berr.gov.uk/files/file47158.pdf>.

THE LAW COMMISSION
ADULT SOCIAL CARE: CONSULTATION PAPER
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TABLE OF ABBREVIATIONS

ABBREVIATIONS AND SUMMARY OF MAIN COMMUNITY CARE STATUTES

It is estimated that there are currently over 30 Acts of Parliament dealing, to varying degrees, with adult social care. A summary of the main community care statutes referred to in this consultation paper, and the abbreviations which we use to describe them, is provided below. A fuller discussion of the development of adult social care can be found in Part 2 of the adult social care scoping report.

NAA 1948

National Assistance Act 1948

Introduced by the post-war Labour Government, the NAA 1948 establishes a duty to provide residential accommodation and a general duty to provide community services to disabled people.

HSPHA 1968

Health Services and Public Health Act 1968

The HSPHA 1968 gives local authorities a discretionary power to provide services “promoting the welfare of older people”. This did not amend the earlier NAA 1948 but rather establishes a separate statutory power to provide services.

CSDPA 1970

Chronically Sick and Disabled Persons Act 1970

Originally a Private Member’s Bill, the CSDPA 1970 augments the general duty in the NAA 1948 to provide community services. It provides a strong duty to provide services to disabled people. The CSDPA 1970 did not amend the NAA 1948 but instead operates in parallel.

Mental Health Act 1983

Section 117 of the Mental Health Act 1983

Section 117 places a strong joint duty on health and social services to provide after-care services to certain former mental health patients.

DP(SCR)A 1986

Disabled Persons (Services, Consultation and Representation) Act 1986

Originally a Private Member’s Bill, the DP(SCR)A 1986 introduced a right for disabled people to request an assessment under the CSDPA 1970 and places a duty on local authorities to have regard to the needs of the carer when deciding which services to provide for a disabled person. It did not, however, amend the CSDPA 1970.

NHSCCA 1990	<p>National Health Service and Community Care Act 1990</p> <p><i>The NHSCCA 1990 introduced a right to an assessment for community care services and gives social services the responsibility for assessing need and arranging a package of care services. It did not consolidate any of the previous legislation.</i></p>
C(RS)A 1995	<p>Carers (Recognition and Services) Act 1995</p> <p><i>The C(RS)A 1995 places a duty on local authorities to carry out a carer's assessment where the cared-for person is being assessed under the NHSCCA 1990 or Children Act 1989.</i></p>
CDCA 2000	<p>Carers and Disabled Children Act 2000</p> <p><i>The CDCA 2000 gives carers a free-standing right to an assessment, independent of the assessment of the cared-for person and gives a power to provide services to carers. It operates in parallel to the C(RS)A 1995.</i></p>
CC(DD)A 2003	<p>Community Care (Delayed Discharges etc) Act 2003</p> <p><i>The CC(DD)A 2003 establishes the delayed discharge regime, which imposes time scales for assessments of NHS inpatients and fines if a delay in discharge is caused by social services.</i></p>
C(EO)A 2004	<p>Carers (Equal Opportunities) Act 2004</p> <p><i>The C(EO)A 2004 amended (but did not consolidate) both the C(RS)A 1995 and the CDCA 2000 by providing a number of new rights for carers.</i></p>
NHS Acts 2006	<p>NHS Act 2006 and the NHS (Wales) Act 2006</p> <p><i>The NHS Acts 2006 place a general duty on local authorities to provide community services for "the prevention of illness and for the care of persons suffering from illness and for the after-care of persons who have been so suffering".</i></p>

OTHER TERMS AND ABBREVIATIONS USED IN THE CONSULTATION PAPER

Choice of accommodation directions	The National Assistance Act 1948 (Choice of Accommodation) Directions 1992 (in England) and the National Assistance Act 1948 (Choice of Accommodation) Directions 1993 (in Wales).
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Directions and approvals	Directions can be issued by the Secretary of State or the Welsh Ministers in order to create further duties on local authorities. They can be issued under section 7A of the Local Authority and Social Services Act 1970 or under powers contained in other legislation. Legislation can also give the Secretary of State or the Welsh Ministers the power to issue approvals. These give local authorities a power but not a duty to do certain things.
Direct payments	Monetary payments made by local authorities directly to individuals who have been assessed as needing certain services, so that they can buy their own services directly.
ECHR	European Convention on Human Rights
FACS	The <i>Fair Access to Care Services</i> statutory guidance, which applies to local authorities in England (LAC(2002)13, <i>Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care</i>).
LAC	Local Authority Circular
LAC(93)10	Approvals and Directions for Arrangements from 1 April 1993 Made Under Schedule 8 to the National Health Service Act 1977 and Sections 21 and 29 of the National Assistance Act 1948
NAFWC	National Assembly for Wales Circular
NHS	National Health Service
Personal budget	A sum of money allocated to a service user by the local social services authority in order to meet their assessed eligible needs.
Practice guidance	Government guidance which is not issued under section 7(1) of the Local Authority and Social Services Act 1970 or any other enactment. It is weaker in status than statutory guidance.
Statutory guidance	Guidance issued by the Secretary of State and the Welsh Ministers under section 7(1) of the Local Authority and Social Services Act 1970. This guidance must be complied with unless there are good reasons for not doing so.
UFSAMC	The <i>Unified and Fair System for Assessing and Manage Care</i> statutory guidance, which applies to local authorities in Wales (NAFWC09A/2002, <i>Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care</i>).

PART 1

INTRODUCTION

- 1.1 At some time in our lives, most of us will need adult social care services, either for ourselves or for a friend or family member. In 2007 to 2008, an estimated 1.77 million people in England were supported by the provision of adult social care services from local authorities.¹ Many people also receive informal care and support from family and friends. These numbers are likely to continue to grow, with the Government predicting that in 20 years' time, over 1.7 million more people will have a need for care and support.² Given the importance of adult social care services, it is a matter for concern that the legal framework for its provision has been described as "exceptionally tortuous".³
- 1.2 This project provides an important opportunity to address this situation, by reviewing the existing legal framework and making recommendations for its reform. The provisional proposals contained in this consultation paper are an important first step towards the introduction of legislation that is clear, consistent and modern. This project also comes at a unique time in the development of adult social care, as the Government is currently reviewing the future funding and structure of the adult social care system and other areas of policy (discussed further below). Our goal in this consultation paper is to create an effective legal framework that can accommodate current and future policies, while also maintaining the core entitlements and obligations that have been established over the past 60 years.

WHAT IS ADULT SOCIAL CARE?

- 1.3 By *adult social care*, we mean the responsibilities of local social services authorities towards adults who need extra support. This includes older people, people with learning disabilities, physically disabled people, people with mental health problems and carers. Adult social care services include the provision of care homes, day centres, equipment and adaptations, meals and home care. It also includes the mechanisms for delivering these services, such as community care assessments, carers' assessments, personal budgets and direct payments, and adult protection procedures.

WHY THIS PROJECT?

- 1.4 As we noted in our Tenth Programme of Law Reform, the legislative framework for adult social care is "inadequate, often incomprehensible and outdated".⁴ To this day, it remains a confusing patchwork of conflicting statutes enacted over a period of 60 years. There is no single, modern statute to which local authorities, service providers and service users can look to understand whether services can

¹ Information Centre, *Community Care Statistics 2007-08: Referrals, Assessments and Packages of Care for Adults, England* (2009).

² HM Government, *The Case for Change: Why England Needs a New Care and Support System* (2008) p 24.

³ *R (F) v Wirral Borough Council* [2009] EWHC 1626 (Admin), (2009) 12 CCLR 452 at [8] by McCombe J.

⁴ Tenth Programme of Law Reform (2008) Law Com No 311, p 10.

or should be provided. Moreover, the proliferation of statutes, subordinate legislation and guidance in this area has led to inefficiency in the system, as much time is required to negotiate the complex and outdated law, and the end result is often uncertain and unclear. Difficult law may also have the effect of stifling innovation and the multiple layers of law can make it difficult to promote flexibility and new policy approaches in practice.

- 1.5 For these and other reasons, we identified adult social care law as in need of reform and made a commitment to undertake a project to review this area of law. The purpose of the proposals made in this consultation paper is to address these problems by establishing a simple, consistent, transparent and modern framework for adult social care law.

THE STRUCTURE OF THE ADULT SOCIAL CARE PROJECT

- 1.6 The scope of the project covers legislation for England and Wales, where adult social care is a devolved matter. However, the Welsh Assembly Government consider that the differences in policy and legislation in Wales are not currently significant enough to justify this being a project jointly sponsored by the Department of Health and the Welsh Assembly Government. However, if circumstances change during the course of the project then it may be necessary to review this arrangement. We have, in any event, sought to take full account of differences in both law and policy between England and Wales.
- 1.7 Given the ambitious size and scope of this project, the Law Commission's Tenth Programme of Law Reform recognised the need for a strong and on-going commitment throughout the project from the Government and the Law Commission. Accordingly, the project was split into three phases, providing break points for both the Law Commission and the Government to consider the desirability of continuing on to the next stage. The first stage was the publication of a scoping report on adult social care law to delineate clearly the scope of the project and to provide it with a detailed agenda for reform. The second stage is the substantive law reform project, consisting of publication of this consultation paper, undertaking a broad public consultation, analysing the responses, and publishing a final report. The third stage consists of production of a draft bill to implement the recommendations of our final report.

Pre-consultation meetings

- 1.8 We have met with the Department of Health, as the sponsoring department for this project, on an ongoing basis throughout the inquiry to ensure that we are aware of developing Government policy in adult social care. We have also met on a similar basis with Welsh Assembly Government officials in Cardiff. We have benefited greatly from a range of pre-consultation meetings with a number of stakeholders and other experts in the field of adult social care law.

POLITICS AND LAW REFORM

- 1.9 Fundamental to this project is the delineation of the respective roles of the Law Commission and Government. The Law Commission undertakes law reform. We have a statutory function to review the law with a view to its systematic development and reform. Political policy, on the other hand, is a matter for Government. It is Government that must make political judgements about the

setting of spending priorities and the making of value judgements about rights and responsibilities.

- 1.10 Drawing a clear distinction between law reform, on the one hand, and political policy on the other is not always easy. Political policy works through and influences law. The form of legal structures can enable or limit both the delivery of policy and its development. Some things are clearly law reform, others are clearly political policy. But where the two meet it can be difficult to disentangle them. Indeed, the nature of the distinction can vary from one law reform project to another. There are some factors which, of course, tend to distinguish the two. Paradigmatically, a decision involving the expenditure of substantial resources falls on the political side of the dividing line. The big decisions about how much of a welfare state we should have and how it should be funded are not decisions for us.
- 1.11 However, these are not bright-line distinctions. Any law reform will necessarily involve *some* expenditure, if only to implement it. In the context of adult social care, if we declined to make any proposals with resource implications, the utility of the project would be seriously compromised. We have sought to make our proposals broadly resource-neutral.⁵ But some proposals may have implications in terms of how any given level of resources are deployed within adult social care. On the other hand, not everything the Government has a view about is necessarily a matter of politics. Perfectly properly, the Government may take a view about whether certain rules should appear in legislation or in some other form; but we are entitled, by virtue of our expertise and our statutory functions, to take a different view.
- 1.12 In a specific context, these are difficult judgements to make and we might not have got them right. We are interested in your views on whether we have drawn the correct line in this consultation paper between areas for politics and areas appropriate for law reform.

POLICY DEVELOPMENTS IN ADULT SOCIAL CARE

- 1.13 Law reform must operate within the broader context of Government policy. The policy environment for adult social care is in a state of development, and we expect it to continue to develop over the lifetime of this project. In some areas, the direction of policy is set, but in others it has yet to be determined. There are also divergences in policy between England and Wales. The following provides a brief overview of some of the main policy developments.

Personalisation

- 1.14 There has been an emphasis in recent years on promoting greater choice and control for service users over the services and support that are provided. The Department of Health refers to this policy as “personalisation”.⁶ Examples of this policy include self-assessment, personal budgets, resource allocation systems and direct payments. The Department of Health argues that personalisation will

⁵ Our core impact assessment analysis is set out in Appendix A.

⁶ See, for example, HM Government and others, *Putting People First* (2007).

lead to “whole system change” and describes it as “transforming social care”.⁷

- 1.15 The Welsh Assembly Government has stated that it will introduce personalised community care services.⁸ However, personal budgets have not, as yet, been implemented in Wales and it remains to be seen to what extent the Welsh Assembly Government will pursue personalisation as a broad policy commitment, on a similar basis to England.

Prevention services

- 1.16 In recent years, Government policy has suggested the need for a retreat from the so-called *traditional model* of social care provision, whereby resources are concentrated on people with the highest levels of need, towards early intervention services to prevent the need for more intensive services. As part of this policy, the Government has proposed providing “re-ablement services” to people leaving hospital or who need care and support for the first time. Similar commitments have been made in Wales.⁹

National reviews of the care and support system in England and Wales

- 1.17 Alongside personalisation, there has been a wider debate about the future funding of adult social care. There is growing recognition that the existing care and support system has significant weaknesses and that it will not be able to cope with the future pressures of demographics and an ageing society, as well as rising expectations about what it should deliver. In 2008, the Department of Health and Welsh Assembly Government each published consultation documents considering these issues¹⁰ and in 2009 both published Green Papers.¹¹ The Green Paper in England, *Shaping the Future of Care Together*, proposes the establishment of a National Care Service, and puts forward different options for how the adult social care system could be funded in the future. The key features of this National Care Service include a focus on prevention services, information and advice, joined-up services and personalised care and support services.
- 1.18 The English and Welsh Green Papers also consider the balance between local and central decision-making in adult social care. While local discretion has been a key feature of the adult social care system, it has also given rise to complaints that care and support services should be the same, or at least comparable, across the country. In response, the Green Paper in England states that “the care and support system should be fair and universal” and must “make sure that everyone who needs care can get it, regardless of where they live”. In pursuance of these aims, it proposes the introduction of a national needs assessment that

⁷ LAC(DH)(2008)1, *Transforming Social Care*, para 22.

⁸ See, for example, Welsh Assembly Government, *A Strategy for Social Services in Wales Over the Next Decade: Fulfilled Lives, Supportive Communities* (2007).

⁹ *Shaping the Future of Care Together* (2009) Cm 7673 pp 50 to 51 and Welsh Assembly Government, *A Strategy for Social Services in Wales Over the Next Decade: Fulfilled Lives, Supportive Communities* (2007) pp 15 and 38.

¹⁰ See HM Government, *The Case for Change: Why England Needs a New Care and Support System* (2008) and Welsh Assembly Government, *Paying for Care in Wales: Creating a Fair and Sustainable System* (2008).

¹¹ See *Shaping the Future of Care Together* (2009) Cm 7673 and Welsh Assembly Government, *Paying for Care in Wales* (2009).

would be portable across all local authorities in England, and national eligibility criteria, whereby the Government, not local authorities, would set the level at which a person becomes eligible to receive services.¹² The Green Paper in Wales puts forward for debate the question whether there should be a nationally or locally determined funding system.

Reviews of Government guidance

- 1.19 The Department of Health and Welsh Assembly Government have undertaken to review several aspects of adult social care guidance, including the eligibility framework, policy for safeguarding adults from abuse and neglect, and the ordinary residence rules.

The relationship between adult social care policy and our project

- 1.20 Clearly, our final recommendations for law reform in this project will need to accommodate both existing and future policy developments and, in relation to England at least, this means taking into account personalisation. In places, this may require adjustments to the legal framework to enable some aspects of policy to develop. However, as a general rule, we believe it would be a mistake to bind our proposals to one particular philosophy or approach to adult social care. As our scoping report demonstrates, the history of adult social care law is littered with examples of statutes which have attempted to implement prevailing policies but which now look increasingly out of date.¹³
- 1.21 While our proposed statute must be capable of accommodating future developments, it is essential that it should also maintain the existing core entitlements and rights that are a crucial aspect of community care law. These are discussed in detail in our consultation paper but include the right to an assessment and the right to have eligible needs met. Although some of these entitlements may need to be clarified and adjusted to ensure that they can be maintained in the context of a single adult social care statute, it is an important aspect of our review to consider the existing legal framework and how this can be consolidated and reformed in a future statute.
- 1.22 Therefore, the approach that we have adopted in our proposals is to create, as far as possible, a neutral legal framework that is not wedded to any particular policy and is capable of accommodating different policies and practices in the future. Underpinning this framework are, we believe, the core entitlements and rights that are crucial to the existing community care legal framework.

THE STRUCTURE OF THIS CONSULTATION PAPER

- 1.23 This paper is divided into 14 Parts. Part 2 considers our approach to the reform of adult social care law, including the objectives of our reform, how the future legal framework should be structured and the general approach to determining the scope of adult social care.
- 1.24 Parts 3 to 10 are concerned with how social services authorities decide if an individual should be provided with a service and if so, which services to provide.

¹² Shaping the Future of Care Together (2009) Cm 7673 pp 122 and 123.

¹³ Law Commission, Adult Social Care: Scoping Report (2008) Part 2.

These Parts have been arranged in sequence to reflect the steps that local authorities should follow in order to make these decisions. Thus, Part 3 considers the role of principles in providing an overall framework for decision-making by local authorities. Part 4 examines the role of community care assessments in determining a person's needs for services, and Part 5 explores similar issues in relation to carers' assessments.

- 1.25 Once a community care or carer's assessment has been completed, a decision must be made about whether the individual is eligible for services. This is considered in Part 6. Specific issues relating to eligibility for services under section 21 of the NAA 1948 and section 2(1) of the CSDPA 1970 are considered in Part 7. Part 8 examines how the ordinary residence rules impact on eligibility for services and the related issue of portability of services.
- 1.26 If a person is assessed as eligible for services, then the local authority must decide which services will be provided. Part 9 examines the scope of adult social care services, including the use of lists of services and user group categories to determine which services can be provided, and the role of statutory prohibitions on the delivery of services. Part 10 considers how the law should facilitate the delivery of services to people with assessed eligible needs, including care plans, the choice of accommodation directions, direct payments and the legal regime for charging.
- 1.27 Parts 11 to 13 are concerned with other more general issues that arise in adult social care law. Part 11 examines joint working between social services and other agencies in areas such as children's services, hospital discharge, the well-being power, prisons, and section 117 of the Mental Health Act 1983. This Part also considers duties to co-operate in adult social care law.
- 1.28 Part 12 considers the powers of social services to take action to safeguard adults from abuse and neglect, including the power to remove people from their homes under section 47 of the NAA 1948. Part 13 then turns to a local authority's obligations in relation to strategic planning, including the register of disabled people, the duty to prepare strategic plans and duties to provide information to the public.
- 1.29 In addition to these substantive Parts, we have set out all of the provisional proposals made in this consultation paper in Part 14. Finally, our core impact assessment analysis is contained in Appendix A. The draft full Impact Assessment is available at http://www.lawcom.gov.uk/adult_social_care.htm. We welcome views on the content of the impact assessment.

Responding to this consultation paper

- 1.30 In this paper we make a number of provisional proposals for law reform. In doing this, we emphasise that these represent our initial view about how the law should be reformed and we will be reviewing these proposals on the basis of the responses to this consultation paper. We will be undertaking a wide consultation process in order to gather many different views and as much information as possible. We welcome responses from all interested parties. Details of how to respond can be found on the inside front page of this consultation paper.

PART 2

OUR APPROACH TO LAW REFORM

- 2.1 This Part considers a number of preliminary issues: the objectives of reform, how our future legal framework should be structured and our approach to the hierarchy of rules used to regulate adult social care. We also provide an overview of how our provisional proposals combine to provide a coherent system for determining eligibility for services and the scope of adult social care.

OBJECTIVES OF REFORM

- 2.2 The provisional proposals put forward in this paper are aimed at simplifying the legal framework. As noted in Part 1, the current legal framework for adult social care law is complex and fragmented. The sheer volume of legislation has led to overlap, duplication and fragmentation. Not all of the Acts sit easily with each other and in some instances they impose inconsistent obligations.
- 2.3 Our proposals also aim to create a legal framework that is clear, consistent and accessible, by removing the inconsistency and undue complexity in the law. Transparent law will help service users to be aware of their rights, and local authorities to understand their responsibilities.
- 2.4 A further objective of the proposals put forward in this paper is to bring adult social care law into line with modern understandings of disability by eradicating the use of discriminatory and stigmatising concepts and developing legislation that is more consistent with human rights considerations.
- 2.5 While any law reform will necessarily involve some expenditure, if only to implement it, our proposals are broadly resource neutral. The proposed legal structure set out in this paper should be capable of operating at any given level of resources. In other words, it would not *require* any greater or reduced level of expenditure.
- 2.6 We also expect that there would be significant overall savings if our proposals were adopted. This is because our structure would replace an outdated, complex and confusing system with a simple, transparent and modern legal framework. This should lead to large savings in time and money for those who have to deal with the law. These issues are examined further in our draft Impact Assessment.
- 2.7 In pursuing the above objectives for reform, we consider that the provisional proposals made in this consultation paper are an important first step towards creating a more effective, efficient and clear framework for adult social care.

STRUCTURE OF REFORM

- 2.8 A preliminary issue to consider is how the future legal framework should be structured. Our central goal is to achieve a simple and consistent legal framework. It is our preliminary view that this would be best achieved by introducing a unified adult social care statute. This would mean that the existing provisions under which services are provided would be consolidated and reformed into a unified adult social care statute. The advantage of a unified statute is that local authority responsibilities and obligations and individual

entitlements to services are set out in one place.

England and Wales

- 2.9 Should there be one unified statute for England and Wales, or one for England and a separate one for Wales? Adult social care is a devolved matter in Wales and the Welsh Assembly Government's responsibilities for adult social care include funding, setting policy, reviewing, inspection and regulation. There are some differences between the adult social care legislation that applies in Wales and England. For example, the CC(DD)A 2003 has only been implemented in England. It is also increasingly the case that secondary legislation, statutory guidance and practice guidance are issued separately in England and in Wales, sometimes with material differences between them.
- 2.10 There is also the potential for more differences to develop in the near future. For example, the Welsh Assembly Government has taken legislative competence in relation to charging for non-residential social care services and "supporting the provision of care by carers and promoting the well-being of carers".¹ The Welsh Assembly Government is also reviewing several areas of adult social care policy, including the future funding of care and support, the eligibility framework and statutory guidance on safeguarding adults from abuse and neglect. The results of these reviews may give rise to policies that diverge from those in England.
- 2.11 At this stage, we provisionally consider that the vehicle for our reform should be a unified adult social care statute covering both England and Wales. While there are differences in the law that applies in England and Wales, we do not believe they are currently such as to require separate statutes for each country. However, we will continue to monitor any divergence in policy between England and Wales throughout this inquiry. We note that the Welsh Assembly Government is committed to calling a referendum on fuller legislative powers for the National Assembly by May 2011 at the latest; we would expect to take full account of any change to the devolution settlement.
- 2.12 Our provisional preference for a single adult social care statute underpins the remainder of this consultation paper, where we refer to this proposal as either our *proposed adult social care statute*, or our *future adult social care statute*.

Provisional Proposal 2-1: We provisionally propose that there should be a single adult social care statute for England and Wales, unless policy in Wales diverges enough to require separate statutes for England and Wales.

HIERARCHY OF RULES

- 2.13 Adult social care is currently regulated through a range of mechanisms, including primary legislation, regulations, directions and approvals, statutory guidance and practice guidance. Under the current legal framework, it is rare that a statute, by itself, provides the answer to whether a local authority has a power or a duty to provide services. For example, the majority of community care services are set out in approvals or directions, which means local authorities have no power to

¹ See National Assembly for Wales (Legislative Competence) (Social Welfare) Order 2008, WSI 2008 No 1785 and National Assembly for Wales (Legislative Competence) (Social Welfare) Order 2009, WSI 2009 No 3010.

make arrangements for any such services unless and until approvals or directions have been issued. It is also necessary to have regard to statutory guidance, such as FACS in England and UFSAMC in Wales, to decipher whether a local authority has a power or a duty to provide a community care service.

Provisional view

- 2.14 In general, we have tried to adopt a straightforward approach to the hierarchy of rules in our proposed reforms. As a first level, we believe that our proposed adult social care statute, as primary legislation, should set out the duties imposed and powers conferred on local authorities. This will serve legal clarity and certainty. It should also mean that it is possible to see what the basic responsibilities and entitlements are by reading the statute. This approach means that in some instances we propose that requirements currently set out in statutory guidance or directions should be placed in the statute, where they represent fundamental requirements or entitlements.
- 2.15 We have also avoided requirements that the powers of local authorities should be subject to further direction and approval by the Secretary of State and Welsh Ministers. In our view, the use of approvals and directions adds to the complexity of the law by establishing parallel systems of legal entitlement for services. It also means that reference has to be made to a number of instruments in order to decide whether a duty or power arises. Given our goals of simplification and consistency, we believe the core duties and powers of local authorities should be set out on the face of the statute itself.
- 2.16 As a second level, where more detail is required or more prescription is considered appropriate, this may appropriately be placed in statutory instruments such as regulations. Generally, we have proposed that regulations be used where there is a need to expand on details set out in statute law, or to prescribe a definition for a term used in the statute. Regulations carry the full force of law and are subject to a degree of Parliamentary scrutiny.
- 2.17 As a third level, we have proposed that statutory guidance continue to be used when the Department of Health and Welsh Assembly Government want to guide the exercise of social services functions and discretions by local authorities. While statutory guidance issued under section 7(1) of the Local Authority Social Services Act 1970 must be complied with and can only be departed from with good reason,² it can also be amended fairly easily and can be a useful vehicle to ensure that practice accords with the policy approach adopted by the Department of Health and Welsh Assembly Government.

Question 2-1: Is our proposed three-level structure for the regulation of adult social care law (consisting of primary legislation, statutory instruments and guidance) appropriate?

- 2.18 We have not made any proposals for reform in relation to the amount of guidance in this area of law. As a general proposition, however, any consolidation of the law provides a valuable opportunity to consolidate and revise the associated guidance. However, we believe that there may be merit in placing a duty on the

² *R v Islington London Borough Council ex p Rixon* (1997-98) 1 CCLR 119.

Secretary of State and Welsh Ministers to prepare a code of practice to accompany the adult social care statute. This would not add a further layer to our proposed structure but would provide the form under which all of the statutory guidance in the third level was issued. It would mean that the current obligations placed on local authorities in statutory guidance could be consolidated into a single instrument. The code would then sit alongside our proposed adult social care statute and mean that practitioners and individuals need only have regard to a single statute and one code of practice to understand their obligations and entitlements. There are precedents in the Mental Health Act 1983 and Mental Capacity Act 2005 for adopting a code of practice.³ These codes have the added advantage of being subject to Parliamentary oversight through the negative resolution procedure.

Question 2-2: Should there be a duty on the Secretary of State and Welsh Ministers to prepare a code of practice to bring together statutory guidance?

OUR OVERALL APPROACH TO DETERMINING THE SCOPE OF ADULT SOCIAL CARE

- 2.19 The following section provides a brief overview of how the individual proposals made in this consultation paper combine to provide a coherent legal framework for adult social care. Our analysis of the existing framework presented throughout this consultation paper indicates that adult social care operates through a combination of *process-driven elements*, such as community care assessments and the use of an eligibility framework under FACS and UFSAMC; and *legal definitions*, such as the definition of community care services, categories of user groups and prohibitions on the provision of community care services.
- 2.20 Of these two approaches, we believe that the process-based elements are the most significant factors in determining the scope of adult social care. As discussed in Part 6 (Eligibility for Services), the eligibility framework set out in FACS and UFSAMC provide the objectives that must be met by any community care services which *are* provided. For example, if a person has assessed eligible needs that are categorised under the eligibility framework as an inability to carry out *the majority of personal care or domestic routines*, the purpose of the service provided must be to ensure that the person is able to carry out these routines. Thus, the eligibility framework indicates both the type of service that must be provided and what the outcome is that the service should achieve.
- 2.21 In contrast, the legal definitions of community care services and user groups fail to delineate in any meaningful way the scope of adult social care. The statutory lists of community care services either describe general types of services (such as *centres*) or specify the purpose of the service rather than the actual service itself (such as *recreational activities*). It is unlikely these lists perform a useful legal purpose by limiting the provision of services in any meaningful way. Similarly, the categories of user groups are extremely broad and fail to limit effectively the provision of community care services.
- 2.22 The prohibitions on the provision of adult social care services by local authorities have a role to play in determining the scope of adult social care law. As

³ Mental Health Act 1983, s 118 and Mental Capacity Act 2005, s 42.

discussed in Part 9 (Scope of Adult Social Care Services), these prohibitions help to establish an interface between adult social care and NHS care, housing, and immigration and asylum law but they do not establish a clear dividing line.

- 2.23 We believe that the most effective way of providing a coherent legal framework for adult social care is to build on the process-driven elements by establishing tightly defined processes for determining the scope of adult social care. At the centre of our proposed statute is the community care assessment, the eligibility decision and the formation of a care plan. The assessment starts the process by identifying a person's social care needs and the outcomes they wish to achieve. The decision as to which needs are eligible for services is made using the prescribed eligibility framework in FACS and UFSAMC, which set out the risks to independence that may call for services and the objectives that must be met by any community care services which are provided. To reinforce the importance of the eligibility framework to determining the scope of adult social care, our statute would require government ministers to set out this framework in regulations rather than guidance. The final step of this process is to require that local authorities prepare a care plan for each individual with assessed eligible needs.
- 2.24 In addition to these process-driven elements, there are a number of additional aspects of our proposed legal structure that would help to determine, in a more general sense, the scope of adult social care. *First*, the scope of adult social care would be limited by prohibitions on the types of services that can be provided by social services authorities (as discussed in Part 9 (Scope of Adult Social Care Services)). *Second*, community care services would be defined by reference to a broad list of services, which would appear in the statute itself (also discussed in Part 9). *Third*, statutory principles would be introduced to guide decision-makers and to help to identify the purpose and aims of adult social care (as discussed in Part 3 (Statutory Principles)). It is important to emphasise that we do not envisage that the prohibitions, list of community care services or statutory principles would define the scope of adult social care precisely. Instead, they would operate more generally to provide a framework for decision-makers acting under the legislation.
- 2.25 In summary, adult social care will be those community care services (broadly described and subject to statutory prohibitions) provided or arranged by social services authorities to those individuals, whose identity is determined through an assessment and eligibility decision (and recognised in a care plan), in a process which is prescribed in legislation and guided by statutory principles.

<p>Question 2-3: Is our process-driven approach to adult social care (a prescribed assessment and eligibility process, with support from prohibitions, a broad list of services, care plans and statutory principles) sufficient to determine the scope of adult social care, or is further definition required?</p>

PART 3

STATUTORY PRINCIPLES

- 3.1 Social welfare statutes often include a statement of fundamental principles, upon which the legislation is based. The primary examples are the Children Act 1989, the Children and Adoption Act 2002 and the Mental Capacity Act 2005. In contrast, community care statute law contains no such statement. Instead, the principles must be discerned from numerous sets of guidance and other supporting documents. This Part considers whether our proposed statute should include a statement of principles and if so, what those principles should be.

WHAT ARE STATUTORY PRINCIPLES?

- 3.2 Statutory principles are often referred to in a general sense, but legally they differ in their effect and nature. A statutory principle can be drafted in such a way that gives it primacy. Section 1(1) of the Children Act 1989, which places the child's welfare as the court's "paramount consideration", is an example of this approach. Similarly, section 1(5) of the Mental Capacity Act 2005 requires that all actions and decisions on behalf of a person who lacks capacity must be done or made in that person's "best interests". The interpretation of both of these principles is assisted by a check-list of factors that should be considered and weighed against each other.¹
- 3.3 A principle can also establish a rule that directs the decision-maker to consider a particular point. For example, section 1(5) of the Children Act states that a court should not make an order unless "doing so would be better for the child than making no order at all". This principle is intended to complement the welfare principle, although tension can arise in practice.² Principles can also establish more general rules, which describe factors to be taken into account when decisions are being made. These principles are also designed to complement the primary principle of the legislation. For example, section 1(2) of the Children Act states courts must "have regard to the general principle that any delay in determining the question is likely to prejudice the welfare of the child". Similarly, section 1(6) of the Mental Capacity Act requires decision-makers to have regard to whether the purpose of an act or decision on behalf of a person who lacks capacity could be achieved in a way that is less restrictive of the person's rights and freedom of actions.
- 3.4 Alternatively, principles can set out statutory assumptions, which are phrased in mandatory terms but contain general caveats or are broadly worded to give decision-makers sufficient flexibility. These types of principles are normally given equal status. For example, the first three principles of the Mental Capacity Act provide that a person must be assumed to have capacity unless it is established that they lack capacity; a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success; and a person is not to be treated as unable to make a decision merely because they make an unwise decision.

¹ Children Act 1989, s 1(3) and the Mental Capacity Act 2005, s 4.

² R White and others, *The Children Act in Practice* (4th ed 2008) para 2.77.

STATUTORY PRINCIPLES IN ADULT SOCIAL CARE

- 3.5 A number of arguments can be put forward in favour of principles in adult social care. However, this does not by itself establish a case for *statutory* principles. The key issue for present purposes is whether principles should be set out in statute law, as opposed to some other document, such as guidance. We acknowledge however, that it is difficult to answer in the abstract the question of whether there should be principles in adult social care legislation, without some knowledge of what the principles might be and what effect they might have. These issues are discussed later in this Part.
- 3.6 First, a statement of principles can guide decision-makers acting under the legislation. This does not mean that principles have to provide a complete answer to all questions raised in relation to the legislation but they can help decision-makers to achieve the necessary balance between competing objectives. Adult social care is full of such competing objectives and tensions. Principles may help to ensure the legislation is implemented in the way intended by the framers by creating a clear framework to guide practitioners. A statement of principles can, therefore, help to promote the consistent application of legislation. This may represent a strong argument for including principles on the face of statute law. It is a legitimate use of legislation to ensure that those responsible for implementing the legislation will come to decisions, using the structure of the Act, that they might not have come to otherwise.
- 3.7 Second, principles can articulate and clarify the underlying aims of the legislation. Thus, principles can also be used to bring together the various provisions of the legislation and provide a coherent framework and conceptual clarity to the statute. However, it is not clear that the best place for such a statement of principles would be statute law. The purpose of statute law is not primarily to sum up the overall aims or philosophy of the legislation in a more convenient form. A more appropriate place for the principles that have inspired or informed legislation might be a policy document, press release, explanatory note, guidance or handbook rather than the statute itself. A statement of principles may therefore be a useful mechanism for clarifying the underlying aims of the legislation, but on its own this argument does not provide strong support for the case in favour of statutory principles.
- 3.8 Third, statutory principles can be used to emphasise principles that already exist but are not consistently recognised or applied. For example, the best interests principle in the Mental Capacity Act 2005 was designed to codify a well-established principle in the common law.³ Setting out principles on the face of a statute may give them a special prominence that might be lost if they were contained elsewhere. Professor Luke Clements has argued that adult social care principles stated in guidance often become obscured by the mass of text in the guidance itself, and also amongst the volumes of guidance and various policy documents.⁴ However, this may be a fault with the design and drafting of policy documents or the sheer volume of guidance in this area of law. Statutory

³ See, for example, *Re MB (Medical Treatment)* [1997] 2 FLR 426; *Re A (Male Sterilisation)* [2000] 1 FLR 549; and *Re S (Sterilisation: Patient's Best Interests)* [2000] 2 FLR 389.

⁴ L Clements, *The Need for New Legislation* (2007) p 5, http://www.lukeclements.co.uk/downloads/PDF_Sep08_04.pdf (last visited 4 February 2010).

principles may be comparatively prominent and distinct but a reduction in the amount of guidance and an improvement in its drafting may give principles in guidance similar prominence. Furthermore, the need to emphasise certain principles will very much depend on what the principles in question are. We consider that the prominence of the principles is a sound argument in favour of statutory principles, but on its own it does not make an overwhelming case.

- 3.9 Fourth, it can be argued that statutory principles are preferable to principles in guidance because they are stronger. Statutory principles *must* be taken seriously by practitioners, and service users will feel more confident about demanding compliance with them. Concerns about the strength of principles contained in guidance were articulated by Lord Carlile of Berriew, during the Parliamentary debates on the Mental Health Bill 2006:

The influence of a code of practice upon a court, on a take-account basis, is quite different from the influence upon a court of principles in the statute ... the literal imprimatur of inclusion on the statute is most important.⁵

- 3.10 However, the binding effect of statutory principles will depend on their wording. Some principles are drafted in mandatory terms but others allow more flexibility and require only that decision-makers should *have regard* to them. This would give them a status similar to statutory guidance. But it is important to note that statutory guidance can be departed from where there is good reason to do so.⁶ Therefore, the relative strength of statutory principles is an important argument for the inclusion of principles in legislation.
- 3.11 Fifth, principles can perform an important educational function by promoting positive images of marginalised groups of people and setting out ethical standards that apply for the purposes of the legislation. Disabled people, for example, may benefit from the inclusion of principles that present positive images and set out ethical standards for professional practice. This may be particularly important in the context of adult social care law, which has been widely criticised for perpetuating outdated and discriminatory notions of disability. But in legal terms, the primary purpose of legislation is to state the law, not to educate people about it. So we do not think this argument adds substantially to the case for statutory principles. However, education may be an important by-product of legislation. We, therefore, welcome views on the educative role of statutory principles, particularly any evidence there may be from the implementation of the principles of the Mental Capacity Act.
- 3.12 Finally, an important aspect of statutory principles is that they can be fully debated and only amended by Parliament. In contrast, guidance is issued by the Secretary of State or Welsh Ministers and is not usually subject to debate or approval by the legislature. Even codes of practice that are required to be laid before Parliament are normally subject only to the negative resolution procedure. On the other hand, it can be argued that statutory principles might themselves become too rigid and unresponsive to changing practice or policies. We provisionally consider that there are sound arguments in favour of ensuring full

⁵ *Hansard* (HL), 8 January 2007, vol 688, col 36.

⁶ *R v Islington Borough Council ex p Rixon* (1997-98) 1 CCLR 119.

Parliamentary scrutiny of principles before they are introduced or changed. However, there may also be a need to ensure flexibility. We are, therefore, interested to receive views on how important it would be to have principles in statute law that are not easily changed or updated.

Provisional view

- 3.13 Our provisional view is that there is a compelling case for principles on the face of our proposed adult social care statute. Statutory principles can help guide decision-making under the legislation, give prominence to existing principles and have a greater strength than principles contained elsewhere. In addition, they provide a clear statement of the legislation's purpose, although on its own this would not make an overwhelming case. Statutory principles may also perform an important educational role, although again this argument is not central to our case for statutory principles. Finally, it may be important to ensure full Parliamentary scrutiny of principles before they can be changed or altered.

Provisional Proposal 3-1: We provisionally propose that our future adult social care statute should include a statement of principles.

PRINCIPLES IN ADULT SOCIAL CARE

- 3.14 At this stage of the project, we are not considering the precise wording of the statutory principles. Instead, we are looking at general concepts with a view to considering whether they are capable of forming the basis of statutory principles. The precise drafting of the principles would be determined at a later stage. However, there are a number of important propositions that must be borne in mind when considering the content of the principles.
- (1) A principle appearing in legislation must be capable of acting as a proposition of law. To do so it should be clear and precise. It should not be merely rhetorical.
 - (2) Each principle must be capable of *doing some legal work*. This would mean the outcome of a decision made under the Act would or might be different in the absence of the principle.
 - (3) Principles should assist decision-makers acting under the legislation and should not give rise to actionable rights.
 - (4) Statutory principles should not provide an overly restrictive decision-making framework, reducing individual practitioners' discretion to an inappropriate level. This is important in the context of adult social care, which relies heavily on professional judgment.
 - (5) The principles must not be inconsistent with each other, and each principle must be of truly general application to the rest of the statute, or of general application subject only to limited and specified exceptions.
 - (6) Principles must not be inconsistent with any relevant provision elsewhere in legislation (subject to specified exceptions, if any). For example, a community care assessment of a person who lacks capacity must be in accordance with the principles of the Mental Capacity Act 2005.

- (7) Principles should not simply repeat other provisions or principles stated elsewhere in legislation. For example, it would be unnecessary to include a principle that local authorities must respect and promote the human rights of disabled people, since this is already required under the Human Rights Act 1998. However, there may be exception to this general rule if an existing legal provision is relevant, but is not clearly stated or expressed in terms relevant to adult social care.
- 3.15 Taking into account the criteria outlined above, we have identified a number of potential principles for our proposed statute. These have been identified through reference to the common law, existing guidance and Government policy. However, we welcome views on whether there are any other principles that could be included in our proposed adult social care statute.

Choice and control

- 3.16 The principle of service user choice and control over service provision has been central to various adult social care policy documents issued over the past 20 years.⁷ Choice and control have been given statutory expression in the choice of accommodation directions and direct payments, and are central to a number of policy developments, such as self-assessment and personal budgets.
- 3.17 The courts have recognised that the wishes and preference of a person, while not binding, are relevant considerations that must be taken into account by the local authority in assessing their needs, and failure to do so could render a community care assessment unlawful.⁸ Furthermore, where two care packages are both capable of meeting the assessed needs of a person, and if there were no resource implications, then the local authority might be forced to provide the care package that corresponds to the person in need's preference.⁹
- 3.18 An almost identical approach – albeit in a diluted form – arises in the principle that *the wishes and feelings of a person are significant factors to which decision-makers must pay close regard*. The need to consider a person's ascertainable past and present wishes and feelings is recognised expressly in the Mental Capacity Act 2005 as an important aspect of the best interests principle.¹⁰ This principle is also relevant in some cases where a "vulnerable adult" has capacity.¹¹

Provisional view

- 3.19 The principles of choice and control are now fundamental to adult social care. These principles have been considered and applied by the courts, and would be capable of forming the basis of a statutory principle that could operate as a proposition of law. There are, of course, a number of factors that may limit this principle, such as the mental capacity of the person to understand the choices

⁷ See, for example, *Caring For People: Community Care in the Next Decade and Beyond* (1989) Cm 849, para 1.8 and *Shaping the Future of Care Together* (2009) Cm 7673, p 57.

⁸ *R v North Yorkshire County Council ex p Hargreaves* (1997-98) 1 CCLR 104.

⁹ *R (Khana) v Southwark London Borough Council* [2001] EWCA Civ 999, (2001) 4 CCLR 267 at [59].

¹⁰ Mental Capacity Act 2005, s 4(6)(a).

¹¹ *Local Authority X v MM* [2007] EWHC 2003 (Fam), (2008) 11 CCLR 119 at [121].

available to them, the cost effectiveness of the choices available and the local authority's views on the suitability of the choices. Therefore, the wording of this principle would need to give sufficient flexibility to the decision-maker. We would see such a principle as subsuming the *wishes and feelings* principle, without derogating from the development of that principle under the Mental Capacity Act 2005. We welcome views on this point.

Question 3-1: Should there be a principle in our proposed adult social care statute which provides that decision-makers must maximise the choice and control of service users?

Person-centred planning

- 3.20 Person-centred planning is described by the Government as placing the individual “firmly in the centre in identifying what is personally important to deliver his or her outcomes” and enabling people to “design the support or care arrangements that best suit their specific needs”.¹² This approach is often contrasted with a so-called traditional model of service provision, whereby professionals decide care packages by reference to pre-commissioned services and focus on the person's deficits and problems, viewing them as passive recipients of care.
- 3.21 Person-centred planning was adopted as Government policy in the 2001 White Paper *Valuing People* and is now promoted by most Government guidance.¹³ It is also a key aspect of the Government's policy of personalisation and self-directed support. For example, both *Putting People First* and *Transforming Social Care* state that person-centred planning is a core component of a personalised adult social care system and will become mainstream in England by 2011.¹⁴ A similar commitment has been made in Wales.¹⁵
- 3.22 The courts have not considered directly person-centred planning, but have considered the related point that local authorities must assess and re-assess people's needs individually. For example, it has been held that authorities are not entitled to make blanket decisions to cut services, merely because of a reduction in revenues, without any individual re-assessments of the people affected; assessments must be “needs-led by reference to the particular needs of a particular disabled person”.¹⁶ Furthermore, the duty to carry out an individual assessment is not satisfied by writing letters to those affected by cuts in service provision and simply offering them a re-assessment.¹⁷

¹² LAC(DH)(2008)1, *Transforming Social Care*, para 17.

¹³ *Valuing People: A New Strategy for Learning Disability for the 21st Century* (2001) Cm 5086. See also, for example, Department of Health, *Single Assessment Process: Guidance for Local Implementation* (2002) annex A and UFSAMC paras 2.8 to 2.10.

¹⁴ HM Government and others, *Putting People First* (2007) p 3 and LAC(DH)(2008)1, *Transforming Social Care*, appendix B, para 10.

¹⁵ Welsh Assembly Government, *A Strategy for Social Services in Wales Over the Next Decade: Fulfilled Lives, Supportive Communities* (2007) pp 23 and 37.

¹⁶ *R v Islington London Borough Council ex p McMillan* (1997-98) 1 CCLR 7, 16(F).

¹⁷ *R v Gloucestershire County Council ex p Radar* (1997-98) 1 CCLR 476.

Provisional view

- 3.23 Although most aspects of person-centred planning are too broad and insufficiently precise to form the basis of a statutory principle, there are elements that may be capable of operating as legal propositions. This might include a principle that a person *must always be assessed individually, and that decisions about service provision should be based upon the individual circumstances of the person and not blanket assumptions on the basis of, for example, their age, appearance or condition*. As noted above, this principle has proved capable of being considered and applied by the courts. It also dovetails with the requirement in the Mental Capacity Act 2005 that a lack of capacity cannot be established merely by reference to a person's age, appearance, condition or behaviour.¹⁸
- 3.24 However, it may be that in practice this principle would *not do any legal work*, since the outcome would be achieved by other provisions in the statute. In particular, the duty to assess is expressed to apply to individuals and as proposed in Part 4 (Community Care Assessments), the focus of the duty would be on the person's needs and the outcomes they wish to achieve. We welcome views on whether the concept of person-centred planning should form the basis of a statutory principle and if so, how it could be expressed.

Question 3-2: Should there be a principle in our proposed adult social care statute based on person-centred planning – or should this be incorporated into other provisions of the legislation?

A broad range of needs

- 3.25 Government guidance emphasises that local authorities should have regard to a wide range of potential needs when conducting an assessment and any subsequent care and support planning.¹⁹ Need is described in practice guidance as being “a multi-faceted concept” which can be divided into personal and social care; health care; accommodation; finance; education, employment and leisure; and transport and access.²⁰ Furthermore, the *Single Assessment Process* guidance identifies nine domains and advises that in reaching decisions professionals may “err on the side of caution” and apply all the domains in order to ensure that treatable health conditions or other needs do not go undetected or misdiagnosed.²¹ This approach is also central to the Government's policy of personalisation and self-directed support, which emphasises the need to broaden the areas of life that publicly funded social care support should be expected to impact upon. This might involve the provision of non-traditional social services, such as trips to football matches and the cinema.²²
- 3.26 The courts have been reluctant to adopt an overly rigid approach to the

¹⁸ Mental Capacity Act 2005, s 2(3).

¹⁹ For example, FACS para 34 and UFSAMC para 2.36.

²⁰ Department of Health Social Services Inspectorate and Scottish Office Social Work Services Group, *Care Management and Assessment: Practitioners' Guide* (1991) pp 12 to 13.

²¹ Department of Health, *Single Assessment Process: Guidance for Local Implementation* (2002) p 15 and annex F.

²² See Department of Health, *Secretary of State Report on Disability Equality: Health and Social Care Services* (2008) para 4.16.

assessment process. However, they have been prepared to intervene where the scope of the assessment has been restricted for policy or financial reasons. In *R v Haringey London Borough Council ex parte Norton*, the court rejected the local authority's submission that, while it could meet the person's personal care needs, it did not need to provide for their social, recreational and leisure needs on the basis that it was "forced to make decisions based upon prioritising need and working within existing resources".²³ It was held that the care package should have been "a multi-faceted package", which included consideration of "the social intercourse achieved in recreational facilities such as the playing of bridge, swimming etc".²⁴ The courts have also been critical of local authorities whose assessments have failed to take into account the views of the person's general practitioner;²⁵ a comprehensive social work assessment report,²⁶ and the needs of a person for a holiday.²⁷

- 3.27 Of course, this does not mean that all community care assessments must be comprehensive. In general terms, the type and level of the assessment will be proportionate to the level and complexity of the person's need and therefore "simple needs will require less investigation than more complex ones".²⁸ However, the assessment process must ensure that, as far as practicable, all relevant information is collected and taken into account when decisions about the provision of services are made.

Provisional view

- 3.28 The principle that *a person's needs should be viewed broadly* when a local authority conducts an assessment and provides services has been considered and applied by the courts. We have doubts, however, as to whether it is really something that could be sufficiently precisely stated to operate as a statutory principle. It may be more appropriately seen as a (central) element of good practice. We welcome views on this point.

Question 3-3: Should there be a principle in our future adult social care statute which provides that a person's needs should be viewed broadly?

Prevention services

- 3.29 Prevention services are described as "early interventions that prevent or defer the need for more costly intensive support".²⁹ They include a continuum of services from "intermediate care services at the top end of the spectrum to 'low-level'

²³ *R v Haringey London Borough Council ex p Norton* (1997-98) 1 CCLR 168, 172(F) by Mr Henderson QC.

²⁴ As above, 181(B) by Mr Henderson QC.

²⁵ *R v Birmingham City Council ex p Killigrew* [2000] 3 CCLR 109.

²⁶ *R (Goldsmith) v Wandsworth London Borough Council* [2004] EWCA Civ 1170, (2004) 7 CCLR 472.

²⁷ *R v North Yorkshire County Council ex p Hargreaves* (1997-98) 1 CCLR 104.

²⁸ Department of Health Social Services Inspectorate and Scottish Office Social Work Services Group, *Care Management and Assessment: Practitioners' Guide* (1991) p 47.

²⁹ Independence, Well-being and Choice (2005) Cm 6499, para 5.9.

interventions and community services supporting social inclusion at the other”.³⁰

- 3.30 Statutory guidance requires local authorities to develop prevention services and to state explicitly in their eligibility criteria how they will achieve this.³¹ In recent years, prevention services have been identified as a policy priority. By 2011, all councils in England must have in place “a strategic shift in the focus of care and support away from intervention at the point of crisis” to a more “holistic, pro-active and preventative model centred on improved well-being”.³² Similarly the Social Services Strategy for Wales promises substantial progress on re-focusing services towards prevention and early intervention by 2001 to 2014, and for this to have become the norm by 2014 to 2018.³³

Provisional view

- 3.31 We accept that the term *prevention services* is often used loosely and can refer to different things in different circumstances. In addition, it has not been considered and applied by the courts. We believe, however, that if this concept were reformulated into more precise terms, it might be capable of forming the basis of a statutory principle. For example, a principle might be based on a requirement that *wherever possible support should be provided that removes or reduces the level of help that will be required in the future and builds independence*.³⁴

Question 3-4: Should there be a principle in our proposed adult social care statute based on the need to remove or reduce future need?

Independent living

- 3.32 Independent living is often associated with the social model of disability, which emphasises that “people are disabled by barriers – social, economic, and attitudinal – in society, rather than by impairment in itself” and that “choice and control, therefore, depend on the removal of these external barriers”.³⁵ Generally, independent living is regarded as a “concept rather than an issue requiring precise legal definition”, and there have been several attempts to provide a definition.³⁶ The Government has adopted the following definition:

all disabled people having the same choice, control and freedom as any other citizen – at home, at work, and as members of the community. This does not necessarily mean disabled people “doing

³⁰ B Hudson and M Henwood, *Prevention, Personalisation and Prioritisation in Social Care: Squaring the Circle?* (2008) para 2.1.

³¹ FACS paras 21 to 22 and UFSAMC para 5.27.

³² LAC(DH)(2008)1, *Transforming Social Care*, appendix B, para 10.

³³ Welsh Assembly Government, *A Strategy for Social Services in Wales Over the Next Decade: Fulfilled Lives, Supportive Communities* (2007) pp 39 to 40.

³⁴ Adapted from In Control, *Ethical Values: The Beliefs and Values that Underpin In Control's Work* (2008) p 3.

³⁵ Office for Disability Issues, *The Costs and Benefits of Independent Living* (2007) para 2.5.

³⁶ C Parker and L Clements, “The UN Convention on the Rights of Persons with Disabilities: A New Right to Independent Living?” [2008] 4 *European Human Rights Law Review* 508, 508.

everything for themselves”, but it does mean that any practical assistance people need should be based on their own choices and aspirations.³⁷

- 3.33 Independent living can be described as a fairly broad concept. Indeed, some definitions are augmented by a long list of various constituent elements. For example, the Disabled Persons (Independent Living) Bill 2006 supplements its definition of independent living with a list of 11 principles and eight outcomes that independent living should achieve.³⁸ We do not see this approach as providing a useful model for statutory principles in our proposed statute.
- 3.34 Both domestic law and international treaties give some recognition to the concept of independent living. For example, section 49A of the Disability Discrimination Act 1995 places a duty on public authorities to have due regard to the need to promote equality of opportunity between disabled persons and other persons. In furtherance of this duty, public bodies must develop Disability Equality Schemes which, in the case of local authorities, should be aimed at increasing the “proportion of disabled people who are enabled to live independently”.³⁹ Internationally, Article 19 of the UN Convention on the Rights of Persons with Disabilities provides expressly for “living independently and being included in the community”. It has also been argued that aspects of independent living are recognised in article 8 of the ECHR, article 26 of the European Union Charter of Fundamental Rights 2000, and article 13 of the Treaty of Amsterdam.⁴⁰
- 3.35 Adult social care statute law does not contain any specific reference to the concept of independent living. However, guidance includes a number of statements that could be read as being broadly supportive. Furthermore, a number of policy documents identify independent living as a key aim.⁴¹

Provisional view

- 3.36 Independent living is a broad concept encompassing various aims and principles. Indeed, the concept of independent living is wider even than adult social care, covering areas such as discrimination and human rights law. Independent living is not, therefore, easily translated into a precise statutory principle that could be included in our adult social care statute. However, we welcome further views on how this principle could be reformulated into more precise terms.
- 3.37 We recognise that in recent years many people have campaigned for a right to independent living as means to establishing enforceable legal rights to services

³⁷ Prime Minister’s Strategy Unit, *Improving the Life Chances of Disabled People* (2005) p 70. This was originally put forward by the Disability Rights Commission.

³⁸ Disabled Persons (Independent Living) Bill 2006, cl 1 and 3.

³⁹ Disability Rights Commission, *The Social Care Sector and the Disability Equality Duty: A Guide to the Disability Equality Duty and Disability Discrimination Act 2005 for Social Care Organisations* (2006) p 30.

⁴⁰ C Parker and L Clements, “The UN Convention on the Rights of Persons with Disabilities: a New Right to Independent Living?” [2008] 4 *European Human Rights Law Review* 508.

⁴¹ See, for example, Department of Health Social Services Inspectorate and Scottish Office Social Work Services Group, *Care Management and Assessment: Practitioners’ Guide* (1991) p 23; and HM Government, *Valuing People Now: A New Three-Year Strategy for People with Learning Disabilities* (2009) p 30.

and ensuring that disabled people do not encounter unlawful discrimination. In our view, statutory principles would not be the best place to achieve these desired aims. In our view, the purpose of principles is to assist decision-makers in exercising their functions, rather than establishing enforceable legal duties.

Question 3-5: Should there be a principle in our proposed adult social care statute based on the concept of independent living?

An assumption of home-based care

- 3.38 An assumption in favour of home-based care is essentially a constituent element of independent living. It would, in effect, mean that local authorities would be required to start from the position that service users should receive a home-based package of care, unless there are legitimate reasons for favouring residential or other institutional care. The Council of Europe has emphasised the need to promote home-based care in its *Disability Action Plan*.⁴²
- 3.39 The 1990 statutory guidance, *Caring for People*, includes a number of statements that could be interpreted as supporting an assumption of home-based care. For example, it advises that care plans should seek the “objective of ensuring that service provision should, as far as possible, preserve or restore normal living” and that this means support for the service user at home should be given priority over the provision of residential care.⁴³
- 3.40 The courts have held that this guidance and the relevant legislation requires local authorities to take “very full account” of the wishes of a person, including the “fundamental aim” of preserving independence in the community and in their own homes “for as long and as fully as possible”. However, the decision about how to meet assessed needs rests ultimately with the authority.⁴⁴ In *R (Gunter) v South Western Staffordshire Primary Care Trust*, it was held that moving a disabled person from their family home into residential care, where this was contrary to the person’s expressed views, was an “obvious” interference with article 8 of the ECHR and must be justified as proportionate.⁴⁵ The Local Government Ombudsman has also argued that, in circumstances where a local authority rejected the wishes of a family in deciding that residential care was needed, “the principle of promoting independent living should not be lightly disregarded”.⁴⁶

⁴² Council of Europe, *Council of Europe Action Plan to Promote the Rights and Full Participation of People with Disabilities in Society* (2006) p 6.

⁴³ Department of Health, *Caring for People: Community Care in the Next Decade and Beyond: Policy Guidance* (1990) para 3.24.

⁴⁴ *R (Khana) v Southwark London Borough Council* [2001] EWCA Civ 999, (2001) 4 CCLR 267 at [56].

⁴⁵ [2005] EWHC 1894 (Admin), (2006) 9 CCLR 121 at [20].

⁴⁶ Report on an Investigation into Complaint No. 07/A/01436 against London Borough of Hillingdon, 18 September 2008, para 31.

Provisional view

- 3.41 In the opinion of the courts, the provision of home-based care is an important aim but only in circumstances where this is in accordance with the person's wishes. The key issue is the weight to be given to these wishes, as opposed to a general assumption in favour of home-based care. It follows that any statutory principle in favour of home based care would need to be worded in such a way that it can be trumped in cases where the preference of the person is for residential care. In effect, this would appear to be a subset of, and would add little to, the principle of choice and control discussed above.
- 3.42 Furthermore, it may be difficult to draft a principle in favour of home-based care, as there would need to be a clear distinction made between care being provided at home and care being provided in an institution. However, some housing can be described as both, such as sheltered accommodation, Shared Lives, group homes, cluster housing, and supported tenancy schemes.

Question 3-6: Should there be a principle in our proposed adult social care statute based on an assumption of home-based living?

Dignity in care

- 3.43 There has been a proliferation of reports, circulars, guidance and toolkits on dignity in care over recent years. It has been the subject of a Department of Health campaign launched in 2006 and a national programme in Wales launched in 2007. The campaign in England has been supported by the publication of a national practice guide setting out expectations of what constitutes a service that respects dignity.⁴⁷
- 3.44 Dignity in care has, however, proved a difficult concept to define, often because it is subjective and will differ from one person to another. The Social Care Institute for Excellence proposed the following form of words:

A state, quality or manner worthy of esteem or respect; and (by extension) self-worth. Dignity in care, therefore, means the kind of care, in any setting, which supports and promotes, and does not undermine, a person's self-respect regardless of any difference.⁴⁸

- 3.45 The principle of dignity has also been applied and developed by the courts, mainly in the context of article 3 and article 8 of the ECHR. In *R (A) v East Sussex County Council*, Lord Justice Munby, when he was a High Court judge, described dignity as "one of the core values – in truth the core value – of our society".⁴⁹ The judgment recognised the article 8 rights of disabled people to participate in the life of the community and to have access to "essential economic and social activities and to an appropriate range of recreational and cultural activities" and that this is matched by a positive obligation on the state to take measures to ensure "to the greatest extent feasible that a disabled person is not so circumscribed and so isolated as to be deprived of the possibility of developing

⁴⁷ Social Care Institute for Excellence, *Dignity in Care: Guide 15* (2008) p 10.

⁴⁸ As above, p 6.

⁴⁹ [2003] EWHC 167 (Admin), (2003) 6 CCLR 194 at [86].

his personality”.⁵⁰

- 3.46 In *R (Bernard) v Enfield London Borough Council*, Lord Justice Sullivan, when he was a High Court judge, held that the local authority’s failure to provide suitably adapted accommodation services for a disabled person was incompatible with article 8 because such accommodation “would not merely have facilitated the normal incidents of family life” but would also have secured her “physical and psychological integrity” and, in short, “it would have restored her dignity as a human being”.⁵¹

Provisional view

- 3.47 We accept that the definition of dignity in care is subjective and will differ from one person to another. However, there are limits to the concept of dignity. Baroness Hale has pointed out that “dignity can so often be used on both sides of an argument”, particularly in arguments concerning assisted suicide, abortion or stem cell research; and that it “may have to be balanced against other rights, or against the interests of the community as a whole, and then ... begins to lose its universal quality”.⁵² It is also fluid and wide-ranging, and would need to be narrowed down before it could operate as a proposition of legislation. However, given the fundamental importance of the aim of this principle, to address poor and undignified standards of care, we welcome views on whether this principle could be clearly defined or even broken down into more precise constituent elements, in order to operate as a statutory principle.
- 3.48 The principle of dignity in care has already been developed by the courts in the context of articles 3 and 8 and it may be unnecessary and a source of confusion to include it on the face of an adult social care statute. Against that, it could be argued that it would be advantageous to restate the principle to make it explicit and applicable to all adult social care. Furthermore, the word *dignity* does not appear in articles 3 or 8, or anywhere else in the ECHR, and on this basis it may be important to recognise this principle in statute law.

Question 3-7: Should there be a principle in our proposed adult social care statute based on dignity in care?

Safeguarding adults from abuse and neglect

- 3.49 As noted in Part 12 (Safeguarding Adults at Risk), social services authorities have a number of legal powers to safeguard people from abuse and neglect through a combination of statute law, guidance, the common law and public law obligations. Therefore, there may be merit in developing a statutory principle based on the need to protect an adult from harm.
- 3.50 This may be particularly important in the current policy environment of personalisation, which emphasises the importance of people exercising choice and control. In this context, it may be important to recognise that some people

⁵⁰ *R (A) v East Sussex County Council* [2003] EWHC 167 (Admin), (2003) 6 CCLR 194 at [99].

⁵¹ [2002] EWHC 2282 (Admin), (2002) 5 CCLR 577 at [33].

⁵² B Hale, “Dignity” (2009) 31 *Journal of Social Welfare and Family Law* 101, 106 to 107.

may need safeguarding from abuse and neglect.⁵³ Of course, choice and control and safeguarding will, in most cases, be compatible principles. However, there will be cases where it will be necessary to come down on the side of either choice and control, or safeguarding. In other cases the emphasis will be on “sensible risk appraisal, not striving to avoid all risk, whatever the price, but instead seeking a proper balance and being willing to tolerate manageable or acceptable risks”.⁵⁴ The approach taken may, at least in part, depend on the person’s capacity to make the decision in question; if a person falls just above or below the borderline of capacity, “the more weight must in principle be attached to [their] wishes and feelings”.⁵⁵

Provisional view

- 3.51 We welcome views on whether it is desirable or possible to develop a statutory principle based on the importance of having regard to safeguarding adults from abuse and neglect. In Part 12 (Safeguarding Adults at Risk) we provisionally propose to introduce a statutory duty on local authorities to make enquiries in cases of abuse and neglect. It may, therefore, be unnecessary to include such a principle, since it may not add anything to the duty to investigate.

Question 3-8: Should there be a principle in our proposed adult social care statute based on the need to safeguard adults at risk from abuse and neglect?

THE EFFECT OF THE PRINCIPLES

- 3.52 The relative strength and relationship of the principles in our proposed adult social care statute will depend on which principles are eventually recommended and what they are trying to achieve. It would, therefore, be premature to make provisional proposals about the strength of the principles. However, we are interested in views on whether any principles of adult social care are capable of being primary principles of the legislation and therefore, must be the paramount consideration.
- 3.53 In our provisional view, none of the principles that we have considered in this Part are capable of operating in the same way as section 1(1) of the Children Act 1989 or section 1(5) of the Mental Capacity Act 2005. However, it might be possible to draft a principle which was always applicable because it incorporated within itself the necessary qualifications. For example, the principle of choice and control may be capable of operating in this way, if expressed with suitable qualifications. Alternatively a principle based on the concept of dignity in care may be capable of operating in this way. We welcome further views on whether any principle is capable of operating as the primary principle of adult social care legislation.

Question 3-9: Should any one principle in adult social care be given primacy over all other principles?

⁵³ See, for example, M Flynn and others, “Warning: Health ‘Choices’ Can Kill” (2003) 5 *The Journal of Adult Protection* 30, 34.

⁵⁴ *Local Authority X v MM* [2007] EWHC 2003 (Fam), (2008) 11 CCLR 119 at [120].

⁵⁵ As above, at [124].

PART 4

COMMUNITY CARE ASSESSMENTS

- 4.1 The assessment process is the gateway to the provision of community care services. This Part examines the community care assessment process in detail and considers how this should be expressed in our proposed adult social care statute. This Part does not examine the decision that follows a community care assessment; namely, whether or not a person's needs are eligible for services. This is discussed separately in Part 6 (Eligibility for Services). The assessment process for carers is also examined separately in Part 5 (Carers' Assessments).

CURRENT DUTIES TO ASSESS FOR COMMUNITY CARE SERVICES

Section 47 of the NHSCCA 1990

- 4.2 Section 47(1) of the NHSCCA 1990 is the primary duty to assess an individual's needs for community care services. It provides that:

Where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority—

- (a) shall carry out an assessment of his needs for those services; and
 - (b) having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services.
- 4.3 In order to trigger this duty, it must appear to the local authority that a person may be in need of community care services that it may provide or arrange. There are two aspects of this test. First, a local authority must possess the legal power to provide or arrange community care services to the individual in question, but it does not require that the local authority have an actual, practical ability to do so.¹ Therefore, the authority cannot refuse to assess on the basis that it does not have in place arrangements to provide services which the individual is likely to need, or that it does not have the resources to meet a need.² The duty to assess also does not depend on the person concerned being ordinarily resident in the local authority's area, as section 47(1)(a) only requires a power to provide a service not a duty.³
- 4.4 Second, a person must have an appearance of need for community care services. The statutory guidance, FACS and UFSAMC, require local authorities to "set a low threshold, and avoid screening individuals out of the assessment process before sufficient information is known about them".⁴ FACS provides that

¹ *R v Berkshire County Council ex p P* (1997-98) 1 CCLR 141, 147(G).

² As above, 146(I) and *R v Bristol City Council ex p Penfold* (1997-98) 1 CCLR 315, 322(K).

³ *R v Berkshire County Council ex p P* (1997-98) 1 CCLR 141. Ordinary residence is discussed in Part 8.

⁴ FACS para 30. See also UFSAMC para 2.23.

an individual's financial circumstances "should have no bearing on whether a council carries out a community care assessment or not".⁵ A person who has the finances to fund their own care will be eligible for an assessment so long as they appear to be in need of services, regardless of the fact that they may have to pay for any service that is provided as a result of that assessment.

- 4.5 The current wording of section 47(1) is misleading in one respect. Section 47(1) provides that the duty is triggered where the person appears to a local authority to be in need of community care services, which suggests that a person must have a need *for a service*. Thus, the process appears to be service-led rather than needs-led. However, as discussed later in this Part, the guidance makes it clear that needs and services should be considered separately.

Section 2(1) of the CSDPA 1970

- 4.6 Section 47(1) of the NHSCCA 1990 did not replace assessment duties in earlier legislation, such as the CSDPA 1970. Section 2(1) of the CSDPA 1970 places a duty on local authorities to make arrangements for the provision of welfare services to persons to whom section 29 of the NAA 1948 applies, if "satisfied" the services are necessary in order to meet the needs of that person. In order to be satisfied, it would appear necessary for an assessment to be undertaken.
- 4.7 The assessment duty in section 2(1) of the CSDPA 1970 is narrower than the section 47(1)(a) duty in several respects. First, it only applies to people who fall within the definition of disability under section 29(1) of the NAA 1948. As discussed in Part 13 (Strategic Planning), this definition excludes many disabled people and others who would be eligible for an assessment under section 47(1)(a) of the NHSCCA 1990. Secondly, the section 2(1) assessment duty only relates to the provision of welfare services under section 29 of the NAA 1948. Welfare services are one category of services but not the only category to which a section 47(1) assessment relates.
- 4.8 A further problem is that section 2(1) does not refer explicitly to an assessment at all. This failure was noted by Baroness Trumpington during the Parliamentary debates on the Disabled Person (Services, Consultation and Representation) Bill 1986. She argued that section 2(1) does not "make it explicitly clear whether a local authority has a duty to determine what the needs of a disabled person are".⁶ To address this difficulty, section 4 of the DP(SCR)A 1986 was introduced.

Section 4 of the DP(SCR)A 1986

- 4.9 Section 4 of the DP(SCR)A 1986 provides that when requested by a disabled person or their carer, a local authority must decide whether the needs of the disabled person call for the provision of any services in accordance with section 2(1) of the CSDPA. The Court of Appeal suggested that section 4 was enacted because local authorities were not required by section 2(1) to "make any decision under it, and in some instances they were failing to do so".⁷

⁵ FACS para 70. This point is not directly addressed in UFSAMC.

⁶ *Hansard* (HL), 18 June 1986, vol 476, col 978 (Baroness Trumpington).

⁷ *R v Gloucestershire County Council ex p Barry* (1997-98) 1 CCLR 19, 32(J) by Swinton Thomas LJ.

- 4.10 Section 4 of the DP(SCR)A 1986 does not so much create a separate duty to assess, but rather directs that a local authority make a decision under the CSDPA 1970. As section 4 acts as a gateway to the CSDPA 1970, it has the same limitations. In particular, it does not apply to people who fall outside the definition of disability in section 29(1) of the NAA 1948 and only relates to the provision of welfare services. Furthermore, section 4 depends on a request being made by the disabled person or their carer. This not only requires people to know of their right to services before an assessment, but it also may exclude people who do not make a request but nonetheless require an assessment.
- 4.11 Section 47(1)(a) of the NHSCCA 1990 was thought to remedy these problems by making the trigger for the duty to assess the appearance of need, rather than a request. However, section 47(1) did not replace nor repeal section 4 of the DP(SCR)A 1986; section 4 remains in place and continues to give disabled people a standalone and enforceable right to request an assessment. In fact, the continued operation of section 4 of the DP(SCR)A 1986 is ensured specifically by section 47(2) of the NHSCCA 1990.

Section 47(2) of the NHSCCA 1990

- 4.12 Section 47(2) of the NHSCCA 1990 adds another layer to the current framework of assessment duties. It provides that if at any time during a community care assessment, it appears to a local authority that the person being assessed is disabled, the authority must decide whether services are required as mentioned in section 4 of the DP(SCR)A 1986, without the disabled person having to make a request. The authority must also inform the person being assessed that it will be doing so and of their rights under the DP(SCR)A 1986.
- 4.13 The services mentioned in section 4 are services under section 2(1) of the CSDPA 1970. As the Court of Appeal has explained, if the person being assessed is disabled, then they fall into a distinct category which:

In turn triggers the duty laid down in section 4 of the 1986 Act to make a decision which, in turn, triggers the duty to decide whether the needs of the disabled person call for the provision of any services in accordance with section 2(1) of the 1970 Act. Accordingly section 47(2) of the 1990 Act takes one back to the provisions of section 2 of the 1970 Act.⁸

- 4.14 It seems that the main difference between going through section 47(2) and going straight to section 4 of the DP(SCR)A 1986, is that section 47(2) does not depend on a request being made by the service user or carer, whereas section 4 does. The other difference is that under section 47(2) a disabled person is entitled to certain information about the assessment process and their rights.
- 4.15 It is unclear why subsection 47(2) was enacted and whether, in practice, it adds anything to the duty to assess in section 47(1)(a) of the NHSCCA 1990. Practice guidance initially suggested that the section required local authorities “to offer a comprehensive assessment” to a person who appears to be disabled,

⁸ *R v Gloucestershire County Council ex p Barry* (1997-98) 1 CCLR 19, 33(J) by Swinton Thomas LJ.

irrespective of the scale of need that is initially presented.⁹ However, this view was dismissed in *R v Gloucestershire ex parte RADAR*.¹⁰ Lord Clyde suggested in *R v Gloucester ex parte Barry* that the purpose of section 47(2) is to highlight a procedural difference in the assessment of disabled people rather than a practical difference.¹¹ However, it is not clear why a separate procedure is necessary or what it amounts to in practice. The duty to assess in section 47(1) extends to the provision of services under section 2(1) of the CSDPA 1970, without requiring a separate legal provision to direct people to this legislation.¹²

Provisional view

- 4.16 A duty to assess is a crucial feature of adult social care law. An assessment by the local authority can be a service in its own right and can help an individual identify their needs, inform them as to the support available, and discuss the support they want. Assessments can also serve a broader purpose in identifying levels of need in a community at large and helping to develop and commission services to respond to those needs.¹³
- 4.17 However, the current legal framework for assessments is overlapping, complex and confusing and in urgent need of reform. We therefore provisionally consider that the current law should be reformed to provide for a single gateway into the provision of community care services. This would increase clarity and consistency in the law and offer a more streamlined route to services. In our provisional view, the assessment duty in our proposed adult social care statute should reflect the following key principles.
- 4.18 First, there should be a clear and explicit requirement that an assessment must be carried out, such as that contained in section 47(1)(a) of the NHSCCA 1990. Section 2(1) of the CSDPA 1970 does not contain such a requirement, which has caused confusion.
- 4.19 Second, there should be a low threshold for qualifying for an assessment which does not distinguish between user groups. For example, the duty to assess in section 47(1)(a) is triggered when it appears to a local authority that a person may be in need of community care services and not on the basis of the person falling within a specific user group, such as a disabled person under section 29 of the NAA 1948.
- 4.20 Third, the assessment duty should state clearly that a person must have needs *that can be met by* community care services, rather than a need *for* community care services. This would not change the substance of the trigger, but would underline that assessments should be needs-led rather than services-led.
- 4.21 Finally, a local authority's duty to assess should be triggered where it has a legal power to provide or arrange for the provision of community care services. This

⁹ Department of Health Social Services Inspectorate and Scottish Office Social Work Services Group, *Care Management and Assessment: Practitioners' Guide* (1991) p 43.

¹⁰ (1997-98) 1 CCLR 476, 484(C) to 484(E).

¹¹ *R v Gloucestershire County Council ex p Barry* [1997] AC 584, 612.

¹² *R v Powys County Council ex p Hambidge* (1997-98) 1 CCLR 458.

¹³ As recognised in *R v Bristol City Council ex p Penfold* (1997-98) 1 CCLR 315, 322(I).

reflects the current position under section 47(1)(a) of the NHSCCA 1990 and means that a person does not have to be ordinarily resident in a local authority area in order to trigger the duty to assess.

- 4.22 We do not believe it is necessary to retain the separate procedural process for disabled people provided in section 47(2) of the NHSCCA 1990. It is not evident that this provision adds anything of substance to the normal community care assessment. It does, however, add to the fragmentation and confusion of the legal framework. In our view, this section should be repealed, along with the separate assessment processes in section 2(1) of the CSDPA 1970 and section 4 of the DP(SCR)A 1986.
- 4.23 In making these provisional proposals, we recognise there may be problems with the assessment duty under section 47(1)(a) of the NHSCCA 1990, which mean that, for example, people are not being assessed or are turned down for assessment. We are interested in receiving evidence on this point as well as views on whether any problems identified are due to a design fault in section 47(1)(a) or the way in which the duty is exercised in practice.

Provisional Proposal 4-1: We provisionally propose that there should be a duty to undertake a community care assessment in our future adult social care statute, triggered where a person appears to the local authority to have social care needs that can be met by the provision of community care services (including a direct payment in lieu of services) and where a local authority has a legal power to provide or arrange for the provision of community care services (or a direct payment) to the person.

THE RIGHT TO HAVE AN ASSESSMENT ON REQUEST

- 4.24 One further issue to review is whether there should be a right to have an assessment on request. In practice, many assessments are carried out following a request being made by the individual concerned, or their carer, friends or family. Technically, however, a local authority does not have to undertake an assessment under section 47(1)(a) if a person requests one; the duty only arises if there is an appearance of need and a legal power to provide services.
- 4.25 In contrast, section 4 of the DP(SCR)A 1986 gives a disabled person or their carer the right to request the local authority to decide whether the needs of the disabled person call for the provision of services under section 2(1) of the CSDPA 1970. If so requested, the local authority must make that decision.

Provisional view

- 4.26 Provisionally, we consider that a request mechanism is only necessary if the current duty, based on the appearance of need, is not working. This may be the case if people generally, or particular user groups, are being excluded from assessments unlawfully. For example, there is evidence to suggest that self-

funders are not being assessed in circumstances where they are legally entitled to an assessment.¹⁴

- 4.27 We welcome views on whether a right to have an assessment on request should be included in our proposed adult social care statute. If such a right is included, it could take two forms. The first is that a request could trigger the duty to assess, as is the case with section 4 of the DP(SCR)A 1986. We note that if a similar right was included in our statute, it may be necessary to have a procedure to avoid frivolous or vexatious requests. An alternate approach is provided by section 228 of the Mental Health (Care and Treatment) (Scotland) Act 2003, where a request does not trigger a duty to assess, but a council must consider a request and if it refuses to carry out an assessment it must give reasons why.

Question 4-1: Should our proposed adult social care statute include a right to have an assessment on request?

THE FOCUS OF THE COMMUNITY CARE ASSESSMENT DUTY

The current “needs-led” assessment

- 4.28 A local authority is required under section 47(1)(a) of the NHSCCA 1990 to carry out an assessment of “a person’s needs” for community care services. This has been explained, in various guidance, as requiring an assessment which focuses on the person’s *needs* and “what the individual can and cannot do, and could be expected to achieve” (a *needs-led* assessment); rather than an assessment which focuses only on “the user’s suitability for a particular existing service” (a *service-led* assessment).¹⁵ Thus, an assessment is concerned with evaluating those issues and problems that are identified when an individual approaches the authority and how they constrain or support the person’s capacity to live a full and independent life. Only once those needs are identified should they be evaluated against the eligibility framework and then a decision made about services.¹⁶
- 4.29 There are three main concerns with the current focus of assessments. The first is that despite the intention of most statutory guidance to focus on needs alone, the linking of needs to community care services in the language of the statute may encourage service-led assessment. The “continuing influence” of a service-led model was reflected in evidence submitted to the review of the eligibility framework by the Commission for Social Care Inspection, which found that needs are often equated with certain services.¹⁷
- 4.30 Second, it is claimed that a needs-led assessment adopts a deficit model, in which the focus is on a person’s problems and the difficulties they face. This has been described as “disabling” for the person being assessed, as it requires them

¹⁴ Commission for Social Care Inspection, *Cutting the Cake Fairly* (2008) para 3.48; Commission for Social Care Inspection, *The State of Social Care in England 2006-07* (2008) Part 2; C Williams, “A Fair Deal For Self-Funders?” (30 April 2009) 1768 *Community Care* 24.

¹⁵ *Caring for People: Community Care in the Next Decade and Beyond* (1989) Cm 849, para 3.2.3.

¹⁶ FACS para 28. A similar point is made in UFSAMC paras 2.40 to 2.42.

¹⁷ Commission for Social Care Inspection, *Cutting the Cake Fairly* (2008) paras 3.12 to 3.13.

to emphasise their negative points, which “failed to support or promote independence”.¹⁸ Consequently, it has been argued that:

In order to determine eligibility for scarce resources, assessments commonly measure dependency levels: they thus often ask “what is wrong *with* this person?” rather than “what is wrong *for* this person?”¹⁹

- 4.31 Third, focusing on needs may mean neglecting consideration of the outcomes that people want to achieve. In recent policy documents, there has been a greater focus on identifying and summarising the person’s desired outcomes.²⁰ However, it may be that a focus on outcomes can be incorporated as part of a needs-led assessment. For example, the Department of Health has stated that outcomes may be a way to “stimulate a person’s own consideration of their needs, and what support or care they personally feel would help them achieve these outcomes”.²¹ Nevertheless, an outcomes-focused assessment may also be seen as an alternative to a needs-led assessment.²²

Provisional view

- 4.32 In our provisional view, a needs-led assessment does not prevent a focus on outcomes. Indeed, needs and outcomes can be seen as opposite sides of the same coin. In a general sense, outcomes are the objectives and aspirations that a person wants to achieve in their life, such as improved health and emotional well-being, and improved quality of life. Needs are “the requirements of individuals to enable them to achieve, maintain or restore” those outcomes.²³
- 4.33 We do not believe that an outcomes-focused assessment could replace a needs-led assessment. It is difficult to see how an assessment focused on outcomes alone would work in practice. For example, an outcome would need to be assessed with reference to a person’s needs or risk factors, in order to determine where scarce resources should be allocated. Furthermore, if the outcomes a person wishes to achieve are not being achieved, it would be necessary to identify what is preventing this, which are the person’s needs. Focusing only on outcomes may also not be appropriate for everyone. For example, it has been suggested that older people may find outcomes-focused assessment difficult, “with their ability to identify outcomes restricted by their perceptions of social services’ responsibilities; of the help they think it legitimate to request; and of the services they think are available”.²⁴

¹⁸ Commission for Social Care Inspection, *The State of Social Care in England 2007-08* (2009) para 9.69.

¹⁹ J Morris, “Independent Living and Community Care: A Disempowering Framework” (2004) 19 *Disability and Society* 427, 432.

²⁰ Department of Health, *Common Assessment Framework for Adults: Consultation* (2009).

²¹ As above, p 23.

²² See, for example, C Glendinning and others, *Evaluation of the Individual Budgets Pilot Programme: Final Report* (2008) p 152.

²³ See Department of Health Social Services Inspectorate and Scottish Office Social Work Services Group, *Care Management and Assessment: Practitioners’ Guide* (1991) p 12.

²⁴ Social Care Institute for Excellence, *Outcomes-Focused Services for Older People: Knowledge Review 13* (2006) p 11.

- 4.34 On the other hand, focusing on need alone may mean neglecting consideration of the outcomes that people want to achieve. For example, while community care assessments for older people “may identify activities with which help is needed, they may fail to specify the ways in which older people wish help to be given, including practices consistent with personal, cultural or religious preferences”.²⁵ Therefore, we believe our proposed adult social care statute should specify that an assessment should identify both a person’s needs *and* the outcomes they wish to achieve.
- 4.35 We also provisionally propose that the current language which links needs to services should be amended. On its face, this suggests an assessment *for services*, which is contrary to the clear intention of statutory guidance that assessments must be needs-led and not limited or restricted by the services available. Specifying that an assessment should focus on the person’s social care needs would avoid this link to services, but would also delineate clearly the scope of assessment to needs that can be met by social care services.

Provisional Proposal 4-2: We provisionally propose that the focus of the community care assessment duty should be an assessment of a person’s social care needs and the outcomes they wish to achieve, and should not focus on the person’s suitability for a particular service.

SELF-ASSESSMENT

- 4.36 A key aspect of developing policy in England is the use of self-assessment.²⁶ We said in our scoping report that we would consider how it fits into the existing legal framework.²⁷ Self-assessment can indicate a range of options giving individuals a varying degree of control over their assessment. In most cases, self-assessment does not mean that the entire assessment process is carried out by an individual on their own. It may be incorporated as a stage in the community care assessment process, whereby a person completes a self-assessment which is then reviewed, finalised and approved by the local authority, or is taken into account in the local authority’s own assessment of the person’s needs.²⁸ In other instances, self-assessment is integrated into the community care assessment, by enabling people to assess their own “circumstances and support needs in partnership with the professional whose role is to advise, support and help to identify and resolve potential risks”.²⁹ We believe that in practice most self-assessments are in fact *co-produced* self-assessments, in that they are produced in conjunction with the local authority in the ways described above.³⁰

²⁵ Social Care Institute for Excellence, *Outcomes-Focused Services for Older People: Knowledge Review 13* (2006) p 18.

²⁶ See Independence, Well-being and Choice (2005) Cm 6499; Our Health, Our Care, Our Say (2006) Cm 6737; HM Government and others, *Putting People First* (2007) p 3.

²⁷ Law Commission, *Adult Social Care: Scoping Report* (2008) para 4.41.

²⁸ See S Duffy, “Care Management and Self-Directed Support” (2007) 15 *Journal of Integrated Care* 3, 9.

²⁹ Department of Health, *Common Assessment Framework for Adults: Consultation* (2009) p 21.

³⁰ See Commission for Social Care Inspection, *The State of Social Care in England 2007-08* (2009) para 9.72.

- 4.37 It has been suggested that the advantage of incorporating self-assessment into the assessment process is that it can put control of the assessment process in the hands of the service user, rather than the supposedly traditional approach of a local authority deciding what a person's needs are. It may also be seen "as an indication that people's views were taken seriously".³¹

Is self-assessment legal?

- 4.38 Section 47(1) of the NHSCCA 1990 places a duty on a local authority to carry out a community care assessment and to make the decision about the provision of services. Relying on a self-assessment alone to assess a person's needs without any validation or review of the assessment would effectively amount to a delegation of this statutory duty. Generally, a discretion conferred by statute is intended to be exercised by the authority on which the statute has conferred it and cannot be delegated, although this presumption "may be rebutted by any contrary indications found in the language, scope or object of the statute".³²
- 4.39 There is no express power in the NHSCCA 1990 for a local authority to delegate to a third party, including a potential service user, its statutory duty to undertake an assessment. The only power to delegate this function is under the NHS Acts 2006, which enable prescribed functions to be carried out by a health body.³³ While a local authority might involve other persons or organisations in the assessment process, and might contract with another body to carry out part of the assessment process on its behalf, it must retain overall control of the process.
- 4.40 We consider that a co-produced self-assessment is consistent with the requirement that a local authority retains overall control of the process and is therefore compliant with the current statutory framework. Section 47(1)(a) does not prescribe how an assessment should be undertaken. A local authority can include a stage of self-assessment as a way of generating discussion about needs and outcomes, which can then be incorporated into, or compared against, their own assessment of the person's needs. Alternatively, a local authority could adopt the approach of a co-produced self-assessment by working with the individual to identify their needs.
- 4.41 However, at the other end of the spectrum, a local authority cannot use a self-assessment as the sole means by which a person is assessed without any verification or validation. This is recognised in the draft FACS guidance, which notes that "self-assessment does not negate a council's duty to carry out its own assessment".³⁴ A local authority must also have regard to other matters in undertaking an assessment, which might not be satisfied through relying on a pure self-assessment. For example, local authorities have a duty under section 8 of the DP(SCR)A 1986 to take into account the ability of a carer to continue to provide care in deciding whether a person's needs call for the provision of

³¹ C Glendinning and others, *Evaluation of the Individual Budgets Pilot Programme: Final Report* (2008) p 147.

³² H Woolf and others, *De Smith's Judicial Review* (6th ed 2007) para 5-139 citing J Willis "Delegatus non potest delegare" (1943) 21 *Canadian Bar Review* 257, 259.

³³ See NHS Act 2006, s 75 and NHS (Wales) Act 2006, s 33.

³⁴ Department of Health, *Prioritising Need in the Context of Putting People First: Guidance on Eligibility Criteria for Adult Social Care (Consultation Stage)* (2009) para 66.

services; a pure self-assessment completed by the service user may fail to highlight these issues.

Allowing for “pure” self-assessment

- 4.42 While the majority of self-assessments in practice appear to be co-produced and thus lawful, there may still be some that are “pure”, in the sense that the self-assessment is not co-produced or subject to review by the local authority. For example, it was reported that pure self-assessment was used in four of the 13 individual budget pilot sites.³⁵
- 4.43 As set out above, relying on a pure self-assessment would be unlawful. However, it may be the case that the ability to undertake a pure self-assessment might be appropriate for some people, albeit a small number, and should be facilitated in the legal framework. For example, some people may feel that asking for help from social services is stigmatising and a sign of personal failure, or they may not want the inconvenience of dealing with a large bureaucracy or the perceived intrusiveness of having a full assessment.³⁶ For such people, a pure self-assessment may be preferable and ensure they can access support. There may also be cost savings, particularly in cases of relatively straightforward needs, as social workers would be freed up from undertaking assessments and could spend more time on supporting service users.
- 4.44 The law could be reformed to facilitate pure self-assessment. For example, the local authority could be given a power to delegate their duty to undertake an assessment to a person who appears to have social care needs or their representative, where they thought it was appropriate. However, this would require some initial mechanism to enable the local authority to decide whether it was appropriate to delegate the assessment duty. This may, in effect, be similar to a co-produced self-assessment, as the local authority would retain oversight.
- 4.45 It is also relevant to consider whether a pure self-assessment would be an effective assessment mechanism on its own, even if it were lawful.³⁷ A pure self-assessment may not be the best way to capture all of an individual’s needs and identify risks to their independence and safety.³⁸ Research has shown that people often tailor their needs or restrict their choices at assessment according to their perception of the available budget and services on offer.³⁹

³⁵ See C Glendinning and others, *Evaluation of the Individual Budgets Pilot Programme: Final Report* (2008) p 147.

³⁶ See, for example, Commission for Social Care Inspection, *Cutting the Cake Fairly* (2008) para 3.15.

³⁷ The situations where self-assessment may not be appropriate are discussed in *Independence, Well-being and Choice* (2005) Cm 6499, para 4.13.

³⁸ See C Glendinning and others, *Evaluation of the Individual Budgets Pilot Programme: Final Report* (2008) pp 146 to 147.

³⁹ See B Hardy and others, “Dimensions of Choice in the Assessment and Care Management Process: The Views of Older People, Carers and Care Managers” (1999) *7 Health and Social Care in the Community* 483.

Provisional view

- 4.46 We consider co-produced self-assessments to be legal under the current legislation and they would remain so in our proposed statute. Consequently, it is not *legally* necessary to put self-assessments on a statutory footing in our statute. On the other hand, doing so would make it clear that they are a lawful form of assessment. We are interested in views as to whether the adult social care statute should recognise co-produced self-assessments in this way.
- 4.47 As set out above, we do not believe relying on a pure self-assessment would be lawful. We welcome views on whether pure self-assessment would be appropriate for some people and whether the ability to undertake a pure self-assessment should be accommodated in the legal framework.

Question 4-2: Should our proposed adult social care statute recognise co-produced self-assessments as a lawful form of assessment?

Question 4-3: Should our proposed adult social care statute allow for a pure self-assessment for certain people or groups of people?

THE ASSESSMENT PROCESS

Prescribing the assessment process

- 4.48 Section 47(1)(a) of the NHSCCA 1990 sets out the core duty on local authorities to undertake an assessment but goes no further in prescribing how that assessment should be carried out. However, section 47(4) vests power in the Secretary of State to give directions as to the manner in which an assessment is to be carried out, or the form it is to take.
- 4.49 The Community Care Assessment Directions 2004 have been issued under this power. They require that, in assessing the needs of a person, local authorities in England must consult the person and, where they think it appropriate, any carers, and they must take all reasonable steps to reach agreement with the person and their carers on the community care services which they are considering providing to the person. Local authorities must also provide information about the amount of the payment (if any) which the person will be liable to make in respect of the provision of community care services.⁴⁰
- 4.50 Statutory and practice guidance prescribe other elements of the assessment process, such as the initial screening process,⁴¹ the type of assessment to be undertaken⁴² and recording the results of assessment.⁴³ However, many aspects of the assessment process are not set out in directions or guidance, such as the time scale for the completion of community care assessments.

⁴⁰ See LAC(2004)24, *The Community Care Assessment Directions 2004*.

⁴¹ Department of Health, *Caring for People: Community Care in the Next Decade and Beyond: Policy Guidance* (1990) para 3.20; FACS para 30; UFSAMC para 2.23.

⁴² FACS para 34 and UFSAMC para 2.9.

⁴³ FACS para 46; UFSAMC para 2.44; Department of Health, *Caring for People: Community Care in the Next Decade and Beyond: Policy Guidance* (1990) para 3.27.

Approaches in other social welfare legislation

- 4.51 Other social welfare legislation adopts different approaches to detailing an assessment process. Rather than leaving detail in directions and guidance, the detail is placed on the face of the statute itself, or a mixture of primary and secondary legislation is used to prescribe details of the assessment process.
- 4.52 For example, section 3 of the DP(SCR)A 1986 prescribes detail of the assessment process in the statute itself (although this section has never been brought into force). The CC(DD)A 2003 and Education Act 1996 use a combination of primary and secondary legislation to set out the detail of the assessment process. A third model is the Children (Leaving Care) Act 2000, which gives the Secretary of State and Welsh Ministers power to make regulations about assessments and specifies the matters to be addressed. The regulations issued under this section then elaborate upon each of these areas.⁴⁴

Provisional view

- 4.53 There are several advantages to confining the detail of the process to directions and guidance, as in the current framework. This approach is capable of ensuring flexibility in how the duty can be exercised and allows new policies and approaches to assessment to develop. In addition, the detail can be more easily updated or amended than would be the case if it were set out in primary legislation. However, these advantages are only relevant if the process itself is clear and accessible. A particular characteristic of the current framework is that details of the assessment process are spread over multiple documents. Leaving the detail of assessments to guidance may also mean that it is seen as optional or *best practice*, even when it is set out in statutory guidance.
- 4.54 Given these disadvantages, we consider that there are strong arguments for prescribing certain requirements of the assessment process in the legislation itself. This approach is particularly important in the context of our proposed legal structure where the assessment process will play a key role in determining the overall scope of adult social care (see Part 2 (Our Approach to Law Reform)).
- 4.55 This detail could be placed on the face of the statute. For example, the content of the Community Care Assessment Directions 2004 could be placed on the face of the statute (rather than left in secondary legislation), so that the statute required explicitly the involvement of service users and their carers in the community care assessment and care planning process, and the need to agree with service users and carers on service provision. This would ensure clarity and give prominence to the requirement to involve service users and carers in the assessment process. However, it would be difficult to amend the primary legislation in order to keep up to date with changing practice.
- 4.56 Another option would be to adopt a similar approach to the Children (Leaving Care) Act 2000 and leave the core duty to assess in the statute, and provide the Secretary of State and Welsh Ministers with a duty to make regulations about assessments. The statute could then specify the kind of areas about which the regulations must make provision. Using the Children (Leaving Care) Act 2000 as an example, these could include who is to be consulted in an assessment; the

⁴⁴ See, for example, Children (Leaving Care) (England) Regulations 2001, SI 2001 No 2874.

way in which an assessment is to be carried out; who can carry out the assessment and when; the recording of the results of an assessment; and the considerations to which the local authority must have regard in carrying out an assessment.

- 4.57 This approach would have several advantages. It would ensure that our proposed adult social care statute was not laden with the detail of the assessment process. However, it would be more prescriptive than a general power to issue directions or regulations about the assessment process (as contained in section 47(4) of the NHSCCA 1990), since there would be a duty to issue regulations, and a requirement that the regulations cover certain matters. Given the centrality of the assessment process, we consider that it would be appropriate to place a duty on the Secretary of State and Welsh Ministers, rather than a power. We welcome views on what matters the statute should require the regulations to cover, perhaps adapting those in the Children (Leaving Care) Act 2000.

Provisional Proposal 4-3: We provisionally propose that our future adult social care statute should place a duty on the Secretary of State and Welsh Ministers to make regulations which prescribe details of the assessment process. The statute should specify the areas which these regulations must cover.

URGENT SERVICE PROVISION

- 4.58 Section 47(5) of the NHSCCA 1990 allows a local authority to provide temporary community care services without having undertaken an assessment where in the opinion of the authority the person requires those services as a matter of urgency. Subsection 47(6) provides that if, by virtue of subsection (5), services have been provided temporarily, then as soon as practicable thereafter an assessment of the person's needs must be made in accordance with section 47(1).
- 4.59 This approach is supported by FACS and UFSAMC, both of which specify that local authorities should provide an immediate response to individuals who approach them or are referred for social care support in emergencies. After the initial response, however, "they should inform the individual that a fuller assessment will follow, and services may be withdrawn or changed as a result".⁴⁵ As noted in Part 12 (Safeguarding Adults at Risk), this provision can be an important element of safeguarding adults who are at risk of abuse and neglect.

Provisional view

- 4.60 We believe section 47(5) and 47(6) of the NHSCCA 1990 should be retained in our proposed adult social care statute. In our view, this power provides a useful mechanism to deal with situations of crisis or emergency. However, we welcome views on how often it is used and whether it is a useful provision in practice.

Provisional Proposal 4-4: We provisionally propose that local authorities should retain the ability to provide temporary services in urgent cases.

⁴⁵ FACS para 69. See also UFSAMC para 5.36.

PART 5

CARERS' ASSESSMENTS

- 5.1 This Part examines the current legal framework for carers' assessments and considers how it could be expressed in our future adult social care statute.

CURRENT LEGAL FRAMEWORK

- 5.2 The legislative framework for carers' assessments epitomises the piecemeal and complex nature of community care law. First there is the C(RS)A 1995, which provides carers with the right to request an assessment *if* the carer provides or intends to provide a substantial amount of care on a regular basis to the cared-for person *and* the local authority is carrying out an assessment of that cared-for person under section 47(1)(a) of the NHSCCA 1990. The resulting carer's assessment is of the carer's ability to provide and to continue to provide care to the cared-for person, and the local authority must take the results of the carer's assessment into account when deciding whether to provide services to the cared-for person. The C(RS)A 1995 applies to all carers regardless of their age, but carers are only entitled to a carer's assessment if the person they are caring for is being assessed under the NHSCCA 1990. If the cared-for person refuses an assessment under the NHSCCA 1990, a carer will not be entitled to request a carer's assessment under the C(RS)A 1995.
- 5.3 This limitation of the C(RS)A 1995 was addressed in the CDCA 2000, which introduced a free-standing right to a carer's assessment which did not depend on the cared-for person having a community care assessment under the NHSCCA 1990. The Act states that if a carer provides a substantial amount of care on a regular basis to the cared-for person and the local authority is satisfied that the cared-for person is someone for whom it "may provide" community care services, then the carer is entitled to request an assessment. This applies even if the cared-for person has refused an assessment under the NHSCCA 1990. The purpose of the assessment is also different to that under the C(RS)A 1995, as it is to decide whether to provide services to the carer, rather than whether to provide services to the cared-for person. However, while the CDCA 2000 may seem wider than the C(RS)A 1995, it only extends the right to a free-standing assessment and the possibility of services to carers aged 16 and above.
- 5.4 Both the C(RS)A 1995 and CDCA 2000 operate alongside each other, and both were amended by the C(EO)A 2004. As a result of these amendments, local authorities are under a duty to inform carers of their right to request a carer's assessment where the authority believes the carer may be entitled to an assessment under either the C(RS)A 1995 or the CDCA 2000. The C(EO)A 2004 also amended the C(RS)A 1995 and CDCA 2000 by introducing a requirement that any assessment conducted must include consideration of whether the carer works or wishes to work, and is undertaking, or wishes to undertake, education, training or any leisure activity.
- 5.5 In addition to these specific statutes on carers' assessments, there is the DP(SCR)A 1986. This Act requires local authorities to have regard to the ability of a carer to "continue to provide substantial care on a regular basis" to a disabled person when assessing whether the disabled person's needs call for the

provision of services. While not as substantial as a right to an assessment, it obliges a local authority to take account of a carer's ability to care, even if the carer has not made a request for, or has declined, an assessment under the C(RS)A 1995 or the CDCA 2000. This may apply, for example, if a person lacked capacity to make a request.

- 5.6 Operating alongside these statutes are the Community Care Assessment Directions 2004. These Directions require that local authorities in England include carers, where appropriate, in the assessment and care planning process for the cared-for person. This applies to all carers, and not just those providing substantial care on a regular basis.
- 5.7 While the above legislation applies in Wales, the National Assembly for Wales (Legislative Competence) (Social Welfare) Order 2009 extended the legislative competence of the National Assembly for Wales to include "supporting the provision of care by carers and promoting the well-being of carers".¹ In putting forward the Legislative Competence Order, the Welsh Assembly Government pointed to gaps in service provision for carers that cannot be addressed in the current legal framework, including concerns that carers' assessments and services for carers "vary greatly and are very patchy across Wales".² In January 2010, the Welsh Assembly Government introduced the proposed Carers Strategy (Wales) Measure 2010, which will allow Welsh Ministers to set out, in subordinate legislation, requirements on NHS and local authorities to prepare, publish and implement joint strategies in relation to carers.

Provisional view

- 5.8 The current legal framework for carers' assessments is fragmented, multi-layered and internally inconsistent. There are three different statutes that deal with carers, which must be read in conjunction with each other. The C(RS)A 1995 and the CDCA 2000 create duties to undertake a carer's assessment but in different circumstances and with a different purpose. The DP(SCR)A 1986 operates in parallel and requires local authorities to undertake similar, but not identical, considerations of the carer's role.
- 5.9 We believe that this fragmentation of the duty to assess carers across three statutes creates unnecessary complexity and confusion for those trying to navigate the system. We have provisionally proposed earlier that there be a single adult social care statute for England and Wales. We believe that this statute should set out a single duty to assess a carer, consolidating the requirements of the C(RS)A 1995 and CDCA 2000 (including the amendments made by the C(EO)A 2004) in one place. A local authority would have a duty to carry out an assessment of the carer's ability to provide and to continue to provide care for the person cared for, taking into consideration whether the carer works or wishes to work, or is undertaking, or wishes to undertake, education, training or any leisure activity.

¹ National Assembly for Wales (Legislative Competence) (Social Welfare) Order 2009, WSI 2009 No 3010.

² Memorandum from the Deputy Minister for Health and Social Services: Proposal for a Legislative Competence Order Relating to Carers (2008) paras 12 to 13.

- 5.10 Adopting the approach of the CDCA 2000, the duty to assess a carer would be a stand alone duty and would not depend on the cared-for person being concurrently assessed. It would require only that the local authority be satisfied that the person cared for is someone for whom it *may* provide or arrange for the provision of community care services. The carer's assessment would need to be taken into account in deciding whether the cared-for person's needs call for the provision of community care services and in deciding whether the carer's needs call for the provision of carers' services.³

Provisional Proposal 5-1: We provisionally propose that there should be a duty to undertake a carer's assessment in our future adult social care statute.

TRIGGERING THE DUTY TO ASSESS

- 5.11 Under the current legal framework, the duty to assess a carer is triggered when the carer provides a substantial amount of care on a regular basis and requests an assessment. Each aspect of the trigger is discussed in turn.

The substantial and regular test

- 5.12 In order to qualify for a carer's assessment, the DP(SCR)A 1986, C(RS)A 1995 and CDCA 2000 all require that the carer must be providing (or intending to provide) *a substantial amount of care on a regular basis*. This expression is not defined. However, statutory guidance issued by the Department of Health provides that deciding whether care is substantial and regular is based on a consideration of two dimensions: "key factors relevant to sustaining the chosen caring role, [and the] extent of the risk to the sustainability of that role". The guidance explains that any judgement "should recognise that it is not only the time spent caring that has an impact on carers". A caring role may be substantial and regular where the carer has "responsibilities that are not necessarily based on physical tasks and the caring role may be sporadic or preventative in nature". Evaluating a caring role should also consider whether it conflicts with other family responsibilities, such as parenting or holding down a job.⁴
- 5.13 While statutory guidance sets out factors that should be considered, leaving the term undefined in legislation means it is "for local authorities to establish and practitioners to interpret".⁵ In our review of the information provided on some local authority websites, we found that local authorities interpret the term in a variety of ways. Some equate *substantial and regular care* with the provision of particular types of support, such as practical and personal support. Others define it in terms of hours per week, ranging from 10 to 20 hours per week in different local authorities. Other local authorities do not specifically define the term at all.
- 5.14 The difference in interpretation may arise in part because the guidance is often hard to reconcile with an ordinary understanding of what *substantial and regular care* means. If taken at face value, the statutory language of "a substantial

³ Eligibility for carers' services is discussed separately in Part 6.

⁴ Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) paras 48 to 49.

⁵ D Seddon and others, "In Their Own Right: Translating the Policy of Carer Assessment into Practice" (2007) 37 *British Journal of Social Work* 1335, 1343.

amount of care on a regular basis” would appear to suggest a focus on when and how much care is being provided. However, as noted above, the guidance makes it clear that it is the overall impact of caring that should be considered. Similarly, while the statutes require that the care be provided regularly, the guidance provides that the care may be sporadic.⁶ While the more expansive interpretation provided in the statutory guidance may be a welcome development for many carers, it is difficult to justify from the language of the statute itself.

The operation of the substantial and regular test

- 5.15 The differences in how *substantial and regular* are interpreted suggest that the test does not provide a clear and consistent gateway to carers’ assessments. A carer may satisfy the interpretation of substantial and regular in one local authority, but not another. This inconsistency may be regarded as particularly problematic given that it is a test of whether a carer can request an assessment, not eligibility for services. It is also complex, requiring local authorities to ascertain the impact of caring on a person’s life *before* undertaking an assessment – an issue which might be more reasonably thought of as the purpose of the assessment itself. Indeed, the practice guidance on carers’ assessments recognises that, in some instances, the only way to ascertain whether a carer is providing substantial and regular care is to carry out an assessment.⁷
- 5.16 One way to introduce greater clarity and consistency could be to prescribe in legislation how substantial and regular should be interpreted. This is the approach adopted in section 70 of the Social Security Contributions and Benefits Act 1992, which requires that the carer must be “regularly and substantially engaged in caring” for a relevant person in order to qualify for carers allowance. However, unlike the carers’ assessment legislation, this Act gives the Secretary of State a power to prescribe in regulations what this term means. The definition prescribed is that the carer is, or is likely to be, “engaged and regularly engaged for at least 35 hours a week in caring for that severely disabled person”.⁸
- 5.17 Leaving aside the actual number of hours set here (which, while perhaps appropriate for a welfare benefit, would not be as a threshold for assessment), it would of course be possible to set a certain, lesser, number of hours a week as the test for a carer’s assessment. Doing so would ensure consistent practice. But it would contradict the intention of the statutory guidance and may be seen as a crude measure to differentiate between the many different types and variations of caring relationships at play (quite apart from creating its own problems – would, for instance, time spent monitoring a person while they sleep count?).
- 5.18 In any event, it is not clear why only carers who provide a certain amount of care should be entitled to an assessment, rather than the amount and impact of caring being a relevant consideration in deciding whether to provide services. It is interesting to compare the threshold for carers’ assessments against the

⁶ Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 49.

⁷ Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) paras 54 and 56.

⁸ See Social Security (Carers Allowance) Regulations 1976, SI 1976 No 409, reg 4.

threshold for triggering a community care assessment. A local authority must undertake a community care assessment when it appears to the local authority that a person may be in need of community care services. They must set a low threshold for this test and once accepted for assessment, the depth and breadth of that assessment should be proportionate to the individual's needs and circumstances.⁹ If the person's needs are eligible, then they will be entitled to have those needs met with services. In comparison, carers have to meet a high threshold in order to access an assessment of their ability to sustain their caring role. This is the case even though a carer's assessment will not necessarily lead to services, as services to carers are at the discretion of local authorities.

Provisional view

- 5.19 On balance, we do not, provisionally, consider that the substantial and regular test performs a useful function as a gateway to carers' assessments. We provisionally prefer the alternative: a carer's assessment should be available for all carers who are providing care (subject to the second element of the trigger, discussed below). The term carers can be left undefined, except for the existing exclusions of employed or volunteer care workers (which are discussed below).
- 5.20 Removing the substantial and regular threshold should simplify and streamline the process by which an assessment is triggered and make the availability of carers' assessments more consistent across local authorities. Rather than spending time on the initial question of whether a carer is providing substantial and regular care and thus is eligible for an assessment, local authorities could proceed straight to an assessment. The overall impact of caring would be part of evaluating the sustainability of the caring role, rather than acting as a gateway into the assessment itself.
- 5.21 While on its face this approach appears to widen the potential recipients of a carer's assessment to all carers who are providing care, it reflects the current best practice recommended by the Department of Health. For example, the Department recommends that local authorities "may wish to have a policy of offering carers an initial assessment in circumstances where the carer is providing support to a community care service-user".¹⁰ This initial assessment can help "establish the degree of impact of the caring responsibility on the carer, and whether a full carer's assessment is required".¹¹ Thus whether the local authority need go on to undertake a fuller assessment would be determined by the scale of needs presented by the carer. This is consistent with a local authority's duty to assess people in need under section 47(1) of the NHSCCA 1990. It may also help facilitate a more preventative approach, allowing local authorities to support carers' needs from an early stage (that is, not just at the point where they are providing substantial amounts of care), which may help

⁹ FACS paras 30 and 34.

¹⁰ Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) para 49. See also LAC(2004)24, *The Community Care Assessment Directions 2004*, para 2.2.

¹¹ Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) para 54.

reduce the need for more intensive services for both the carer and cared-for person at a later date.¹²

Provisional Proposal 5-2: We provisionally propose that the duty to assess a carer should apply to all carers who are providing or intend to provide care to another person, not just those providing a substantial amount of care on a regular basis.

Assessment on request

- 5.22 In addition to requiring that a carer be providing, or intending to provide, a substantial amount of care on a regular basis, the C(RS)A 1995 and CDCA 2000 require that the carer must request the local authority to undertake the assessment in order to trigger the duty to assess. Giving carers a legal right to request an assessment was seen as an important mechanism to ensure that carers were able to access their own assessment, when they wanted one.¹³ However, relying on a request to trigger an assessment is different to the approach taken for community care assessments, which are triggered by the appearance of need for community care services.
- 5.23 Relying on a request to trigger the duty to undertake a carer's assessment requires the carer to know they have the right to make the request. While this should be addressed by the amendments introduced by the C(EO)A 2004, which require that carers are informed of their right to ask for an assessment, research still finds that a key problem for carers is lack of information, including in relation to assessments.¹⁴ Relying on a request also requires the carer to initiate the assessment process. This may deter many carers, particularly in circumstances where they may be reluctant to ask for help for fear of seeming disloyal, or where they do not see themselves as a carer or as having needs. Others may be reluctant to request an assessment because they are concerned that it will trigger contact with other services, such as child protection services. Requiring a request may also exclude carers who do not have capacity to make the request.
- 5.24 Another problem with the request mechanism is that it is not necessarily clear what constitutes a request. In one case, the court found that a letter to a local authority requesting a full enquiry into a carer's needs, but which did not mention the C(RS)A 1995, was "insufficiently specific to amount to a request under section 1 of the 1995 Act".¹⁵ This in part illustrates another problem, which is that the whole process seems to be overly bureaucratic.¹⁶ Technically, the law requires a local authority to inform carers of their right to request an assessment (having satisfied itself that the carer is providing substantial and regular care) and

¹² The importance of early intervention for carers was recognised in Department of Health Social Services Inspectorate, *Carers (Recognition and Services) Act 1995: Practice Guide* (1996) para 9.6, <http://www.carersnet.org.uk/documents/documents.html> (last visited 4 February 2010).

¹³ See, for example, *Hansard* (HL), 17 May 1995, vol 564, col 628.

¹⁴ S Yeandle and others, *Stages and Transitions in the Experience of Caring: Report No 1* (2007).

¹⁵ *R (AB) v Nottingham City Council* [2001] EWHC 235 (Admin), (2001) 4 CCLR 295 at [51].

¹⁶ This was recognised in National Assembly for Wales, *Practitioners Guide to Carers' Assessment: Carers and Disabled Children Act 2000* (2001) para 4.1.3.

then requires the carer to make the request for an assessment, in order to trigger the assessment process.

Provisional view

- 5.25 The request mechanism seems to add an unnecessary bureaucratic hurdle in order to receive a carer's assessment. We provisionally consider that a local authority should be required to undertake a carer's assessment where the person appears to have needs that can be met by the provision of carers' services or by the provision of services to the cared-for person. Taken with the proposal above – that carers' assessments be available for all carers who are providing care to another person – this proposal would give local authorities greater flexibility to respond to carers' needs.
- 5.26 Furthermore, the request mechanism may operate to ensure that a local authority can only undertake a carer's assessment of those people who agree to such an assessment. A duty to assess based on appearance of need could be triggered in some circumstances where the carer does not actively consent. We consider that this could be an important legal safeguard where, for example, the carer lacks capacity to make a request or where there are safeguarding concerns. We welcome further views on this point.
- 5.27 While a trigger based on the appearance of need would remove the requirement for carers to request an assessment, it would not prevent carers from asking for an assessment; indeed a request for an assessment may be taken as evidence of an appearance of need.
- 5.28 We recognise that one difficulty with a trigger based on the appearance of need is that it may not cover a carer who is intending to start providing care and will have needs for services upon doing so, but has not yet started caring. This situation may arise, for example, where the carer is about to leave their employment to start caring full time. Currently, such carers are still entitled to request an assessment under the C(RS)A 1995 and CDCA 2000. In order to ensure that carers who are intending to provide care continue to have rights to an assessment under our proposed adult social care statute, we consider that our proposed statute should specify that an assessment should be undertaken where the carer appears to have, *or will have upon commencing the caring role*, needs that could be met either by the provision of carers' services or by the provision of services to the cared-for person.
- 5.29 In making this provisional proposal we do not wish to dilute the existing rights of carers. It may be that having the right to ask for an assessment is considered a more powerful or concrete right than a trigger based on the appearance of need. Alternatively, it might be considered that having both triggers – the appearance of need and a right to have an assessment on request – would be desirable. We welcome views on these points.

Provisional Proposal 5-3: We provisionally propose that the duty to assess a carer should not be triggered by the carer making a request, but should be triggered where a carer appears to have, or will have upon commencing the caring role, needs that could be met either by the provision of carers' services or by the provision of services to the cared-for person.

Exceptions to the definition of a carer

- 5.30 The C(RS)A 1995 and CDCA 2000 exclude from the definition of a carer someone who provides or will provide the care in question by virtue of a contract of employment or other contract with any person, or as a volunteer for a voluntary organisation. Similarly, the DP(SCR)A 1986 excludes persons employed to provide care by any body in the exercise of its functions under any enactment. These exclusions are sometimes described in terms of the distinction between an *informal* or unpaid carer and a paid or volunteer care worker.
- 5.31 One issue that has arisen since the introduction of direct payments and personal budgets¹⁷ is whether a carer who had previously performed their role on an unpaid basis but is now paid for the care they provide through the cared-for person's direct payment would still qualify as an unpaid carer. It might be argued that they fall into the above exclusions because they are being employed or paid by the service user for some or all of the care they are providing. Alternatively, it might be argued that any care to which a direct payment related would be disregarded when considering whether or not the carer is providing substantial and regular care. This issue has important ramifications for unpaid carers because if receipt of payment from the cared-for person's direct payment means the receiving person falls outside the definition of a carer, then they would not be entitled to an assessment or to services in their own right.¹⁸ This could mean, for example, that their employment needs, or education and leisure needs are not met. Alternatively the carer might want their care arrangements reviewed but would legally not be in a position to request an assessment.

Provisional view

- 5.32 We consider that under the existing legal framework, it could be unlawful to adopt a blanket policy of excluding all unpaid carers who receive payment for their services (through direct payments received by the cared-for person) from the definition of a carer, without allowing for consideration of special circumstances or exceptional cases. In our view, this is likely to amount to an unlawful fettering of the local authority's discretion.¹⁹ At the most, any care to which a direct payment relates should be disregarded when considering whether or not the carer is providing substantial and regular care. However, any other care that is being provided by the carer, which is not covered by the payment, should be taken into account.
- 5.33 The effect of this interpretation is that many carers will find it difficult (and many will find it impossible) to qualify as a carer if they are paid for the services they provide through the cared-for person's direct payment. A previously unpaid carer will be excluded from a carer's assessment if they do not provide any (or enough) additional care above that to which the payment relates. This would apply even if the test of substantial and regular care was removed.
- 5.34 On one hand, this may not be viewed as a problem. One of the advantages cited for paying carers is that this recognises the important role played by the carer

¹⁷ Direct payments are discussed in Part 10 and personal budgets are discussed in Part 6.

¹⁸ This issue was noted in C Glendinning and others, *The Individual Budgets Pilot Projects: Impact and Outcomes for Carers* (2009) p 42.

¹⁹ See *R v Port of London Authority ex p Kynoch* [1919] 1 KB 176, 184 by Bankes LJ.

and rewards it accordingly.²⁰ On the other hand, it would treat previously unpaid carers in the same way as volunteer or paid care workers, even though they are often in very different situations which will call for different treatment. The underlying relationship between an unpaid carer and the cared-for person is not based on a contract of employment but on deeper emotional ties, whether as family or friends. This underlying relationship is unlikely to change because the previously unpaid carer is now receiving payment for the care provided. In other words, the receipt of money will not necessarily *professionalise* a carer such that they are akin to a paid or volunteer care worker.

- 5.35 Consequently, there are likely to be different obligations and dynamics at play in the relationship between a cared-for person and their previously unpaid (and now paid) carer. For example, a previously unpaid carer, particularly where they live with the cared-for person, may not feel they can reduce or cease their caring role. Even if they did want to reduce their caring role, there would be no ability for the carer to request an assessment of the sustainability of the caring role; at best, the carer may be able to request a re-assessment of the cared-for person. Further, a caring role may not be any more sustainable if a carer was paid for some hours of care but not all because “the carer would still have all the caring responsibilities and might prefer to have a break rather than to be paid”.²¹ In these circumstances, it is likely that a previously unpaid carer would benefit from being able to access an assessment of the sustainability of the caring role.
- 5.36 Of course, there may be some grey areas where a receipt of payment does professionalise a carer so that they are like a paid care worker. However, we believe the best approach to this difficult situation is not automatically to exclude previously unpaid carers from a carer’s assessment. Similarly, a carer who is paid for some but not all of the care they provide should not be excluded, nor should a carer where the local authority believes the caring relationship is not principally a commercial one. We believe this approach offers more clarity about the eligibility of carers for assessment, and also gives local authorities flexibility to support carers where they believe that the primary foundation of the caring relationship is not commercial or as a volunteer from a voluntary organisation.

Provisional Proposal 5-4: We provisionally propose that our future adult social care statute provides that the following carers are not excluded from the definition of a carer for the purposes of a carer’s assessment: (1) a previously unpaid carer who now receives payment for their services through direct payments received by the cared-for person; (2) a carer who is paid for some but not all of the care they provide; and (3) a carer where the local authority believes the caring relationship is not principally a commercial one.

Young carers and parent carers

- 5.37 The discussion above relates to carers aged 18 years and above who are caring for people aged 18 years and above. The particular position of young carers and parent carers is discussed in Part 11 (Joint Working).

²⁰ See C Glendinning and others, *The Individual Budgets Pilot Projects: Impact and Outcomes for Carers* (2009) p 42.

²¹ C Glendinning and others, *The Individual Budgets Pilot Projects: Impact and Outcomes for Carers* (2009) p 43.

ENCOURAGING A UNIFIED ASSESSMENT PROCESS

- 5.38 The effect of the above proposals, taken with our proposals in Part 4 (Community Care Assessments), is that our future adult social care statute would set out two assessment duties. A local authority would have a duty to undertake a community care assessment where a person appeared to the local authority to have social care needs that can be met with the provision of community care services, and where the local authority has the legal power to provide or arrange for the provision of community care services to that person. It would also have a duty to undertake a carer's assessment where a carer was providing or intending to provide care to a person and the carer appeared to have, or will have on commencing the caring role, needs that can be met with the provision of carers' services or services to the cared-for person. Each type of assessment would have its own distinct focus. A community care assessment would focus on the person's social care needs and the outcomes they wish to achieve. The focus of a carer's assessment would be the carer's ability to provide and to continue to provide care to the cared-for person.
- 5.39 Our proposals would streamline the existing law and bring the two types of assessments together in one statute. In itself, this should help reduce the complexity of the current law, where the duties to assess service users and carers are spread over a number of different statutes. However, our proposed statute could go further than this, and encourage, where appropriate, a more integrated approach to community care and carers' assessments. In many cases there will be advantages for ensuring a unified process for assessments, especially where the carer's needs would best be met by the provision of services to the cared-for person. This would be consistent with practice guidance issued by the Department of Health, which provides that carers' assessments:
- should be seen as part of a holistic assessment of the needs for support of the cared for person and the carer, identifying the outcomes desired by both and it should be reflected in the care plan (where it is appropriate for cared for person and carer's issues to be dealt with together) or in a separately held carer's plan (where there is a need for confidentiality).²²
- 5.40 There are several ways in which our proposed statute could encourage a more unified assessment process. In Part 4, we proposed that the Secretary of State and Welsh Ministers should have a duty to make regulations which prescribe details of the assessment process, with the statute specifying the areas which these regulations must cover.²³ These regulations could require that the results of the carer's and cared-for person's assessments should inform each other and that the family's situation as a whole should be considered. They could also require that where appropriate the same assessor or team should undertake the community care and carer's assessment. Furthermore, the regulations could prescribe a common form for carers' assessments, which directed those undertaking the assessment to consider whether the carer also has needs for

²² Department of Health, *A Practitioner's Guide to Carers' Assessments under the Carers and Disabled Children Act 2000* (2001) para 30.

²³ These are the matters specified in the Children (Leaving Care) Act 2000.

community care services. We welcome further views on how a more unified assessment for carers and cared-for people could be encouraged.

- 5.41 However, a unified assessment process may not be appropriate in all cases; for example, where there is a difference of opinion between the carer or the cared-for person, or where the carer wants an assessment completed by a person independent of the team responsible for the cared-for person (such as where the carer is not happy with the services provided or lack of service provision to the cared-for person). Therefore, a regulation-making power would need to be flexible to take into account these circumstances. Furthermore, it would not be desirable for a statutory carer's assessment form to duplicate unnecessarily any existing legal assessment forms, such as the Single Assessment Process for older people and the Care Programme Approach for those under specialist mental health care.²⁴
- 5.42 A unified process for assessment could also be facilitated through duties of co-operation in cases where the carer and cared-for person live in different local authority areas. In Part 11 (Joint Working), we propose that there be an enhanced duty to co-operate, whereby a local authority can request another body to assist in the assessment or service provision process, and the requested body must give due consideration to the request. This duty of co-operation could be used to encourage a more unified assessment process for both carers and cared-for people. For example, where a local authority is assessing a carer who lives in a different authority and appears to have broader needs (such as where the carer is also disabled), it could notify the carer's local authority and request assistance or even a joint assessment.
- 5.43 We welcome views on whether legislation should encourage a unified assessment process where appropriate or whether this is a matter best left to practice guidance.

Question 5-1: Should our proposed adult social care statute encourage a more unified assessment process for carers and cared-for people?

MERGED ASSESSMENT DUTY

- 5.44 The proposals discussed above are aimed at encouraging a more unified carers' and community care assessment process. A more radical option for reform that we noted in the scoping report would be to remove the distinction between carers and cared-for people in law, and have the statute focus simply on people with social care needs.²⁵ This would mean there was a merged duty to assess a person who appeared to be in need of community care services or carers' services and the assessment would focus on the person's social care needs and the outcomes they wish to achieve (referred to as a *merged assessment duty*).
- 5.45 One of the advantages of a merged assessment duty is that it would encourage a broader assessment of a carer's needs than is currently the case. Rather than

²⁴ See Department of Health, *Single Assessment Process: Guidance for Local Implementation* (2002) and Department of Health, *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* (2008).

²⁵ Law Commission, *Adult Social Care: Scoping Report* (2008) para 4.71.

focusing on the sustainability of the caring role, the assessment would focus on the person's needs, irrespective of the source of those needs. This would not mean that the caring role was irrelevant. In cases where the caring role is the main source of the person's needs, it would remain the focus of the assessment. In other cases, the caring role would be considered alongside other needs. The broader focus of a merged assessment duty is therefore able to deal holistically with a carer who, for example, has community care needs in their own right. Under the current system, the local authority would have to carry out a community care assessment under section 47(1)(a) of the NHSCCA 1990 to address those needs, in addition to the carer's assessment.²⁶

- 5.46 One disadvantage is that a merged assessment duty may not be seen as offering appropriate recognition of the caring role. The availability of a separate assessment duty gives carers a clear legal status and provides, of itself, general acknowledgement of the distinct contribution made by unpaid carers in the delivery of community care services.²⁷ Although a merged assessment duty may offer a broader assessment of a carer's needs, it may be seen as removing this clear legal status. However, one of the criticisms made of the existing legal framework for carers' assessments is the assumption that the carer is willing to continue to provide care.²⁸ A merged assessment duty may help ensure that professionals avoid making this assumption.
- 5.47 Two other consequences of a merged assessment duty should also be noted. The first is that as a merged assessment duty depends on there being no distinction between a service user and carer, all people with social care needs would be subject to the same eligibility framework and would be able to establish rights to services if they had eligible needs. It would be inconsistent with a merged assessment duty to separate carers and service users following assessment for the purposes of applying different eligibility criteria.
- 5.48 The second issue which arises out of a merged assessment duty is the operation of the ordinary residence rules to determine which authority has the power to assess carers and provide services. Currently the ordinary residence rules do not apply to carers' services and instead the system depends on the identification of a person as a *carer*, with the responsibility to assess and the power to provide services to a carer falling on the local authority in which the cared-for person is ordinarily resident.
- 5.49 Adopting a merged assessment duty would mean that the ordinary residence rules would apply to all services, including carers' services, since there would be no distinction between carers and service users. This raises no problems where the carer and cared-for person live in the same local authority. However, the question arises how the ordinary residence rules would operate for a person who is in reality a carer (but who, under a merged assessment duty, is identified only as a person in need) and who lives in a different local authority area than the

²⁶ Department of Health Social Services Inspectorate, *Carers (Recognition and Services) Act 1995: Policy Guidance* (1996) para 17, <http://www.carersnet.org.uk/documents/documents.html> (last visited 4 February 2010).

²⁷ B Gillies, "Acting Up: Role Ambiguity and the Legal Recognition of Carers", (2000) 20 *Ageing and Society* 429, 429.

²⁸ J Harris "Caring for Citizenship" (2002) 32 *British Journal of Social Work* 267, 272.

person they care for. How would responsibility be allocated to the cared-for person's local authority if the carer is not in fact identified as a carer?

- 5.50 One way to address this issue would be to provide that the local authority in which the carer is living is responsible for providing services to the carer. However, we cannot see how this could work effectively in practice. For example, a carer may often need services to be provided to the cared-for person and in such cases the carer's local authority would need to liaise with the cared-for person's local authority to ensure the services are delivered. In many cases it may be undesirable to have different authorities with different social workers dealing with two individuals as though they are not linked. At the very minimum, it would call for strong co-operation between authorities and may also require re-assessment. Furthermore, making the carer's local authority responsible for assessing and providing services to the carer undermines the principle that the local authority which benefits from the informal care being provided by the carer (that is, the cared-for person's local authority) should be responsible for providing carers' services.
- 5.51 Alternatively, it would be possible to give a person the opportunity to identify themselves as a carer at some point during the assessment, upon which the responsibility for their assessment and service provision would be given to the cared-for person's local authority. But if this approach were adopted, it is difficult to see what advantage accrued from the merged assessment duty; the very existence of a mechanism to identify a carer undermines the point of having a merged duty. Another possibility might be to allow the carer and cared-for person to declare themselves to have *associated care needs* (without identifying one as carer and the other as cared-for). This, however, raises the question about which local authority they should be allocated to. If the individual concerned were able to choose, it may unfairly increase the burden on the more generous authority.
- 5.52 For these reasons, while we recognise that a merged assessment duty may be considered desirable, we do not see it as being practicable. However, we welcome views on this issue.

Question 5-2: Do you think the carers' assessment duty should be merged with the community care assessment duty in our proposed adult social care statute?

PART 6

ELIGIBILITY FOR SERVICES

- 6.1 This Part examines the issue of eligibility for community care and carers' services. It does not discuss the duties to provide services in section 21 of the NAA 1948 and section 2(1) of the CSDPA 1970, which are discussed in Part 7.

ELIGIBILITY FOR SERVICES AND SECTION 47(1)(B) OF THE NHSCCA 1990

- 6.2 Once a local authority has carried out an assessment of a person's needs under section 47(1)(a) of the NHSCCA 1990, section 47(1)(b) requires that the local authority, having regard to the results of that assessment, shall then decide whether the person's needs call for the provision by them of any community care services.
- 6.3 The language of section 47(1)(b) suggests that local authorities have both a duty and discretion when deciding whether a person's needs call for the provision of services: a duty arises to make a decision about the provision of services, but a discretion is given to decide whether or not the person's needs call for the provision of services.
- 6.4 On its face, section 47(1)(b) does not explain *how* a local authority is meant to decide whether a person's needs call for the provision of services. However, FACS and UFSAMC have been issued to help local authorities make this decision. Although they differ in detail and emphasis, both FACS and UFSAMC essentially establish the same overall standardised framework for setting eligibility criteria for community care services.

The eligibility framework

- 6.5 The premise of FACS and UFSAMC is to provide individual local authorities with a tool to decide whether a person's needs call for the provision of services. In order to make this decision, the statutory guidance sets out an eligibility framework which is "based on the impact of needs on factors that are key to maintaining an individual's independence over time".¹ Both FACS and UFSAMC grade the eligibility framework into four bands: critical; substantial; moderate; and low. Each band includes a number of descriptors or risk factors, which describe the "seriousness of the risk to independence or other consequences if needs are not addressed".² Local authorities may add additional risk factors within a band but they cannot delete or amend the wording of the eligibility framework.³ Although all social services authorities must use this framework, each authority has discretion to decide which of the four bands it will provide services to meet. This is known as the local authority's *eligibility criteria*.
- 6.6 In deciding which bands it will include in its eligibility criteria, FACS and UFSAMC state that the local authority can take account of its resources, local expectations

¹ FACS para 15 and UFSAMC para 5.8.

² FACS para 16 and UFSAMC para 5.15.

³ Department of Health, *Fair Access to Care Services: Practice Guidance* (2003) Q 3.1.

and local costs.⁴ However, resources cannot be the sole factor in deciding which of the bands to include in its eligibility criteria. A local authority must have regard to the Human Rights Act 1998 and Disability Discrimination Act 1995, amongst others, when determining which bands to include in its eligibility criteria.⁵

The legal duty to meet eligible needs

- 6.7 The process of determining a person's eligibility for services starts with a community care assessment, which assesses a person's "presenting needs".⁶ The needs are evaluated against the risks to the person's autonomy, health and safety, ability to manage daily routines, and involvement in family and wider community life, both in the immediate and longer-term.⁷ The identified risks to independence are then compared against the local authority's eligibility criteria; that is, the bands from the FACS and UFSAMC eligibility framework that the authority has decided to provide services to meet.⁸ If the individual's "presenting needs" fall into one or more of these bands then such needs are termed "eligible needs" and FACS and UFSAMC state that the local authority must meet those needs.⁹
- 6.8 While FACS and UFSAMC provide that local authorities have a duty to meet all eligible needs, this statement is contentious. As noted above, section 47(1)(b) of the NHSCCA 1990 requires local authorities to decide which of a person's needs call for the provision of "community care services". These services are defined in section 46(3) by reference to a list of legislation, some of which confers powers on local authorities to provide community care services whereas other provisions impose duties. The difficulty, therefore, could arise where a person has needs that meet their local authority's eligibility criteria, but their needs can only be met by services that a local authority has a power rather than a duty to provide. Do FACS and UFSAMC transform this statutory power into a duty, such that the service must be provided, or does the local authority retain discretion to provide the service? Two different interpretations arise.

FACS and UFSAMC create a duty to provide services

- 6.9 The first interpretation is that the combination of an assessment under section 47(1) of the NHSCCA 1990 and the application of FACS and UFSAMC determines a person's eligibility for community care services and also provides the legal requirement to meet eligible needs. This means that if a person is assessed and found to have an eligible need that calls for the provision of a service that a local authority has a *power* to provide, then the effect of FACS and

⁴ FACS para 18 and UFSAMC para 5.19. This reflects the ruling in *R v Gloucestershire County Council ex p Barry* [1997] AC 584.

⁵ FACS para 12 and UFSAMC paras 2.19, 5.23 and Annex 1. See also *R (Chavda) v Harrow London Borough Council* [2007] EWHC 3064 (Admin), (2008) 11 CCLR 187 at [40].

⁶ The term "presenting needs" is defined in FACS para 13.

⁷ FACS para 42 and UFSAMC paras 5.9 and 5.10. The Welsh guidance refers to evaluating the assessment domains against four key factors of independence.

⁸ FACS para 42 and UFSAMC para 5.13.

⁹ FACS para 52. Although the Welsh guidance does not include this exact statement, the point is implicit throughout. See UFSAMC paras 5.4, 5.5, 5.13 and 5.32.

UFSAMC, as statutory guidance, is to convert the discretion to provide the service into a duty.

- 6.10 The difficulty with this interpretation is that it fails to explain the purpose of the community care legislation listed in section 46(3) of the NHSCCA 1990. In effect, the legislation is being by-passed and the duties and powers established by the legislation become almost irrelevant for the purposes of deciding whether a person's needs call for the provision of services; FACS and UFSAMC are used instead. On the other hand, however, this interpretation seems to represent the general understanding of local authorities of how the community care legal system operates and is also the approach taken in FACS, which does not distinguish between the different pieces of community care legislation and states clearly that there is a duty to meet all eligible needs.¹⁰

Section 47(1)(b) as a signpost

- 6.11 The alternative interpretation is that section 47(1)(b) acts as a signpost to the legislation under which community care services are provided. Thus, section 47(1)(b) does no more than direct the local authority to their decision under the applicable power or duty. If the person satisfies the criteria for the exercise of a duty, then the duty must be exercised and the services must be provided. Similarly, if a local authority only has a power to provide a service then this will not be altered by the person being assessed as having an eligible need on the basis that they satisfy the local authority's eligibility criteria. Support for this position was expressed by Sir Anthony May in *R (Manchester City Council) v St Helens Borough Council*, although the judgment does not address the significance of FACS and UFSAMC and the central question for the court was the portability of service provision.¹¹
- 6.12 The difficulty with this interpretation is that it fails to explain the significance of the eligibility framework set out in FACS and UFSAMC and the role of statutory guidance as a whole. In effect, the statutory guidance becomes irrelevant to the decision whether needs call for the provision of services, since it is the underlying community care legislation that determines whether local authorities have a duty or a power to provide a service.

What is the correct legal interpretation?

- 6.13 On our analysis, both of these interpretations are too simplistic. The significance of FACS and UFSAMC varies according to the precise nature of the statutory provision in question. To help illustrate this point, it is useful to draw parallels between duties and powers in community care legislation and in the Children Act 1989. In *R (JL) v Islington London Borough Council*, the High Court considered the use of eligibility criteria in relation to section 20(1) of the Children Act 1989, which is an absolute duty to provide accommodation, and the target duty in section 17 of the same Act, and held that:

¹⁰ FACS para 52. See UFSAMC paras 5.4, 5.5, 5.13 and 5.32.

¹¹ [2009] EWCA Civ 1348 at [49] to [50].

The extent to which a local authority is entitled to rely upon eligibility criteria depends upon which type of statutory provision is in play. The claimants concede that where the local authority merely has a discretion to make provision, it is free to use eligibility criteria. Where a statutory duty arises, the precise nature of the duty must be identified. It may, for example, be an absolute duty to provide for a particular need of an individual child, in which case there is no room for eligibility criteria. It may, on the other hand, be a duty which is qualified in some way, for instance a duty to “take reasonable steps” to achieve a particular objective, in which case the local authority can take into account, amongst other things, its overall financial resources and can, if it wishes, introduce eligibility criteria.¹²

6.14 In the context of community care law, the obligation to take into account the eligibility criteria in FACS and UFSAMC is much stronger, as this guidance is issued under section 7(1) of the Local Authority Social Services Act 1970. As such, it must be followed by local authorities,

with liberty to deviate from it where the local authority judges, on admissible grounds, that there is good reason to do so, but without freedom to take a substantially different course.¹³

6.15 Thus, we consider that the correct legal interpretation of the legal duty to meet eligible needs is as follows:

- (1) where there is a strong individual duty which provides limited scope to take into account the availability of resources (such as section 21 of the NAA 1948), FACS and UFSAMC are almost entirely irrelevant and section 47(1)(b) acts as a signpost to the internal criteria contained in the legislation;
- (2) where there is an individual duty to provide services which gives local authorities a greater ability to have regard to resources or other factors in deciding whether to exercise the duty (such as section 2(1) of the CSDPA 1970), then FACS and UFSAMC are relevant and are the tools that must be used to interpret the statutory duty;
- (3) where there is a general duty to provide services (such as section 29 of the NAA 1948), FACS and UFSAMC can be very relevant as the means through which the duty is crystallised into an individually enforceable duty;¹⁴ and
- (4) where there is a discretionary power (such as section 45 of the HSPHA 1968), FACS and UFSAMC are central and local authorities must use the statutory guidance to decide whether to exercise their discretion and in what circumstances. If eligible needs are identified that call for the provision of services which a local authority has a power to provide, then FACS and UFSAMC effectively will turn that discretionary power into a

¹² [2009] EWHC 458 (Admin), (2009) 12 CCLR 322 at [46].

¹³ *R v Islington London Borough Council ex p Rixon* (1997-98) 1 CCLR 119, 123(J).

¹⁴ *R (Hughes) v Liverpool City Council* [2005] EWHC 428 (Admin), (2005) 8 CCLR 243.

duty, unless the local authority can establish good reason to depart from the statutory guidance.

Provisional view

- 6.16 The discussion above demonstrates the complexity that can arise when there are multiple statutes under which community care services are provided, all of which operate in parallel. This complexity is exacerbated by the imposition of an assessment and eligibility process, which while seeking to establish a common route into the provision of services, does not necessarily recognise, nor accommodate, the underlying duties and powers contained in community care legislation.
- 6.17 The current legal structure is a product of the piecemeal and inconsistent way that adult social care law has developed over the past 60 years. In our provisional view, it would be counter-productive to reproduce such confusion in our proposed adult social care statute. Instead, we consider that it would be clearer, less complex and more effective to adopt the lead of FACS and UFSAMC and make an assessment of a person's social care needs and the application of the eligibility criteria, set by a local authority in accordance with FACS and UFSAMC, the sole means by which a person's eligibility for community care services is determined. This could take the form of two duties on local authorities following an assessment:
- (1) a duty to decide whether a person's social care needs are eligible needs, using eligibility criteria; and
 - (2) a duty to meet all eligible needs with the provision of services, which is owed to and can be enforced by the individual concerned.
- 6.18 This approach is clear and straightforward and would ensure there is a single eligibility decision that applies to all services, which is easy to understand for both professionals and service users. It aligns the statute with FACS and UFSAMC, and is likely to reflect the approach currently used by local authorities.

Provisional Proposal 6-1: We provisionally propose that our future adult social care statute should place a duty on local authorities to: (1) determine whether a person's social care needs are eligible needs, using eligibility criteria; and (2) provide or arrange community care services (including a direct payment in lieu of services) to meet all eligible needs.

Defining eligibility in legislation

- 6.19 Under Provisional Proposal 6-1, the eligibility criteria would become the key means of establishing eligibility for services. Given our process-driven approach to adult social care, it would also become a key mechanism for defining the legal boundaries of adult social care services. Therefore, our provisional view is that the eligibility framework which a local authority must use to set its eligibility criteria should not be left to guidance and should instead be subject to Parliamentary scrutiny. We provisionally propose that our future adult social care statute should impose a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the eligibility framework, and in particular:

- (1) the risks to independence that may call for the provision of services. For example, this could be the four bands of risks currently used in FACS and UFSAMC; and
 - (2) the objectives that are to be achieved by the provision of services. For example, these could be the key aspects of independence identified in FACS and UFSAMC, which are “autonomy and freedom to make choices”; “health and safety including freedom from harm, abuse and neglect”; “ability to manage personal and other daily routines”; and “involvement in family and wider community life”.¹⁵
- 6.20 Our provisional view is that regulations issued in the exercise of this duty should be subject to affirmative resolution by Parliament, which would ensure Parliament is given an opportunity to approve the regulations before they are made, by considering and passing a resolution in each House approving a draft of the instrument. At this stage we provisionally propose that the duty to make regulations be included in the statute but the detail about the eligibility framework would be prescribed in regulations. However, it may be considered that the detail of the eligibility framework and the setting of the eligibility criteria are of such significance that they should be set out on the face of the statute itself. We welcome views on this issue.
- 6.21 Although we have framed the above duty using the language of FACS and UFSAMC, we consider the duty to make regulations in this area could be used to introduce a new eligibility framework that is different to FACS and UFSAMC. Our primary concern is that the regulations define the scope of adult social care by prescribing the types of needs that will call for the provision of services and the objectives that are to be achieved by the provision of services.
- 6.22 Finally, we recognise that FACS and UFSAMC contain much more detail than the eligibility framework itself, such as the process of assessment, care planning and preventative approaches, as well as the duty on local authorities to set their eligibility criteria taking account of resources, local expectations and local costs. We propose that this detail should remain in statutory guidance, which would allow for greater flexibility in amending and updating the content. However, we note that any such amendment to statutory guidance would be subject to full scrutiny and consultation, as is the usual practice for the Department of Health and Welsh Assembly Government.

Provisional Proposal 6-2: We provisionally propose that our future adult social care statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the risks to independence that will call for the provision of services and the objectives that are to be achieved by the provision of services.

POLICY DEVELOPMENTS IN ENGLAND AND WALES

- 6.23 There are a number of policy developments in relation to the eligibility framework for services. We are conscious of the need to set out proposals in the context of the direction of policy in both England and in Wales.

¹⁵ See FACS para 40 and UFSAMC para 2.36.

Prevention and re-ablement services

- 6.24 There is a policy commitment in England and Wales to the development of early intervention and prevention services, which are available regardless of whether the person is eligible for community care services. Re-ablement is defined as short term support to help people regain “the skills and confidence they may have lost through poor health, a disability or going into hospital or residential care”, so they can “get back to their normal lives” and “live independently at home for much longer”.¹⁶
- 6.25 The Department of Health and the Welsh Assembly Government have signalled an intention to provide individuals with a “right to the re-ablement help they will benefit from at home, for example for six weeks”.¹⁷ Similarly, the draft revised FACS guidance recommends that:

Before proceeding to determine eligible needs, councils should consider whether an individual might benefit from a short period of re-ablement or intermediate care to increase what they are able to do for themselves before an assessment of longer-term need is undertaken.¹⁸

Provisional view

- 6.26 If a right to re-ablement services is introduced, we consider that this should be accommodated in our proposed adult social care statute. If it was intended that the re-ablement services would not be subject to eligibility criteria, this would need to be reflected in our adult social care statute.

Provisional Proposal 6-3: If a right to re-ablement services is introduced, we provisionally propose this should be accommodated in our future adult social care statute.

National eligibility criteria

- 6.27 The 2009 Green Paper in England recognised that one of the challenges in the current system of adult social care is that “people with the same needs receive different levels of care depending on where they live”.¹⁹ This is due in part to the policy direction set by FACS and UFSAMC that each local authority should set its own eligibility criteria, having regard to local resources, local expectations and local costs.²⁰
- 6.28 In the Green Paper, the Government put forward a policy option of *national eligibility criteria* whereby the Government, rather than local authorities, would set the eligibility criteria, which would apply throughout England.²¹ If adopted, this

¹⁶ Shaping the Future of Care Together (2009) Cm 7673, p 51.

¹⁷ As above, p 51 and Welsh Assembly Government, *A Strategy for Social Services in Wales Over the Next Decade: Fulfilled Lives, Supportive Communities* (2007) p 38.

¹⁸ Department of Health, *Prioritising Need in the Context of Putting People First: Guidance on Eligibility Criteria for Adult Social Care (Consultation Stage)* (2009) para 31.

¹⁹ Shaping the Future of Care Together (2009) Cm 7673, p 42.

²⁰ FACS para 18 and UFSAMC para 5.19.

²¹ Shaping the Future of Care Together (2009) Cm 7673, p 123.

would mean that local authorities would not decide which of the four FACS bands to include in its eligibility criteria, but instead the threshold of eligibility would be set nationally and would apply to every local authority.

- 6.29 The issue of local or nationally determined eligibility for social care was also discussed in the Green Paper in Wales. The stakeholder advisory group established by the Welsh Assembly Government to consider policy options recommended that the Welsh Assembly Government establish a “national (all-Wales) system for giving support to those who need care, encompassing a clear eligibility framework and a consistent and considered assessment methodology to operate across Wales”.²² The subsequent Green Paper asks for views on whether there should be an all-Wales system for deciding who gets what levels of help, and whether the same system should apply in Wales as in England.²³

Provisional view

- 6.30 While no commitment has been given to this policy option as yet, the Government has confirmed that the direction of policy in England is towards national eligibility criteria, and there also appears to be some support for this in Wales. If implemented, we consider this significant shift in policy should be reflected and facilitated in our proposed adult social care statute. This could be achieved by extending the duty to prescribe the eligibility framework, set out in Provisional Proposal 6-2, to include prescribing the eligibility criteria itself (that is, the threshold at which eligibility is drawn). The duty we propose above to determine whether a person’s social care needs are eligible using eligibility criteria would then be linked to the national eligibility criteria.

<p>Provisional Proposal 6-4: If the eligibility criteria are to be set at a national level in England and in Wales, we provisionally propose that the eligibility criteria should be prescribed in regulations issued by the Secretary of State and Welsh Ministers respectively.</p>
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ELIGIBILITY FOR SERVICES AND PERSONAL BUDGETS

What are personal budgets?

- 6.31 Rather than being provided with services, a personal budget gives individuals who are eligible for social care support a “single transparent sum allocated to them in their name and held on their behalf, rather like a bank account”.²⁴ The individual can then choose to take this money out “either in the form of a direct payment in cash, as provision of services, or as a mixture of both cash and services, up to the value of their total budget”.²⁵

²² Welsh Assembly Government, *Paying for Care in Wales: Report of the Stakeholder Advisory Group* (2009) Rec 15.

²³ Welsh Assembly Government, *Paying for Care in Wales* (2009) pp 46 to 47.

²⁴ Our Health, Our Care, Our Say (2006) Cm 6737, para 4.32.

²⁵ As above, para 4.32.

- 6.32 Personal budgets are usually determined by applying a Resource Allocation System (RAS).²⁶ A RAS is a “transparent set of rules that determines what is the right level of individual funding required to purchase the necessary support to achieve the agreed outcomes”.²⁷ Typically, a RAS uses a scored self-assessment questionnaire which measures the impact of a person’s disability on their life in a number of key areas or domains, such as meeting personal care needs; relationships and social inclusion; and work and learning.²⁸ Each area has different grades of ability, with the greater the need the higher the points allocated. In simple terms, the local authority works out what the average cost (or value) per point is, having regard to existing care packages, local demands, costs and resources.²⁹ A person’s budget is determined by multiplying their total points by the average cost per point. The total may then be adjusted (for example, a percentage reduction) according to the amount of support reasonably available to each person from his or her friends and family.³⁰
- 6.33 A budget is “indicative” until an appropriate support plan has been agreed by the local authority.³¹ Thus, following the allocation of an indicative personal budget, the person, with help if necessary, develops their own support plan, which sets out how they will use their budget to get the help that they require. The support plan must be agreed by the local authority before the budget is finalised.³² Once the budget is finalised, the individual can use it to purchase services that meet the outcomes determined by the RAS.³³ The budget can be deployed in a number of ways including by the individual as a cash direct payment, by the care manager, by a trust, by a payment to a third party to manage on behalf of the recipient or held by a service provider.³⁴

Compatibility with community care law

- 6.34 In England, the Government has committed to introducing “personal budgets for everyone eligible for publicly funded adult social care support other than in

²⁶ There are other ways to determine a personal budget. See C Glendinning and others, *Evaluation of the Individual Budgets Pilot Programme: Final Report* (2008) pp 146 to 147.

²⁷ In Control, *Fairness Requires Transparency: Submission on the Reform of Social Care Funding* (2008) p 11.

²⁸ See, for example, In Control, *Model Self-Assessment Questionnaire* (2008), <http://www.in-control.org.uk/site/INCO/UploadedResources/model%20saq.doc> (last visited 4 February 2010).

²⁹ See In Control, *Fairness Requires Transparency: Submission on the Reform of Social Care Funding* (2008).

³⁰ As above, p 12.

³¹ As above, p 13 and In Control, *Don’t be Fooled by the Law: A Report from In Control, Following a Conference Held on 1 April 2009* (2009) p 9.

³² In Control, *Fairness Requires Transparency: Submission on the Reform of Social Care Funding* (2008) p 13.

³³ In Control, *Guide 1: Personal Budgets* (2007), <http://www.in-control.org.uk/site/INCO/Templates/Library.aspx?pageid=97&cc=GB> (last visited 4 February 2010).

³⁴ See Social Care Institute for Excellence, *The Implementation of Individual Budget Schemes in Adult Social Care* (2009) pp 2 to 3; C Glendinning and others, *Evaluation of the Individual Budgets Pilot Programme: Final Report* (2008) p 4.

circumstances where people require emergency access to provision”.³⁵ However, at this stage, personal budgets are a creature of policy and there have been no changes made to the existing legal framework to accommodate them. Accordingly, personal budgets must operate within that framework.

Personal budgets and the community care assessment process

- 6.35 As described above, local authorities are required to undertake a community care assessment and then use FACS or UFSAMC to decide whether the “presenting needs” identified in the assessment fall within the eligibility criteria, such that they call for the provision of services.³⁶ However, it is not clear that this process is always applied in relation to personal budgets.
- 6.36 In Control has stated that the “RAS process as it stands does not interfere in any way with a local authority’s existing eligibility procedures. Rather it follows on naturally from them”.³⁷ Similarly, the Commission for Social Care Inspection found in its review of eligibility criteria that in some local authorities, there was “a distinct step between being deemed eligible for publicly-funded social care and the resource allocation process”.³⁸ However, the review also discovered evidence that in some local authorities, assessment for eligibility and assessment for RAS were being combined in one process.³⁹ If a RAS is being used to determine a person’s eligibility for services, without any reference to FACS or UFSAMC, then this would not be lawful because the law requires such decisions to be made using the statutory guidance.⁴⁰ Furthermore, it may also be unlawful for decisions about the provision of services to be made without any reference to the underlying community care legislation that often contains its own internal eligibility criteria, such as section 21 of the NAA 1948.
- 6.37 At best, the relationship between personal budgets and section 47(1) of the NHSCCA 1990 is unclear. Some of the RAS assessment forms that we have seen make little or no reference to FACS or UFSAMC or they appear to apply eligibility criteria in a way that is not envisaged by the statutory guidance. This creates a confusing structure, whereby social care practice is not founded in the legal framework. At worst, there may be a danger that some of the assessment procedures for personal budgets and the RAS are not compliant with section 47(1) of the NHSCCA 1990. In addition, the variety of practices adopted in different local authorities around the country may, of itself, raise concerns about the lack of consistency in the legal regime.

³⁵ HM Government and others, *Putting People First* (2007) p 3. This commitment was reiterated in *Shaping the Future of Care Together* (2009) Cm 7673, p 60.

³⁶ FACS para 13.

³⁷ In Control, *Guide 1: Personal Budgets* (2007) p 25, <http://www.in-control.org.uk/site/INCO/Templates/Library.aspx?pageid=97&cc=GB> (last visited 4 February 2010).

³⁸ Commission for Social Care Inspection, *Cutting the Cake Fairly* (2008) para 2.30.

³⁹ As above, para 2.30. See also C Glendinning and others, *Evaluation of the Individual Budgets Pilot Programme: Final Report* (2008) p 146.

⁴⁰ See C Glendinning and others, *Evaluation of the Individual Budgets Pilot Programme: Final Report* (2008) p 142.

Personal budgets and the duty to meet all assessed needs

- 6.38 Personal budgets allocate a sum of money to a need. This is difficult to reconcile with FACS and UFSAMC, which set out the entitlement of an individual to have their needs met by the provision of a community care service (or a direct payment in lieu of a service) and do not refer to a sum of money.⁴¹ The further difficulty with personal budgets is that the allocation of money is linked to achieving general outcomes, rather than securing the provision of specific services that have been matched to meet eligible needs. It is therefore “difficult to establish whether a local authority is actually meeting a person’s needs”.⁴²
- 6.39 In the report on the individual budget pilot programmes, it was found that in some circumstances, the RAS led to an indicative budget that represented a reduction in the amount of social care funding a person received by way of a traditional care package.⁴³ However, this is not necessarily evidence that personal budgets do not meet eligible needs, since it may be the case that personal budgets result in more cost-effective services being purchased. In Control has stated that adjustments to indicative budgets are estimated to be required in around 20% of cases, in order to be able to fund a support plan to meet eligible needs.⁴⁴

Duties in relation to carers

- 6.40 Under the DP(SCR)A 1986 and C(RS)A 1995, if a carer is providing a substantial amount of care on a regular basis, the local authority must have regard to the care being provided in deciding whether to provide services to the cared-for person.⁴⁵ Furthermore, under the Community Care Assessment Directions 2004, local authorities must involve carers, where appropriate, in the community care assessment of the cared-for person.⁴⁶
- 6.41 A feature of the RAS is a percentage reduction in the amount of an indicative budget on the basis of the presence of a carer. Although taking into account the support being provided to an individual when determining eligible needs is compatible with the existing framework, adopting a blanket policy of reducing a person’s budget on the basis of the presence of a carer is less easy to reconcile. At the very least, a local authority would be required to satisfy themselves that the carer is willing to continue to provide the level of care represented by the reduction, and, if there was a high reduction, that the carer had been offered an assessment of their own needs (given that in those circumstances, they would be a substantial and regular carer).

⁴¹ See L Clements, “Individual Budgets and Irrational Exuberance” (2008) 11 CCLR 413, 425.

⁴² M Mandelstam, *Community Care Practice and the Law* (4th ed 2009) p 359.

⁴³ C Glendinning and others, *Evaluation of the Individual Budgets Pilot Programme: Final Report* (2008) pp 98 and 246, and C Glendinning and others, *Evaluation of the Individual Budgets Pilot Programme: Summary Report* (2008) p 14.

⁴⁴ In Control, *Fairness Requires Transparency: Submission on the Reform of Social Care Funding* (2008) p 13.

⁴⁵ See DP(SCR)A 1986, s 8 and C(RS)A 1995, s 1.

⁴⁶ LAC(2004)24, *The Community Care Assessment Directions 2004*.

Policy in Wales

- 6.42 On the whole, Wales has adopted a more cautious approach to personal budgets than England. The recent Welsh Green Paper noted that Wales has not adopted the individual budget approach that is presently being rolled out in England. However, the Green Paper also states that the Welsh Assembly Government will “continue to assess the evidence from the personal/individual budget pilot schemes in England and the more detailed arrangements for their operation as they are developed and implemented”.⁴⁷

Provisional view

- 6.43 The above discussion illustrates that there are several aspects of personal budgets that do not sit entirely comfortably within the existing statutory framework. As a general observation, there are different philosophies underpinning the NHSCCA 1990 and FACS and UFSAMC on the one hand, and personal budgets on the other. Whilst FACS and UFSAMC are concerned with managing scarce resources, personal budgets are aimed at ensuring choice and control over which services are provided. However, this does not mean necessarily that the philosophies are incompatible.

- 6.44 It is surprising that such a fundamental and major change to adult social care has been introduced outside the statutory framework. Given the Department of Health’s commitment to introducing personal budgets, we believe it is important that the law and personal budgets are more closely aligned. Furthermore, it is important that the existing ambiguity and confusion over how and where personal budgets fit into the current law be clarified. Otherwise, local authorities will be required to implement personal budgets without a clear legal framework and will sometimes be required to operate at the margin of legality.

- 6.45 The Department of Health has stated that:

Calculating what resources should be made available to individuals should not detract from a council’s duty to determine eligibility following assessment and to meet eligible needs. Rather a RAS should be applied as a means of giving an approximate indication of what it may reasonably cost to meet a person’s particular needs according to their individual circumstances.⁴⁸

- 6.46 We agree that this is the correct interpretation of how personal budgets and the RAS fit into the community care assessment process and we, therefore, propose that this should be made clear in our future adult social care statute.

- 6.47 However, our statute also needs to reflect the different policy position of Wales on personal budgets. While the Department of Health has stated that everyone who is eligible for services will have a personal budget, except in exceptional circumstances, the Welsh Assembly Government has not made a similar commitment. Given this divergence in policy, our provisional view is that the duty or otherwise to provide a personal budget should be set out in regulations issued

⁴⁷ Welsh Assembly Government, *Paying for Care in Wales* (2009) p 21.

⁴⁸ Department of Health, *Prioritising Need in the Context of Putting People First: Guidance on Eligibility Criteria for Adult Social Care (Consultation Stage)* (2009) para 105.

by the Secretary of State in relation to England, and the Welsh Ministers in relation to Wales. This would allow each country to prescribe in regulations whether a local authority must allocate a personal budget to meet all needs that are eligible. Regulations issued under this power may make provision specifying the circumstances in which a local authority is not required to allocate a personal budget, such as the exceptional circumstances noted above.

Provisional Proposal 6-5: We provisionally propose that our future adult social care statute should prescribe that the Secretary of State or Welsh Ministers may by regulations require that a local authority must allocate a personal budget in fulfilling the duty to meet all needs that are eligible.

THE ELIGIBILITY FRAMEWORK FOR CARERS' SERVICES

The legal framework

- 6.48 The CDCA 2000 gives local authorities a power to provide services to carers. This Act requires local authorities to carry out a carer's assessment and decide whether the carer has any needs in relation to the care which they provide or intend to provide and if so, whether they could be satisfied (wholly or partly) by services which the local authority may provide. If they are so satisfied, the local authority has discretion whether or not to provide services to the carer.⁴⁹

The eligibility framework in England

- 6.49 In order to decide whether or not to provide services, practice guidance in England advises that local authorities should implement an eligibility framework based on the extent of risk to the sustainability of the caring role.⁵⁰ The suggested eligibility framework adopts the same banding as the FACS and UFSAMC guidance: critical, substantial, moderate and low. The guidance recommends that local authorities "should consider the level at which they fix eligibility in relation to sustainability of the caring role".⁵¹ The content of the two eligibility frameworks is similar. The critical bands of each are compared in the following table.

⁴⁹ CDCA 2000, s 2(1).

⁵⁰ Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) para 70.

⁵¹ As above, para 70.

FACS ⁵²	Carers Practice Guidance ⁵³
Critical – when:	Critical risk to sustainability of the caring role arises when:
Life is, or will be, threatened; and/or	Their life may be threatened
Significant health problems have developed or will develop; and/or	Major health problems have developed or will develop;
There is, or will be, little or no choice and control over vital aspects of the immediate environment; and/or	There is, or will be, an extensive loss of autonomy for the carer in decisions about the nature of tasks they will perform and how much time they will give to their caring role;
Serious abuse or neglect has occurred or will occur; and/or	
There is, or will be, an inability to carry out vital personal care or domestic routines; and/or	There is, or will be, an inability to look after their own domestic needs and other daily routines while sustaining their caring role;
Vital involvement in work, education or learning cannot or will not be sustained; and/or	Involvement in employment or other responsibilities is, or will be, at risk;
Vital social support systems and relationships cannot or will not be sustained; and/or	Many significant social support systems and relationships are, or will be, at risk.
Vital family and other social roles and responsibilities cannot or will not be undertaken.	

Eligibility framework in Wales

- 6.50 The practice guidance on the CDCA 2000 issued by the Welsh Assembly Government does not contain the eligibility framework set out in the equivalent English practice guidance. In fact, the guidance does not specify that an eligibility framework should be used at all. It does, however, mention that the National Assembly is developing Fair Access to Care guidance which will “provide a common framework for local authorities to determine eligibility for adult social care services”.⁵⁴ While the guidance goes on to state that “there is no place for artificial divides in the assessment process”, it does not specify that the developed eligibility criteria will apply to carers.⁵⁵
- 6.51 The UFSAMC guidance that was eventually published does not specify an eligibility framework for carers. In relation to exercising the power to provide services under the CDCA 2000, the Welsh guidance provides that:

⁵² FACS para 16.

⁵³ Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) para 70.

⁵⁴ National Assembly for Wales, *Practitioners Guide to Carers’ Assessment: Carers and Disabled Children Act 2000* (2001) p 2.

⁵⁵ As above, p 2.

Any outcome valued by the carer may be a legitimate use of local authority resources if it genuinely will support the carer in their caring role or help them maintain their own health and well-being.⁵⁶

- 6.52 The National Assembly for Wales (Legislative Competence) (Social Welfare) Order 2009 extended the legislative competence of the National Assembly for Wales to include “supporting the provision of care by carers and promoting their well-being”.⁵⁷ In January 2010, the Welsh Assembly Government introduced the proposed Carers Strategy (Wales) Measure 2010, which will allow Welsh Ministers to set out, in subordinate legislation, requirements on NHS and local authorities to prepare and publish a joint strategy in relation to carers setting out, amongst other things, how they “will provide for the provision of information and advice to carers” and for the “effective involvement” of carers “when making decisions about the provision of services to or for carers or the person cared for”.⁵⁸

Does a duty to provide carers’ services arise in law?

- 6.53 In contrast to FACS and UFSAMC, local authorities are not required to apply the eligibility framework set out in the practice guidance when deciding whether or not to provide services to carers. Even if a local authority does apply this framework and sets eligibility criteria for services to carers, there would be no duty to meet *eligible needs*. Moreover, there is no duty to provide a service even if, for example, the carer’s needs fall into one or more bands that the local authority has decided, in relation to service users, that it will provide services to meet.
- 6.54 On the other hand, a local authority could not adopt a policy never to exercise the power to provide services, since this would amount to fettering its discretion.⁵⁹ A local authority must decide on a case-by-case basis whether to exercise that power in relation to the individual carer or not. In addition, any decision taken by the local authority would have to be “reasonable” based on the *Wednesbury* principles, taking into account all relevant considerations and ignoring all factors that are not relevant to the case.⁶⁰
- 6.55 In addition, if a carer’s needs fall into the critical category, it is likely that existing community care legislation would require a response in these circumstances.⁶¹ Under both the DP(SCR)A 1986 and C(RS)A 1995, a local authority must take into account the ability of a carer to continue to provide care in deciding upon services to the cared-for person. Consequently, a local authority would be required to take into account a critical risk to the sustainability of the caring role in deciding whether to provide services to the cared-for person.

⁵⁶ As above, p 11.

⁵⁷ National Assembly for Wales (Legislative Competence) (Social Welfare) Order 2009, WSI 2009 No 3010.

⁵⁸ Explanatory Memorandum to the Proposed Carers Strategies (Wales) Measure, para 1.2.

⁵⁹ See, for example, *R v London County Council ex p Corrie* [1918] 1 KB 68. See also P Craig, *Administrative Law* (6th ed 2008) para 16-013.

⁶⁰ *Associated Provincial Picture Houses v Wednesbury Corporation* [1948] 1 KB 223.

⁶¹ See L Clements, *Carers and their Rights* (3rd ed 2009) para 4.79.

6.56 Such a risk to the sustainability of the caring role is likely to equate to the FACS or UFSAMC critical indicator of “vital social support systems and relationships cannot or will not be sustained”, which is used to denote a critical need.⁶² If such a critical need was identified in the cared-for person’s assessment, then it would require the provision of services to meet the need, since in practice all local authorities must meet the critical needs of the cared-for person.⁶³ Furthermore, although the services provided must be provided to the cared-for person, the services must address the eligible need, which is the inability to sustain the support and relationship systems. Therefore, any services provided would need to benefit the carer. We also believe that on human rights grounds a carer’s critical needs may require the provision of services either to the cared-for person or the carer themselves.⁶⁴

Does the duty to provide carers’ services arise in practice?

6.57 Although a duty to provide services to carers does not arise in law, at least in most cases, it may be that in practice local authorities are using an eligibility framework when deciding whether or not to provide services to carers and are generally meeting eligible needs. In other words, a duty to provide a service to a carer who meets the eligibility criteria is accepted in practice even if it does not exist in law.

6.58 We have reviewed information provided on the websites of local authorities in England and Wales to ascertain whether or not the local authority specified eligibility criteria for carers to determine the carer’s eligibility for services. We recognise that such research has its limitations, as information on websites may not include internal policies or may be out of date.⁶⁵ In many instances we were not able to find information which specified whether the local authority used eligibility criteria for carers. Consequently, we welcome information from local authorities in England and Wales about whether they use eligibility criteria to decide whether to provide services to carers, and if so, what the criteria are. The findings from our research are discussed below.

6.59 Of the 151 local authorities in England that we reviewed, we found that 72 specified a criterion for determining whether or not services should be provided to carers. In a further 17 local authorities, the website information provided some indication that they used eligibility criteria or provided services to “eligible” carers, but we were not able to ascertain exactly which eligibility criteria were used. Five local authorities specified that they did not use FACS to determine eligibility for carers. In the remaining 57 authorities, we were not able to ascertain whether the authority used eligibility criteria or not. In Wales, a similar picture emerged: of the 22 authorities we reviewed, seven applied eligibility criteria to determine carers’ eligibility; a further six possibly applied criteria and the remaining nine local authorities did not specify.

⁶² FACS para 16 and UFSAMC para 5.16.

⁶³ See FACS and UFSAMC.

⁶⁴ See, for example, *R (Hughes) v Liverpool City Council* [2005] EWHC 428 (Admin), (2005) 8 CCLR 243 at [37] to [38].

⁶⁵ The results of this research are available on the Law Commission website at http://www.lawcom.gov.uk/adult_social_care.htm

- 6.60 Of the local authorities that did specify a criterion for carers' services in England and Wales, the majority applied FACS or UFSAMC. However, within these authorities, there were a variety of approaches taken. Some local authorities (we found 24 in England and six in Wales) stated that they determined eligibility for carers' services by applying the same FACS or UFSAMC eligibility framework that is applied to cared-for people. A further 14 local authorities in England and one in Wales described that they used FACS or eligibility criteria for carers, but did not provide more specificity. A further 16 local authorities in England appeared to adjust FACS to take into account carers-specific indicia. Another approach adopted by seven local authorities in England was to use FACS but the provision of carers' services depended on the service user's, and not carer's, eligibility under FACS. In England, eight local authorities used the eligibility framework set out in the carers' practice guidance, either on its own or with the addition of some further factors.
- 6.61 While the majority of local authorities reviewed did use the FACS or UFSAMC banding, five local authorities in England stated that they did not use FACS to determine eligibility for carers. A further three local authorities specified that they did not use FACS to determine the eligibility of carers for services, but rather used separate government guidance or eligibility criteria. However, the local authorities did not specify what the separate guidance or criteria consisted of.

Provisional view

- 6.62 In our scoping report, we recommended that the review consider the legal framework for the provision of services to carers, with the aim of rationalising and clarifying the existing law, and considering its relationship with the regime for service users.⁶⁶ Our provisional view is that there is a lack of clarity about the circumstances in which local authorities have a duty to provide services to carers, when they should exercise their discretion to provide a service and how eligibility criteria should be applied to carers' services, if at all. The Commission for Social Care Inspection found in its review that there was "considerable misunderstanding around the position of carers in relation to FACS" and recommended that policy towards carers should "be re-stated as there has been confusion and a lack of adherence to legislation and guidance on supporting carers and assessing *their* needs".⁶⁷
- 6.63 We consider that local authorities should be required to use a national eligibility framework in exercising their power to provide services to carers. Making the eligibility framework mandatory in this way would remove the current ambiguity about how decisions are made regarding the provision of services to carers, and would mean that a carer's eligibility for support is assessed against the same framework throughout England and throughout Wales. It is interesting to note that in the absence of a mandatory national framework, many local authorities in England and Wales have voluntarily adopted the FACS or UFSAMC banding to determine a carer's eligibility for services. Arguably, this demonstrates that local authorities have a need for such a system to determine eligibility for services.

⁶⁶ See Law Commission, *Adult Social Care: Scoping Report* (2008) para 4.107.

⁶⁷ Commission for Social Care Inspection, *Cutting the Cake Fairly* (2008) paras 3.22 and 5.10 (emphasis in original).

- 6.64 Introducing a mandatory national eligibility framework would mean that local authorities would be required to allocate a carer's needs to the different bands and to specify which bands it will provide services to meet. This would in effect mean the introduction of a duty to provide carer's services, since local authorities would be required to meet all needs that fall above its eligibility threshold. However, this would not necessarily change the existing legal position. As we have argued above, local authorities already have a duty to meet the critical needs of carers, at least in some circumstances. This would continue to be the case if the eligibility framework is made mandatory. Local authorities would retain their existing discretion to meet critical needs only, or set their eligibility criteria for carer's services at a lower threshold, having regard to resources, local expectations and local costs.
- 6.65 In making these proposals, we are conscious that we are operating at the interface between policy and law reform. We consider these proposals are within the proper remit of law reform. Our view is that the introduction of a mandatory framework would not necessarily extend local authorities' obligations to provide services. Moreover, our research suggests that many local authorities are already adopting eligibility criteria for carers and providing services to carers to meet their eligible needs. Consequently, this proposal should have negligible resource implications.⁶⁸ However, as we acknowledge in Part 1, distinguishing between law reform and policy is often a difficult judgement to make and we recognise that there may be views that we are not drawing the line in the right place here. We welcome responses on the provisional proposal made in this section, as well as the broader question of whether this should be considered a matter of law reform.

Provisional Proposal 6-6: We provisionally propose that there be a mandatory national eligibility framework which local authorities must use to decide whether or not to provide services to carers, and a duty to meet the eligible needs of carers.

⁶⁸ There may be some incidental resource implications, such as training costs. These are discussed in Appendix A and in our full Impact Assessment, see http://www.lawcom.gov.uk/adult_social_care.htm.

PART 7

SECTION 21 OF THE NATIONAL ASSISTANCE ACT 1948 AND SECTION 2(1) OF THE CHRONICALLY SICK AND DISABLED PERSONS ACT 1970

- 7.1 Section 21 of the NAA 1948 and section 2(1) of the CSDPA 1970 are almost unique in community care law because they place strong duties on local authorities to provide certain services. The section 21 duty is to provide residential accommodation and the section 2(1) duty is to arrange certain domiciliary and community-based services. Once eligibility is established under these provisions, an enforceable individual duty arises.
- 7.2 As noted in Part 6 (Eligibility for Services), there is a complex relationship between the eligibility framework established by FACS and UFSAMC, and the powers and duties to provide services under legislation such as section 21 of the NAA 1948 and section 2(1) of the CSDPA 1970. In that Part, we provisionally propose that our future adult social care statute should provide that an assessment of social care needs and the application of eligibility criteria are the sole means by which a person's eligibility for community care services is determined. In effect, almost all of the existing community care statutes would be repealed, including section 21 and section 2(1).
- 7.3 This Part considers the implications of repealing section 21 of the NAA 1948 and section 2(1) of the CSDPA 1970. The aim of our review is not to remove existing entitlements to services but to provide a clear and cohesive legal framework. It is, therefore, important to assess whether removing these duties would lead to a gap, whereby people who are eligible for services under section 21 and section 2(1) would lose this entitlement. If such a gap arises, it may be necessary to retain one or both of these duties.

SECTION 21(1) OF THE NATIONAL ASSISTANCE ACT 1948

- 7.4 Section 21(1) of the NAA 1948, and the relevant directions, give local authorities a duty to provide residential accommodation to any person aged 18 or over who:
- (1) due to age, illness, disability or any other circumstance is in need of care and attention not otherwise available to them; and
 - (2) is ordinarily resident in the authority's area or is in urgent need of residential accommodation.¹
- 7.5 Residential accommodation can be provided in premises managed by the local authority or another local authority, or by the private and voluntary sector.²

¹ LAC(93)10, appendix 1, para 2(1).

² NAA 1948, ss 21(4) and 26(1).

The relevance of resources to the section 21(1) duty

7.6 In *R v Sefton Metropolitan Borough Council ex parte Help the Aged*, the Court of Appeal considered whether local authorities are entitled to take into account their own financial resources in discharging the duty imposed under section 21(1) of the NAA 1948.³ Lord Woolf, in giving judgment, contrasted the section 21(1) duty with the duty to provide non-residential welfare services under section 2(1) of the CSPDA 1970. While he acknowledged similarities in the wording of the two provisions, two important distinctions were noted:

- (1) the non-residential services listed in the CSDPA 1970, while being very important to the recipient, are not of the same significance as residential accommodation provided under section 21(1);⁴ and
- (2) the requirement in the CSDPA 1970 that the services must meet the *needs* of the person and it must be *necessary* to provide those services, provides an “elasticity” in meaning that is absent from section 21(1), so that it is more difficult for a local authority to plead lack of resources under section 21(1) than under the CSDPA 1970.⁵

7.7 In our view, one of the implications of *Sefton* is that the eligibility framework in FACS and UFSAMC becomes almost entirely irrelevant when it comes to the provision of residential accommodation. It is the criteria set out in section 21(1) that must be satisfied in order to provide accommodation. This would hold even if the person did not meet the local authority eligibility criteria. As statutory guidance, FACS and UFSAMC can only be deviated from on an individual basis where there are good reasons to do so.⁶ One reason for deviation would be where statute law establishes a strong duty to provide a service.

To whom is the section 21 duty owed?

7.8 The need for care and attention under section 21 must arise by reason of *age, illness, disability or any other circumstances*. This can include people whose needs arise from having to sleep rough and go without food.⁷ Domestic violence can also make the need for care and attention more acute.⁸

7.9 The meaning of the words *care and attention* should be given their “natural and ordinary meaning”, which is “looking after” or “doing something for the person being cared for which he cannot or should not be expected to do for himself”.⁹ Accommodation itself is not care and attention but is the means whereby the required care and attention can be provided.¹⁰ However, the need for care and

³ *R v Sefton Metropolitan Borough Council ex p Help the Aged* (1997-98) 1 CCLR 57.

⁴ As above, 64(J).

⁵ As above, 67(E) to 67(I).

⁶ *R v Islington London Borough Council ex p Rixon* (1997-98) 1 CCLR 119.

⁷ *R v Westminster City Council ex p M* (1997-98) 1 CCLR 85.

⁸ *R (Khan) v Oxfordshire County Council* [2004] EWCA Civ 309, (2004) 7 CCLR 215.

⁹ *R (M) v Slough Borough Council* [2008] UKHL 52, [2008] 1 WLR 1808 at [33].

¹⁰ *R v Westminster City Council ex p M* (1997-98) 1 CCLR 85.

attention is not confined to those with accommodation-related needs.¹¹ A person in need of care and attention could include someone who is not in immediate need; however, the primary focus must be on present rather than future needs.¹²

7.10 The need for care and attention must be such that it can only be met if residential accommodation is provided. Therefore, section 21 is seen by the courts as a duty of last resort “designed to assist the poorest and most needy members of society, at rock bottom”.¹³ However, it is not a safety net for anyone who happens to be short of accommodation and money; there must be a need demonstrated in individual cases.¹⁴ In *R (M) v Slough Borough Council*, Baroness Hale of Richmond set out two separate categories of people for whom this might be the case:

- (1) people who need “extra care and attention which could not be provided in their own homes”; and
- (2) “people who need care and attention, which could be provided in their own homes, if they had them”.¹⁵

7.11 Where a person potentially falls into the first category (*people who need extra care and attention which cannot be provided in their own homes*) the requirement that the care and attention is *not otherwise available* becomes a significant factor. In some cases, it will be clear that the need for care and attention can only be met if residential accommodation is provided. However, if the need can be met without the provision of accommodation, for example through care in the person’s own home, there is no entitlement under section 21(1). The circumstances in which the care and attention has been held to be otherwise available include where a local authority had concluded that a man with mental health difficulties could be provided with care and attention from his wife in a flat that she owned, even though she would not allow him to live with her until he got better and they had not lived together for over a year.¹⁶

7.12 Where a person potentially falls into the second category (*people who need care and attention which could be provided in their own homes, if they had them*) the requirement that care and attention is *not otherwise available* becomes a less than significant factor. In such cases, the individual has no access to any accommodation in which they can receive care and attention other than by virtue of section 21, and consequently the focus is on whether there is a need for care and attention that requires accommodation in order to deliver services (and in the case of certain asylum seekers, whether the person’s needs are destitution related or not).¹⁷

¹¹ *R (Mani) v London Borough of Lambeth* [2003] EWCA Civ 836, (2003) 6 CCLR 376.

¹² *R (M) v Slough Borough Council* [2008] UKHL 52, [2008] 1 WLR 1808.

¹³ *R v Kensington and Chelsea Royal London Borough Council ex p Kujtim* (1999) 2 CCLR 340, 355(A).

¹⁴ *R v Westminster City Council ex p A* (1997) 1 CCLR 69.

¹⁵ [2008] UKHL 52, [2008] 1 WLR 1808 at [30].

¹⁶ *R (P) v Camden London Borough Council* [2004] EWHC 55 (Admin).

¹⁷ *R v Wandsworth London Borough Council ex p O* [2000] 1 WLR 2539.

- 7.13 It has, therefore, been acknowledged that section 21(1) will have a different effect on each of the two categories identified above and that, in relation to asylum seekers, some will “have a substantially better chance of qualifying for section 21 accommodation than their indigenous counterparts”.¹⁸

Should section 21 be removed?

- 7.14 If section 21 were repealed, our proposed statute would enable local authorities to provide residential accommodation through the general community care assessment process. Authorities will continue to be able to place people in the private and voluntary sector, as they can do now under section 26 of the NAA 1948. Furthermore, placements that involve nursing or personal care would still need to be in care homes registered with the Care Quality Commission or the Care and Social Services Inspectorate Wales.¹⁹
- 7.15 While local authorities would continue to be under an enforceable duty to provide or arrange residential accommodation, the criteria for accommodation would change. Eligibility would no longer depend on a person being *in need of care and attention not otherwise available*; instead, they must have an assessed need that falls above the local authority’s eligibility threshold. As discussed in Part 6, the local authority would have to use a prescribed eligibility framework to determine whether a person’s social care needs are eligible.
- 7.16 Where a person is in the first category identified above (*people who are in need of care and attention which cannot be provided in their own homes*) it is likely that their entitlement to residential accommodation would remain unaffected. This is because, according to *Sefton*, the need for residential accommodation is of greater significance than for other services, and because section 21(1) only enables the provision of residential accommodation when this is the only viable option to meet those needs. Consequently the need for *care and attention* required under section 21(1), translates into a *critical need* for the purposes of FACS and UFSAMC. This means a person who currently meets the section 21(1) criteria would almost certainly also be eligible for residential accommodation by applying the FACS or UFSAMC eligibility criteria.
- 7.17 Where a person is in the second category identified above (*people who need care and attention which could be provided in their own homes, if they had them*), it is also likely that their entitlement to accommodation would remain unaffected. A vulnerable person who has no access to any accommodation in which they can receive care and attention is almost certain to have needs that satisfy the local authority’s eligibility criteria. Even if they did not have sufficiently acute needs now, they are likely to in the near future, and the eligibility framework provides explicitly that eligible needs can include those that exist or will exist.²⁰
- 7.18 However, there may be concerns that some people in this group would not have sufficiently acute needs to qualify for services under the eligibility criteria. This is

¹⁸ *R (Mani) v London Borough of Lambeth* [2003] EWCA Civ 836, (2003) 6 CCLR 376 at [18] by Simon Brown LJ.

¹⁹ Care Standards Act 2000, s 11.

²⁰ FACS para 65. The same point is not made expressly in UFSAMC but is implicit in the wording of the eligibility framework and in para 5.20.

because, in the hypothetical situation that they had access to appropriate accommodation, the person might not be eligible for services. We consider that this would be highly unlikely, particularly because it would mean that the effects of their housing situation were not being taken fully into account. However, we welcome views on this point.

Other considerations

- 7.19 Arguably, the strong nature of the section 21 duty encourages assessments to be service-led, rather than needs-led. If there is a possibility that the person being assessed may need residential accommodation, the section 21(1) criteria will need to be addressed expressly by the assessment and as noted above, FACS and UFSAMC will be almost irrelevant. Therefore, a potential need for accommodation must be identified early in the assessment.
- 7.20 Furthermore, as a duty of last resort, section 21(1) presents a high threshold for the provision of residential accommodation and, except for section 117 of the Mental Health Act 1983 and section 2 of the Local Government Act 2000, a social services authority has no other legal means by which to provide accommodation. However, some people would benefit from residential accommodation (and in practice probably do) but are ineligible under section 21; for example, young disabled people who use residential accommodation as a first step towards gaining essential living skills before moving into independent accommodation.

Provisional view

- 7.21 We do not believe that the removal of section 21 of the NAA 1948 would weaken existing rights to residential accommodation. Nonetheless, we cannot exclude entirely the possibility that a small number of people would lose their entitlement. We welcome views on whether this is a potential effect of repealing section 21.
- 7.22 As noted above, it is not our intention that any groups should lose their rights to services and it is, therefore, important to identify those potentially at risk, even if that risk is remote. We consider that the category of people potentially at risk are those with relatively low social care needs but who require accommodation in order to meet their needs – such as asylum seekers and people ineligible for housing under other legislation.
- 7.23 By *low level social care needs* we are referring to people whose needs fall below the local authority eligibility criteria set under FACS or UFSAMC. However, since 98% of authorities meet at least critical and substantial needs, those people whose needs fall within these bands would, in the overwhelming majority of cases, get the appropriate services anyway.²¹ Therefore, the gap is likely to be in relation to people who fall into the above category and who have *moderate* or *low* level needs.
- 7.24 But even this may be an overestimate of the potential gap between provision under section 21 and provision under FACS and UFSAMC alone. First, since eligibility criteria must take into account future needs, the local authority would have to be satisfied that the person would continue to have only moderate or low level needs even if they were *not* provided with accommodation. If it is likely that

²¹ Commission for Social Care Inspection, *Cutting the Cake Fairly* (2008) para 2.21.

their needs would worsen if they were not provided with accommodation, then they would have to be assessed as eligible for residential accommodation using FACS or UFSAMC. So those with apparently only low or moderate needs would in these cases be accommodated using FACS or UFSAMC.

- 7.25 Secondly, the numbers who would be eligible under section 21 must not be over-estimated. A claimant under section 21 must need looking-after beyond merely the provision of accommodation and must be unable to perform essential tasks without assistance. It is, therefore, unlikely that people with *low level*, as opposed to moderate, needs would be eligible under section 21 anyway.
- 7.26 Therefore, if our proposal impacts on anyone, it will be on a small group of people (mainly people with moderate needs living in local authorities where the eligibility threshold is set at *substantial*). But if there is anyone in this category, then the impact of the loss of accommodation now provided under section 21 would be very great. Once again, we welcome views on whether our interpretation of the potential impact of repealing section 21 is correct.
- 7.27 So our concern is with establishing a principled and coherent way of protecting the rights of this potential small but vulnerable group. One option would be to retain section 21 as a separate statutory provision, either re-enacted in our proposed statute or unrepealed in the NAA 1948. However, this undermines the general approach set out in this consultation paper of a needs-led assessment acting as the single pathway to adult social care services, including residential care. In effect, residential accommodation would be assessed-for and provided separately from all other community care services. In our view, this would recreate the unwelcome and unhelpful distinction between residential care (at least for some) and other community care services. It would also encourage assessments to be service-led rather than needs-led.
- 7.28 It is also difficult to see how we could provide a tailor-made solution within our new system for these groups of people. To do so would require the creation of separate arrangements for people whose needs fall below the eligibility criteria but who come within the category identified above. This would undercut our proposals contained elsewhere in this consultation paper that user group categories should be avoided and would also raise legitimate questions about why this category is being singled out but not other groups.
- 7.29 In our view, the main reason why this category falls outside of our proposed new system is that the vulnerable people who fall within it are currently having recourse to a piece of adult social care legislation – section 21 – only because it is the weakest point in a system that restricts their entitlement to support. At its root, the defining characteristic of the category is *not* that their adult social care needs are sufficiently acute to justify the provision of services, but that, due to a lack of appropriate accommodation, their social care needs cannot be met.
- 7.30 In our view, it is not satisfactory that the provision of appropriate housing should continue to be achieved through the social care system. We believe the proper and principled approach would be that other agencies, which are better placed to address the needs of such people, should be given responsibility for providing accommodation. This would require additional legislative reforms to require, for example, the local housing authority and national asylum support services to

provide housing to these groups. Although the legal framework for housing and immigration is formally beyond the scope of this review, we welcome views – in particular from the Government – on how these groups could be accommodated more appropriately. However, if the Government does not come forward with appropriate housing-centred proposals, we would have to recommend that section 21 should be retained in its current form, but only in relation to the two groups. While this may not be satisfactory in law reform terms, it would at least ensure that these vulnerable groups do not lose their existing rights. We welcome further views and evidence on this point.

Provisional Proposal 7-1: We provisionally propose that section 21 of the National Assistance Act 1948 should be repealed and that the Government should ensure a proper scheme for the provision of residential accommodation to those people who might lose their entitlement.

Provisional Proposal 7-2: If the Government does not introduce a proper scheme for residential accommodation, we propose that section 21 should be retained but *only* in relation to those people who would otherwise lose their entitlement.

Question 7-1: If section 21 of the National Assistance Act 1948 were repealed, do you think that any groups would lose their entitlement to accommodation under our proposed structure?

SECTION 2(1) OF THE CHRONICALLY SICK AND DISABLED PERSONS ACT 1970

7.31 Section 2(1) of the CSDPA 1970 states that a local authority has a duty to provide certain non-residential services where it is satisfied that:

- (1) the person is disabled under the definition in section 29 of the NAA 1948;
- (2) the person is ordinarily resident in their area; and
- (3) it is necessary in order to meet the needs of the person for that authority to make arrangements for all or any of those services.

7.32 The services referred to in section 2(1) are:

- (1) practical assistance at home;
- (2) the provision of, or assistance in obtaining, a wireless, television, library or similar recreational facilities;
- (3) the provision of lectures, games, outings or other recreational facilities outside the person's home or assistance in taking advantage of educational facilities;
- (4) the provision of, or assistance in, travel to the facilities;
- (5) assistance in arranging home adaptations or providing additional facilities designed to ensure safety, comfort or convenience;
- (6) facilitating the taking of holidays;

- (7) the provision of meals; and
- (8) assistance in obtaining a telephone and any special equipment to use it.

The relevance of resources to the section 2(1) duty

- 7.33 The duty under section 2(1) of the CSDPA 1970 is to the disabled person individually and is not a target duty, which is owed towards the local population.²² Nonetheless, the House of Lords held in *R v Gloucestershire County Council ex parte Barry* that a local authority is entitled to have regard to its resources when deciding whether it is necessary, in order to meet the needs of a disabled person, to provide services under section 2(1).²³ This is because the words *necessary* and *needs* are relative expressions, which require criteria in order to determine their meaning. Whilst it is not correct to say that cost and resources must always be considered, they *may* be a proper consideration. Authorities may also take into account current standards of living, the nature and extent of the disability and the manner and extent to which quality of life would be improved by the provision of the particular service in question.²⁴ However, once the section 2(1) duty arises, a shortage of resources cannot justify its non-performance.²⁵
- 7.34 Applying the decision in *Barry*, the House of Lords has held that a local authority can take into account the resources of a third party, in this particular case the parents of disabled children, when considering whether it is necessary to make arrangements to provide section 2(1) services.²⁶ However, subsequent court decisions have distinguished *Barry* as peculiar to the CSDPA 1970, arguing that resources are a *less* relevant consideration when local authorities make decisions about certain other services, such as the provision of residential accommodation under section 21 of the NAA 1948, “suitable education” under the Education Act 1996 and approval for a disabled facilities grant.²⁷

Should section 2(1) be repealed?

- 7.35 Cases such as *Barry* confirm that eligibility criteria can be used to determine whether or not services are “necessary” under section 2(1) of the CSDPA 1970. This means that, under the current legal framework, deciding the necessity of services under section 2(1) is effectively the same as using the applicable eligibility criteria in FACS or UFSAMC to decide whether a person’s “presenting needs” are eligible.²⁸ We therefore consider that disabled people would not lose their entitlements if section 2(1) were removed.

²² *R v Islington London Borough Council ex p McMillan* (1997-98) 1 CCLR 7.

²³ *R v Gloucestershire County Council ex p Barry* [1997] AC 584.

²⁴ As above, 605 by Lord Nicholls of Birkenhead.

²⁵ As above, 610 to 611, by Lord Clyde.

²⁶ *R (Spink) v Wandsworth London Borough Council* [2005] EWCA Civ 302, [2005] 1 WLR 2884.

²⁷ See *R v Sefton Metropolitan Borough Council ex p Help the Aged* (1997-98) 1 CCLR 57, *R v East Sussex County Council ex p Tandy* [1998] AC 714 and *R v Birmingham City Council ex p Mohammed* (1997-98) 1 CCLR 441.

²⁸ FACS para 13 and UFSAMC paras 2.40 to 2.42.

Other considerations

- 7.36 There has been some confusion about the precise status of section 2(1), mainly because it is not included in the definition of community care services contained in section 46(3) of the NHSCCA 1990. In the divisional court, Lord Justice McCowan had suggested that section 2(1) is a free-standing duty and that “what is authorising the local authority to make arrangements under section 2 is section 2”.²⁹ Case law has now established that services provided under section 2(1) should not be regarded as free-standing but are provided under section 29 of the NAA 1948.³⁰ This is because section 2(1) refers to the duty of a local authority to make arrangements “in exercise of their functions under ... section 29 [of the NAA 1948]”. The effect of section 2(1) is to augment the power to provide welfare services under section 29 of the NAA 1948 with a duty.
- 7.37 However, the view that section 2(1) services are provided under section 29 of the NAA 1948 does cause a number of conceptual difficulties. For example, it does not explain fully why section 47(2) of the NHSCCA 1990 creates a different assessment procedure for services under section 2 of the CSDPA 1970 to those services listed under section 46(3).³¹ Furthermore, as noted in *R v Islington London Borough Council ex parte McMillan*, it would lead to the “unattractive” conclusion that home help could not be provided under section 2(1) of the CSDPA 1970, even though this Act explicitly authorises this service.³² This is because section 29(6) of the NAA 1948 prevents a service being provided if it is required to be provided under the NHS Acts 2006 and one of the services required to be provided under the 2006 Acts is home help.³³

Provisional view

- 7.38 We do not believe that the removal of section 2(1) would undermine existing rights to services. Our provisional view is that deciding whether it is necessary to provide section 2(1) services is effectively the same as our proposed approach that a local authority must apply eligibility criteria to determine eligibility for services. We, therefore, provisionally propose that section 2(1) of the CSDPA 1970 should be removed from adult social care legislation. The precise status of section 2(1) has caused some confusion and it is therefore likely that removing section 2(1) would ensure greater legal clarity.
- 7.39 We do, however, recognise that the section 2(1) duty applies to disabled children, as well as adults, by virtue of section 28A of the CSDPA 1970. If section 2(1) were removed, it is necessary to consider how disabled children should retain their existing rights to services. This issue is discussed in Part 11 (Joint Working).

Provisional Proposal 7-3: We provisionally propose that section 2(1) of the Chronically Sick and Disabled Persons Act 1970 should be removed from adult social care legislation.

²⁹ *R v Islington London Borough Council ex p McMillan* (1997-98) 1 CCLR 7, 17(D).

³⁰ *R v Powys County Council ex p Hambidge* (1997-98) 1 CCLR 458.

³¹ L Clements and P Thompson, *Community Care and the Law* (4th ed 2007) paras 9.128 to 9.129. This is discussed further in Part 4 of this consultation paper.

³² (1997-98) 1 CCLR 7, 17(C).

³³ NHS Act 2006, sch 20 para 3. This covers Welsh and English authorities.

PART 8

ORDINARY RESIDENCE AND PORTABILITY

- 8.1 This Part examines two distinct but related issues: ordinary residence and portability of services. The ordinary residence rules are used to establish which local authority is responsible for providing community care services to an individual. The concept of portability of services is concerned with the ability of service users to ensure continuity of support when they change their place of ordinary residence from one local authority area to another.

ORDINARY RESIDENCE

The meaning of ordinary residence

- 8.2 The local authority in which a person is ordinarily resident will usually be responsible for providing services to that person. There is no statutory definition of ordinary residence but, according to guidance, it “should be given its ordinary and natural meaning subject to any interpretation by the courts”.¹ Determining a person’s place of ordinary residence involves questions of fact and degree: factors such as “time, intention and continuity, each of which may be given different weight according to the context, have to be taken into account”.²
- 8.3 In *R v Barnet London Borough Council ex parte Shah*, Lord Scarman stated 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 of long duration.³
- 8.4 In *Levene v Inland Revenue Commissioners*, Viscount Cave said that ordinary residence means residence in a place with some degree of continuity and apart from accidental or temporary absences.⁴
- 8.5 In cases where the person lacks capacity to decide where to live, the concept of having an independent ordinary residence, which has been adopted voluntarily and for a settled purpose, may not arise.⁵ The extent to which this is the case, however, will depend on the particular circumstances of the individual case.
- 8.6 By virtue of section 24(6) of the NAA 1948, if a local authority places a person in a care home in the area of another authority, the individual is regarded as remaining ordinarily resident in the placing authority’s area and therefore, the placing authority has continuing responsibility to fund and care manage the individual’s stay in residential care.

¹ LAC(93)7, *Ordinary Residence*, para 2 and WOC 41/93, *Ordinary Residence – Personal Social Services*, para 4.

² As above, para 2 (England) and para 4 (Wales).

³ *R v Barnet London Borough Council ex p Shah* [1983] 2 AC 309, 343.

⁴ [1928] AC 217, 225.

⁵ *R v Waltham Forest London Borough Council ex p Vale*, *The Times*, 25 February 1985.

The statutory framework for ordinary residence

- 8.7 Some local authority duties to provide community care services depend upon the individual concerned being ordinarily resident in their area. If they are not resident, then the duty may be downgraded to a mere discretion. However, the relevance of ordinary residence varies across adult social care legislation.
- 8.8 The ordinary residence rules are relevant mainly to services provided under the NAA 1948. The duty to provide residential accommodation under section 21(1) of the NAA 1948 applies where a person in need of care and attention is ordinarily resident in the local authority's area.⁶ However, the duty can also apply where the person is not ordinarily resident but is in urgent need of accommodation or has no settled residence and has current or past mental health problems.⁷ An authority has the power, but not a duty, to provide accommodation to a person not resident in its area if that person is of no settled residence; is ordinarily resident in another authority's area (with the consent of that authority); or has current or past mental health problems and has been discharged from hospital.⁸
- 8.9 A duty to provide services under section 29(1) of the NAA 1948 arises where the person is ordinarily resident in the local authority's area.⁹ Local authorities retain a general *power* to provide a range of services under section 29 irrespective of ordinary residence.¹⁰ The duty to provide domiciliary services under section 2(1) of the CSPDA 1970 applies only to those ordinarily resident in the authority's area. There is no power to provide those services to non-residents.
- 8.10 The ordinary residence rules do not apply to services provided under the HSPHA 1968 or the NHS Acts 2006. However, the NHS Act 2006 places a duty on local authorities to provide home help "on such a scale as is adequate for the needs of its area".¹¹ Therefore, some notion of local connection is relevant to the provision of these services, which is likely to be interpreted, in practice, as ordinary residence. By implication, ordinary residence will also be relevant to the power to provide laundry facilities under the NHS Act 2006, since this only applies where home help is being, or can be, provided.¹²
- 8.11 The duty to assess under section 47(1) of the NHSCCA 1990 is not limited to those ordinarily resident in the authority's area. The duty arises if the person appears to be in need of services and the authority has a power (as opposed to a duty) to provide services;¹³ as noted above, local authorities have a number of legal powers to provide services to people not ordinarily resident in their area. A local authority's power under section 47(5) of the NHSCCA 1990 to provide urgent community care services on a temporary basis without carrying out an assessment applies irrespective of ordinary residence.

⁶ LAC(93)10, appendix 1, para 2(1)(b).

⁷ As above, appendix 1, paras 2(1)(b), 2(2) and 3.

⁸ As above, appendix 1, paras 2(1)(a) and 4.

⁹ As above, appendix 2, paras 2(1) and (2).

¹⁰ NAA 1948, s 29(4) and as above, appendix 2, para 3.

¹¹ NHS Act 2006, sch 20, para 3(1)(a). This applies to local authorities in England and Wales.

¹² NHS Act 2006, sch 20, para 3(1)(b). This applies to local authorities in England and Wales.

¹³ *R v Berkshire County Council ex p P* (1997-98) 1 CCLR 141.

Provisional view

- 8.12 The remit of our review does not extend to considering the meaning of ordinary residence or whether the concept of ordinary residence is the most effective way of determining which local authority is responsible for service provision. However, the current statutory framework for ordinary residence is complex and inconsistent. Local authorities can provide the same or a similar service under different legislation and the relevance of ordinary residence will depend on which statute is being used. For example, the provision of meals under the CSDPA 1970 requires the person to be ordinarily resident, whereas the provision of meals under the HSPHA 1968 does not. As our proposals would establish a single adult social care statute, it is necessary to ensure that the ordinary residence rules can operate effectively within this structure.
- 8.13 Provisionally, we consider that in order to maximise consistency and clarity in our proposed structure, the concept of ordinary residence should apply to all community care services. A local authority would have a *duty* to provide services where the person is ordinarily resident, and a *power* to provide services for people not ordinarily resident or of no settled residence. This proposal would, in theory at least, widen the application of the ordinary residence rules to services currently provided under the HSPHA 1968 and the NHS Acts 2006. However, we do not believe that this will lead to a change in practice, since it is unlikely that authorities will make what are often subtle distinctions between services provided under the different statutes and instead will apply the ordinary residence rules to all services. However, we welcome any further evidence on this point.
- 8.14 We also provisionally propose that authorities should have a duty to provide residential accommodation where a person is not ordinarily resident but is in urgent need of accommodation; a duty to carry out an assessment of needs, irrespective of ordinary residence; and a power to provide temporary urgent services, without carrying out an assessment, irrespective of ordinary residence.

Provisional Proposal 8-1: We provisionally propose that the local authority be placed under a *duty* to provide services for people ordinarily resident in their area and have the *power* to provide services for people who are not ordinarily resident in their area. In cases of urgent need of residential accommodation, there should be a duty to provide accommodation to those people not ordinarily resident in the authority's area. Assessments of need and the provision of temporary urgent services should not be limited by the ordinary residence rules.

Responsibility for providing carers' services

- 8.15 The responsibility for providing carers' services is established by the wording of the relevant statutes. The C(RS)A 1995 provides that a carer can make a request for a carer's assessment to the local authority that is carrying out a community care assessment of the cared-for person. The authority is then required to carry out a carer's assessment and take into account the results of that assessment in deciding whether to provide services to the cared-for person.
- 8.16 The CDCA 2000 provides that a local authority must carry out a carer's assessment if it is satisfied that the cared-for person is someone for whom it *may* provide or arrange the provision of community care services. In practice, this is

interpreted as meaning the authority in which the cared-for person lives; however, since local authorities have a power to provide community care services to people not resident in their area, then in law this could apply to any authority.

- 8.17 There are two main policy reasons for giving the local authority in which the cared-for person lives the responsibility for carrying out an assessment and providing carers' services. First, the authority where the cared-for person lives benefits from the informal care being provided by the carer, since it would otherwise need to provide community care services to meet the needs that are being met by the carer. Second, carers' services are often delivered in the form of services to the cared-for person and, therefore, it makes sense from an organisational perspective to have the same authority making decisions about services for both the carer and the cared-for person.
- 8.18 Practice guidance acknowledges that particular difficulties may be faced by carers who care for people who live a long way from them and/or who live across local authority boundaries, and advises that local authorities will need to work in partnership with other authorities in such cases.¹⁴

Provisional view

- 8.19 We propose that our statute should reflect the existing rules and provide that the local authority in which the cared-for person lives should be given primary responsibility for providing carers' services.

<p>Provisional Proposal 8-2: We provisionally propose that the local authority in which the cared-for person lives should be given responsibility for providing carers' services.</p>
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PORTABILITY OF SERVICES

- 8.20 The term *portability of services* refers to the ability of service users to ensure continuity of support when they move between local authority areas. Currently, when a service user moves they often have to start again from scratch to negotiate a new care package with the new authority, even if their needs have not changed. This can be "costly", "bureaucratic" and a source of "frustration and stress" for service users.¹⁵ It is, therefore, argued that the existing legal framework, and in particular the ordinary residence rules, impedes service users' freedom of movement:

There is little point applying for a job in another part of the country unless you know that you can relocate in the sure knowledge that your support will be ready and waiting ... Many disabled and older people provide support to other relatives, but are prevented from moving closer to them because of this fundamental flaw in the system. The same case can be made for moving to areas where housing may be more affordable in retirement. We are all told to

¹⁴ Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) paras 24 to 27.

¹⁵ *Hansard* (HL), 22 May 2008, vol 701, col GC641 (Baroness Campbell).

move, but if your portable support is not with you, then you cannot.¹⁶

- 8.21 In June 2008, the then Parliamentary Under-Secretary of State for Care Services, Ivan Lewis MP, wrote to the Law Commission asking if the adult social care project could include consideration of how the current legal framework, as opposed to practice by local authorities, contributes to the difficulties which services users face when moving from one local authority area to another.

The existing legal framework

- 8.22 In *R v Berkshire County Council ex parte P* it was held that the duty to assess arises where the local authority possesses the legal power to provide or arrange the provision of community care services to the individual in question.¹⁷ Since local authorities have powers to provide services to people who are not ordinarily resident, there may be cases where a receiving authority would be under a duty to assess a person who is planning to move into its area. However, the receiving authority would be entitled to refuse an assessment on the basis that the person does not appear to be in need of community care services; for example, because the person's needs are being met by the authority which they are leaving.
- 8.23 The revised draft ordinary residence guidance suggests that a pragmatic approach should be adopted and where a service user has "firm plans" to move to another authority's area, they can be described as "about to be in need", even though they are receiving services in the area which they are leaving. However, the guidance emphasises that the person's move must be "reasonably certain" and local authorities are not under a duty to assess a person who is "simply considering a move to the area".¹⁸
- 8.24 If a receiving local authority exercises its discretion to assess a service user with firm plans to move (or if a duty arises), the authority will in most cases have a power and not a duty to provide services prior to the move taking place. Due to financial considerations, it will be rare that receiving authorities will exercise this power but there are potential benefits. For example, arranging for a service user to attend a day centre in the new area may help them to become familiar with this service, which may make the move less daunting. A duty to provide residential accommodation would arise if the person is ordinarily resident in one authority area and is in urgent need of accommodation in another local authority area.¹⁹
- 8.25 If an assessment takes place, the receiving local authority could also consider whether services should be provided when the person moves. There may even be circumstances in which the new authority will be under a duty to provide services when the person moves (for example, if the assessment concludes that when the person moves they *will have* eligible needs for services under the receiving authority's eligibility criteria). However, the receiving local authority could legitimately take the position that any offer of services would be conditional upon a further assessment taking place once the person has moved.

¹⁶ *Hansard* (HL), 22 May 2008, vol 701, cols GC641 to GC642 (Baroness Campbell).

¹⁷ (1997-98) 1 CCLR 141.

¹⁸ Department of Health, *Ordinary Residence: A Consultation on the Revision of Guidance on the Ordinary Residence Provisions in the National Assistance Act 1948* (2009) para 8.

¹⁹ LAC(93)10, appendix 1, para 2(1)(b).

- 8.26 Once a service user has moved, FACS suggests a two-step approach to the assessment process. The receiving authority should, pending an assessment, take account of the services that were previously received and the effect of any substantial changes on the service user when reaching an interim decision about what services to provide. The authority should have regard to these factors, as well as the outcomes that were previously pursued, when carrying out the assessment and reaching longer-term decisions about what care services should be provided.²⁰
- 8.27 The draft revised FACS guidance does not set out a formal two-step process but suggests that when a service user moves permanently, the new authority “should take account of the support that was previously received and the effect of any substantial changes on the service user” when carrying out assessments and making decisions about what levels of support will be provided.²¹ Both FACS and the draft revised FACS guidance state that if the receiving local authority intends to pursue “significantly different outcomes” or provide “significantly different services” then a clear written explanation should be given to the service user.²²
- 8.28 In summary, service users are almost entirely reliant on the new local authority to ensure the portability of services. The law does not provide specifically for the portability of services from one authority to another; if a person moves, the package of services they received or the assessment of need undertaken by the previous authority does not travel with them. Therefore, the existing framework means it is extremely difficult for service users to know before the move which services will be provided once they have moved or indeed, whether they will receive services at all.

Options for reform

- 8.29 We have identified a number of proposals for law reform which have been put forward to ensure a greater degree of portability in service provision.

A duty to co-operate

- 8.30 The Equality and Human Rights Commission has recommended that local authorities should co-operate with one another to ensure effective transition, enabling people requiring care and support, as well as their families, to enjoy equal freedom of movement.²³
- 8.31 In Part 11 (Joint Working), we provisionally propose that our future adult social care statute should introduce a general duty and an enhanced duty to co-operate. It is envisaged that the general duty would require local authorities to make arrangements to promote co-operation with other organisations. Although the duty would not mention the portability of services expressly, it is envisaged that the specified organisations will include other local authorities.

²⁰ FACS para 56.

²¹ Department of Health, *Prioritising Need in the Context of Putting People First: Guidance on Eligibility Criteria for Adult Social Care (Consultation Stage)* (2009) para 69.

²² FACS para 56 and as above, para 69.

²³ Equality and Human Rights Commission, *From Safety Net to Springboard: A New Approach to Care and Support for All Based on Equality and Human Rights* (2009) p 23.

- 8.32 The enhanced duty to co-operate would allow a local authority to request certain bodies to provide assistance during an assessment and in providing services. The requested authority would then be under a duty to give *due consideration* to the request. We envisage that this duty would apply in circumstances where a person has firm plans to move; for example, the current authority could request assistance from the new authority or other organisations.
- 8.33 It is important, however, to recognise the limitations of the law to ensure co-operation in these circumstances. The extent of co-operation between agencies will depend on a wide range of factors, such as resources, social circumstances and personal relationships. Many of these issues apply irrespective of the law or whether duties can be enforced. Therefore, the law is only one factor in ensuring greater co-operation between different agencies.

A right to transitional services

- 8.34 There have been a number of failed attempts in Parliament to introduce a right to transitional services. For example, Lord Kilmarnock moved an amendment to the NHS and Community Care Bill 1989 which would have provided that, once a service user has moved, their existing assessment shall apply in the new authority until that authority carries out a new assessment.²⁴ This was later revised to a period of 28 days in default of the new assessment.²⁵
- 8.35 Similarly, Baroness Campbell attempted to amend the Health and Social Care Bill 2007 to give service users who are moving areas a right, for a transitional period, to “equivalent” services or direct payments to cover their needs before they undergo an assessment in the new authority.²⁶ Under this proposal, the original authority would be under a duty to give notice to the new authority if it becomes aware that a service user intends to become ordinarily resident in the new authority’s area; and the original authority would retain responsibility for funding the individual’s care needs for a prescribed period.
- 8.36 A right to transitional services would ensure some degree of certainty about the continuity of support, at least on a transitional basis. It would also encourage receiving authorities to undertake speedy assessments of people who have moved and, therefore, reduce the risks of people falling into the gap between services. However, this would fail to guarantee the provision of long-term services, since the new authority may have more restrictive eligibility criteria than the original authority. Significantly, it appears that the Government has rejected this option and is committed to an alternative approach, described below.

A portable assessment

- 8.37 The 2009 Green Paper, *Shaping the Future of Care Together*, proposes a “national assessment” whereby the results of a person’s assessment of need should apply anywhere in England.²⁷ This would mean that if a service user

²⁴ *Hansard* (HL), 18 June 1990, vol 520, col 617.

²⁵ *Hansard* (HL), 25 June 1990, vol 520, col 1377 to 1378.

²⁶ *Hansard* (HL), 22 May 2008, vol 701, col GC640 and *Hansard* (HL), 1 July 2008, vol 703, col 152.

²⁷ *Shaping the Future of Care Together* (2009) Cm 7673, p 53.

moves they will not have to seek reassessment unless their needs have changed. Thus, service users could establish before moving whether they have eligible needs in the new authority and if so, what services would be provided.

- 8.38 However, this proposal may not remove entirely the need to reassess the service user who has moved areas. The very fact of moving may alter a person's needs and, therefore, the introduction of a portable assessment will not remove the duty of a local authority to assess in these circumstances. Furthermore, this option does not mean necessarily that service users would receive the same package of services that they received in the previous local authority; for example, certain services may be unavailable. Furthermore, since the eligibility criteria in the original and new authority may differ, this option does not remove the possibility that individuals may lose their care package when they move.

National eligibility criteria

- 8.39 The 2009 Green Paper also includes a proposal for the introduction of national eligibility criteria, which would mean the Government would set at a national level the level of need at which someone becomes eligible for state funding and "anyone who had this level of need would be eligible for some support, wherever they go in England".²⁸ If implemented, this proposal would have a radical impact on the portability of service provision. There would be no local variation in eligibility criteria and individuals in any part of the country would be eligible for services if they met the national eligibility criteria.
- 8.40 This would not, however, guarantee that a person with assessed eligible needs would necessarily receive the same services wherever they moved. Local authorities would retain discretion to decide which services to provide in order to meet eligible needs and the resources and levels of support that they are going to provide at each level of need. However, out of all the options discussed, this is by far the strongest in terms of ensuring the portability of services.

Provisional view

- 8.41 Our provisional view is that a number of changes could be made to the legal framework to provide for greater continuity of care and support when service users move area. First, we propose that an enhanced duty to co-operate should include specific provision to promote co-operation between local authorities when individuals are moving areas. Second, we propose that if a national portable assessment is implemented, this should be provided for expressly in our future adult social care statute. Finally, and most significantly, we propose that if eligibility criteria were to be determined at a national level, this should be provided for in regulations issued under our future adult social care statute (see Part 6 (Eligibility for Services)).

Provisional Proposal 8-3: We provisionally propose that our future adult social care statute should enable the portability of services by the introduction of: (1) an enhanced duty to co-operate when service users move areas; and (2) if these policies are implemented, a national portable needs assessment and national eligibility criteria.

²⁸ Shaping the Future of Care Together (2009) Cm 7673, p 123. This is discussed in Part 6.

PART 9

SCOPE OF ADULT SOCIAL CARE SERVICES

- 9.1 Once a local authority has undertaken an assessment and concluded that a person has needs that call for the provision of community care services, then the authority must make arrangements for services to be provided. This Part considers the definition and scope of the services that can be provided under adult social care legislation.

THE DEFINITION OF COMMUNITY CARE SERVICES

- 9.2 Under section 47(1)(b) of the NHSCCA 1990, a local authority must decide which of the individual's needs call for the provision of "community care services". Community care services are defined by section 46(3) as services provided or arranged under Part 3 of the NAA 1948; section 2 of the CSDPA 1970;¹ section 45 of the HSPHA 1968; section 254 and schedule 20 of the NHS Act 2006 and section 192 and schedule 15 of the NHS (Wales) Act 2006; and section 117 of the Mental Health Act 1983.²
- 9.3 The formula adopted by all of these statutes is to entitle a specific group or different groups of service users to certain services.³ However, most of the statutes cover the same or similar services and the definitions of service user groups used in these statutes also overlap.⁴ Some of the statutes establish a duty to provide services and others give discretion, which means that eligibility for different services, and sometimes the same service, can vary according to which statute is being used.⁵
- 9.4 This legal structure is consistent with a body of legislation that has been enacted on a piecemeal basis over a substantial period of time, and which has not been consolidated. To replicate this structure in a single statute would be difficult, if not impossible. Each type of service would need to be linked to a specific group or different groups of service users. For some groups that service would be mandatory, while for other groups the same service would be discretionary.
- 9.5 Even if it were possible to replicate this structure, we do not believe that this would be the correct approach to law reform. The use of separate statutes to establish entitlement to services perpetuates the often baffling complexity of adult social care law. It would be incongruous for this structure to be maintained, given that our primary aim is to provide a clearer and more cohesive legal framework. Our starting point, therefore, is that this legal structure needs to be reformed.

¹ The s 46(3) list does not refer explicitly to s 2(1) of the CSDPA 1970 but it is included by virtue of the reference to Part 3 of the NAA 1948: see *R v Powys County Council ex p Hambidge* (1997-98) 1 CCLR 458.

² Section 117 of the Mental Health Act 1983 is discussed in Part 11.

³ For example, s 2(1) of the CSDPA 1970 enables services to be provided to disabled people, while the NHS Acts 2006 enable services to be provided for the purpose of illness.

⁴ For example, both s 2(1) of the CSDPA 1970 and the NHS Acts 2006 enable meals to be provided; the user groups overlap since people can be disabled through illness.

⁵ For example, s 2(1) of the CSDPA 1970 imposes a duty to provide meals, while the NHS Acts 2006 confer a power to provide meals.

- 9.6 In Part 6 (Eligibility for Services) we provisionally propose that our future adult social care statute should provide that an assessment of social care needs and the application of eligibility criteria are the sole means by which a person's eligibility for community care services is determined. In line with this proposal, we provisionally consider that the provision of specific types of community care services should no longer be linked to certain user groups or any other separate internal criteria. Instead, there should be a generic concept of *community care services*, and any person can potentially be provided with such services (assuming they have assessed eligible needs).

What is the purpose of a definition?

- 9.7 Most community care statutes provide a list of services that can be provided by local authorities. This approach would appear to serve two purposes. First, it establishes a straightforward process whereby the decision about which services to provide is made by referring to a list of specific services. Second, it helps to delineate, in a general sense, the scope of the services that can be provided by social services authorities and identify those services that are beyond its powers.
- 9.8 In practice, however, we consider that the purposes outlined above are not being met by the current definition of community care services. As will be clear in the following discussion, the lists of services provided in community care law do not provide legal clarity. The lists are often made up of broad categories of services that overlap and are described in terms of the purpose of the service rather than the actual service itself. These lists can, therefore, be used to justify the provision of a wide range of services that are not traditionally understood as being social services, including, as Belinda Schwehr has argued, the provision of a caravan, an electronic tracking device, a Wii, air conditioning, financial management services, visits to the pub, pizza delivery and possibly a service user paying for sex.⁶ It is, therefore, unlikely that the existing definition of community care services serves a useful legal purpose and, in particular, it fails to delineate effectively the types of services that can be provided.
- 9.9 Furthermore, there is a difficult relationship between the statutory lists of services and the eligibility framework set out in FACS and UFSAMC. The eligibility framework clarifies the purposes or objectives that must be met by community care services. For example, if a person has eligible needs that are categorised under the eligibility framework as preventing them from carrying out *the majority of personal care or domestic routines*, the purpose of the service provided must be to ensure that the person is able to carry out these routines. Thus, the eligibility framework gives some indication about the type of service that must be provided by identifying the outcome that the service should achieve.
- 9.10 It is not always clear what is added to this process by referring to a separate list of services. For example, in order to ensure that a person is able to carry out the majority of their personal care or domestic routines, the CSDPA 1970 merely allows for the provision of practical assistance in the home. This would appear to add little of value to the eligibility framework.

⁶ B Schwehr, *Personalisation and Individual Budgets: Doing it as Lawfully as Possible* (2009), <http://www.in-control.org.uk/site/INCO/Templates/General.aspx?pageid=1035&cc=GB> (last visited 4 February 2010).

- 9.11 We provisionally propose in Part 6 (Eligibility for Services) that, since the eligibility framework plays a fundamental role in defining eligibility, the framework should not be left to guidance and should instead be set out in regulations and subject to Parliamentary scrutiny. It is, therefore, important to consider how community care services should be defined in our proposed statute.

How should community care services be defined?

- 9.12 A relatively straightforward approach to law reform would be to duplicate the existing lists of community care services in our future adult social care statute. However, there is much overlap and duplication between the services listed in the various pieces of legislation.⁷ Simply bringing all of these lists across to our proposed adult social care statute would perpetuate this duplication and provide little legal clarity. We have, therefore, dismissed this option. Instead, we consider that the various lists could be both consolidated and reformed in such a way that would ensure greater clarity and consistency. This could be achieved in one of two ways.

- 9.13 The first approach would be to consolidate and streamline the existing lists of services into a single list. This would involve taking away any repeated services; grouping some services under more broad categories; and removing specific reference to services that can only be provided to certain client groups. The following is an example of what a consolidated list might consist of:

- (1) residential accommodation;⁸
- (2) assistance in the home, including: home help and laundry services; assistance in arranging home adaptations; additional facilities designed to ensure safety, comfort or convenience; and night sitter services;
- (3) social work service and support and advice;
- (4) centres or other facilities for social rehabilitation; adjustment to disability; and occupational, social, cultural and recreational activities (including payments to people for work undertaken, and ancillary or supplemental services);
- (5) holidays and assistance with holidays;
- (6) travel assistance;
- (7) assistance in finding accommodation;
- (8) warden services and contributions to the cost of wardens;
- (9) meals;
- (10) assistance in taking advantage of educational facilities;

⁷ See Law Commission, *Adult Social Care: Scoping Report* (2008) paras 4.160 to 4.174.

⁸ In Part 7, we propose that s 21 of the NAA 1948 be repealed and residential accommodation be provided on the same basis as other community care services.

- (11) the provision of, or assistance in obtaining, a telephone and any special equipment to use it; and
- (12) the provision of, or assistance in obtaining, wireless, television, library or similar recreational facilities.⁹

9.14 As we have simply consolidated the existing services without much change in language, this list does have a number of potential drawbacks. The wording of some categories is confusing. For example, the description of the purpose of the centres and facilities is long-winded and convoluted, and may not identify adequately which services are actually provided there. It is also not clear why a service user should be enabled to attend educational facilities but not other types of facilities, such as facilities for rehabilitation or adjustment to disability. The list also includes a number of precise descriptions of services, such as a *telephone* or *wireless*. This has the advantage of clarity but is in danger of leaving the law looking increasingly outdated as technology advances.

9.15 The second alternative approach would be to provide a much shorter list, which contains broad categories of services, rather than specific examples. The following is an example of such a list:

- (1) residential accommodation;
- (2) assistance and facilities in the home;
- (3) social work service and support and advice;
- (4) centres or other facilities in the community; and
- (5) social, leisure, communication, education and training activities.

9.16 The advantage of this approach is that local authorities would have flexibility to provide a range of services within each of the general categories. This type of list would also be capable of reflecting current and future developments in the types of community care services that can be provided and so is less likely to become outdated. The disadvantage, however, is that being general and flexible may mean there is less clarity about what these terms cover in practice, although this could be addressed through the provision of guidance.

Provisional view

9.17 We provisionally consider that any list of services should not contain overly long descriptions and confusing language. The list must provide legal clarity but also give flexibility to local authorities. Therefore, we provisionally propose that there should be a short and broad list of services, rather than a long and prescriptive list. This would allow the definition of community care services to evolve and remain up-to-date, whilst also maintaining some degree of clarity and certainty.

9.18 The broad list provided above sets out our provisional proposal for how the list should appear and the services that should be included. We welcome any further

⁹ This list does not include the register of disabled people and information; these are discussed in Part 13.

comments and suggestions about services that could be added or removed from this list, or indeed whether this is the best approach.

Provisional Proposal 9-1: We provisionally propose that community care services should be defined by a short and broad list of services.

At what level in law should the services be listed?

- 9.19 If community care services are to be defined through a list of services, then it is necessary to consider where the list of services should be located. Legislation can provide for lists of services in four different locations: on the face of the statute; in secondary legislation; in approvals and directions; or central government guidance.
- 9.20 The advantage of setting out the services on the face of the statute is that it helps to ensure legal clarity and certainty, since the list of services cannot easily be altered or amended. It also ensures that any future alterations to the list of services must be subject to full Parliamentary scrutiny. The services that are provided under adult social care legislation are a crucial aspect of the legal framework and it may be important to ensure that changes must be considered fully by Parliament. However, a potential disadvantage of this approach is that it could be difficult to keep the list up to date with new developments in service provision. This problem may be ameliorated, however, by adopting a short and general list of services, such as the list suggested above. It is likely that such a list could accommodate a range of new developments within the ambit of its language, without needing amendment.
- 9.21 Setting out community care services in secondary legislation can ensure some degree of flexibility. Regulations are easier to amend than a statute and most statutory instruments are not actively considered before Parliament and simply become law on a specified date in the future. However, it may be the case that regulations would be more suited to a detailed list of services rather than a short and general list.
- 9.22 The majority of community care services are currently set out in approvals or directions issued by the Secretary of State or Welsh Ministers. The statute will often provide an illustrative list of services and specify that local authorities can provide such services with the approval of the Secretary of State or Welsh Ministers and to such extent as they may direct. It follows that social services authorities have no power to make arrangements for any such services unless and until approvals and/or directions have been issued specifying the arrangements that may be made (approved) or must be made (directed). As we have argued in Part 2 (Our Approach to Law Reform), the use of approvals and directions adds to the complexity of the law by establishing parallel systems of legal entitlement for services. It also means that reference has to be made to a number of instruments in order to decide whether a duty or power arises.
- 9.23 Finally, the list of community care services could be set out in guidance. This would ensure that it is flexible and can be kept up to date with developments in service provision. However, as we have argued in Part 2, guidance is a more appropriate instrument for matters of policy or practice; a list of services, being a fundamental legal requirement, is likely to be more suitable for statute law or secondary legislation.

Provisional view

- 9.24 If community care services were to be defined by a short and broad list of services, our provisional view is that the best place to locate such a list would be in statute law. This would provide a clear and easily accessible definition, which would add certainty to community care law. If a more prescriptive list of services was thought desirable, we recognise there may be some advantage to placing such a list in regulations, which can be amended more easily than primary legislation. However, if a short and general list of services is adopted, then we consider that any disadvantage resulting from the inflexibility of primary legislation is offset by the fact that the list itself is broad and capable of accommodating future developments in the types of services being provided.

Provisional Proposal 9-2: We provisionally propose that the list of community care services should be set out on the face of our future adult social care statute.

Leaving community care services undefined

- 9.25 Although our preferred option is to define community care services through a short and broad list of services, we would also like to put forward for discussion the possibility of leaving community care services undefined. This would mean that a local authority's duty to provide services to a person would not be limited to a pre-defined list of statutory services. In effect, the authority could provide or authorise any service it sees fit, as long as that service meets purposes or objectives of services set out in FACS and UFSAMC, and there is no statutory prohibition on providing the service (see below).
- 9.26 One of the main advantages of this approach could be its potential to encourage more flexible and innovative ways of identifying community care services. This would appear to be in keeping with the policy of personalisation and self-directed support.¹⁰ Leaving community care services undefined might, for example, make it clear that a service user could take all or some of their personal budget as a direct payment and choose from a wide range of services. The existence of a pre-defined list of services might appear to limit the range of services available.
- 9.27 There are precedents in community care law for leaving services undefined in this way, such as carers' services under the CDCA 2000 (see discussion below) and after-care services under section 117 of the Mental Health Act 1983 (see Part 11 (Joint Working)). We welcome views on whether these approaches have been successful in practice.
- 9.28 More fundamentally, leaving services undefined would help to clarify the relationship between the eligibility framework in FACS and UFSAMC, and the provision of community care services. Under the current legal framework, a person's assessed eligible needs are defined by reference to the eligibility framework and the service must be capable of meeting the objective set out in the framework. However, in order to provide the service, the local authority must refer to a separate list of services set out in statute. This creates potential difficulties. As noted previously, many of the definitions of services are very broad and add little extra to the purposes or objectives of services set out in the

¹⁰ See, for example, *Shaping the Future of Care Together* (2009) Cm 7673, p 60.

eligibility framework. So they are not currently doing any real legal work. But if they were, then there would be a possibility that a person could have an assessed eligible need for a certain type of service, as defined in the eligibility framework, but which did not appear on the separate lists of services. If the definition was doing any work, therefore, it would probably be undesirable. At the very least, the relationship between the definition of a community care service and the eligibility framework could be described as unclear and would be clarified by ensuring that a community care service can be defined as any service capable of meeting an assessed eligible need.

- 9.29 However, leaving community care services undefined in legislation may have a number of potential disadvantages. It may be confusing for people seeking support services, who will have no reference point in legislation to understand what services they may be entitled to following a community care assessment. Furthermore, it might be difficult for an individual to enforce the provision of a specific service. A person could only enforce the provision of a specific service by arguing that this service alone is capable of meeting their needs; an argument which may be particularly difficult to make out if the pool of services available widens or appears to widen significantly.
- 9.30 A further disadvantage might be that any expansion in the range of services that can be provided or arranged by local authorities might obscure further the boundaries between adult social care, housing legislation and NHS provision. Some needs do not fall neatly into a single category and are capable of being met by social care, housing or health services.¹¹ Without a defined list of services, local authorities might be less capable of arguing that these needs should be picked up by other agencies, or other agencies may withdraw from providing such services. This could have budgetary implications for local social services authorities. It should be noted, however, that the prohibitions on social services authorities providing certain services would operate to delineate the boundaries between social care and other service provision.
- 9.31 Many of the disadvantages associated with leaving community care services undefined depend on whether this would broaden the range of services that can be provided. As set out above, a wide range of community care services can already be provided under community care law. It is, therefore, possible that the effect of leaving community care services undefined would be to make it clearer that a broad range of services can and should be provided, rather than to broaden the range of services.

Provisional view

- 9.32 Provisionally, our view is that community care services should be defined by a short and general list of services, placed on the face of the statute. This would provide some degree of clarity about the types of services that can be provided following a community care assessment. This approach would also ensure that local authorities are authorised to provide a broad range of services.
- 9.33 It is important to recognise that in formal legal terms this definition would not delineate precisely the types of services that can be provided following a

¹¹ For example, bathing services, home adaptations and housing.

community care assessment. The list would operate more generally to provide a framework for decision makers acting under the legislation. Indeed, it is difficult to see how any definition could fulfil this purpose, unless it contained a detailed description of every service that could conceivably be provided by social services authorities. Even if it were possible to construct such a list, it would be very long and would become quickly out of date.

- 9.34 We recognise that there may be a number of advantages in leaving community care services undefined in legislation. Most significantly, it may help to encourage more flexible and innovative ways of identifying community care services. We welcome further views on this option. However, our preferred approach is to use a short and general list of community care services.

Question 9-1: Do you think that community care services should be undefined in our future adult social care statute?

SERVICE PROVISION AND USER GROUP CATEGORIES

- 9.35 Most community care statutes only allow services to be provided to certain categories of user groups. The main user group categories used in community care legislation are disabled people;¹² people who are handicapped as a result of illness or congenital deformity;¹³ older people;¹⁴ people who are, have been or will be suffering from illness;¹⁵ people with a mental disorder;¹⁶ people dependent on drugs or alcohol;¹⁷ and certain former detained mental health patients.¹⁸

Difficulties with the user group categories

- 9.36 Many of the categories of user groups, referred to above, have become outdated. For example, disabled people are defined as those aged 18 and over, who are:

Blind, deaf or dumb, or who suffer from mental disorder of any description, and other persons ... who are substantially and permanently handicapped by illness, injury, or congenital deformity.¹⁹

- 9.37 The language used in this section is widely recognised as stigmatising and at odds with modern approaches to disability. For example, the Prime Minister's Strategy Unit has argued that this definition is "out of date, offensive and does not provide a useful starting point for enabling disabled people to fulfil their roles as citizens".²⁰ The outdated categories utilised in adult social care law may also filter through into types of services and support that can be provided for service users.

¹² NAA 1948, ss 21(1) and 29 and CSDPA 1970, s 2(1).

¹³ NHS Act 2006, sch 20, para 3(2)(c).

¹⁴ NAA 1948, s 21(1), HSPHA 1968, s 45 and NHS Act 2006, sch 20, para 3(2)(c).

¹⁵ NAA 1948, s 21(1), NHS Act 2006, sch 20, para 2(2) and NHS (Wales) Act 2006, sch 15, para 2(2).

¹⁶ LAC(93)10, appendix 3, para 3.

¹⁷ As above.

¹⁸ Mental Health Act 1983, s 117.

¹⁹ NAA 1948, s 29(1). No further disabilities have been prescribed.

²⁰ Prime Minister's Strategy Unit, *Improving the Life Chances of Disabled People* (2005) p 73.

If, for example, services are being designed for people who are *substantially and permanently handicapped by illness, injury, or congenital deformity*, then they are more likely to be based on assumptions of dependency and deficiency rather than promoting independence and choice.

- 9.38 Furthermore, it is doubtful whether many of the existing categories of user groups serve a useful legal purpose. As was discussed in relation to the definition of community care services, the use of user group categories might appear to place boundaries on the provision of community care services, since it seems to set clear rules on who may be provided with services. However, many of the existing categories are very broad and therefore fail to limit effectively the provision of community care services. This point is discussed in more detail below.
- 9.39 Finally, the basic legal structure that certain services can only be provided to individuals who fit into a specific user group category adds to the complexity and confusion that pervades adult social care law. It would not only be difficult to replicate this approach in a single adult social care statute, it would also be inconsistent with our aims of legal clarity and coherence. As a matter of principle, we also believe that it is inherently discriminatory to limit the availability of specific services on the basis of an individual's age, type of disability or clinical diagnosis. We have, therefore, identified three options for reform.

A consolidation of existing user group categories

- 9.40 A relatively straightforward approach to law reform would be to consolidate the existing categories of user groups that are referred to in community care legislation but update the language used to describe these groups. A consolidation of the existing user groups would include the following categories:
- (1) physical disability, learning disability, mental health problems, an illness or health condition, or a dependency on drugs or alcohol; or
 - (2) a person who has had any of the above conditions; or
 - (3) a person who needs services for the prevention of any of the above conditions.
- 9.41 It is important to note that this list does not refer explicitly to older people as a separate user group category. This is on the basis that age is not in itself a condition or disability. However, we welcome views on whether older people should continue to be included as a separate user group. We also welcome views on whether this list covers all user groups.
- 9.42 This option would provide greater legal clarity and consistency. The types of services that can be provided would no longer depend upon an individual falling within a specific user group category. Instead, as long as the person fell into one or more of these categories, they could potentially be provided with a service.
- 9.43 However, the main disadvantage of the definition provided above is that it is so broad, it fails to limit, in any meaningful way, entitlement to services. For example, it could include a person who suffered from a relatively minor illness a number of years ago. To address this difficulty, the definition could be restricted to people with current needs, but this would still be broad and would include, for

example, people with low-level health conditions who would be unlikely to need community care services.

A functional definition

- 9.44 An alternative approach would be to move away from categories of user groups and use instead a functional definition, which focuses on the impact of a person's condition or disability. For example, the Disability Discrimination Act 1995 defines a disabled person as someone with a physical or mental impairment which has a substantial and long term adverse effect on their ability to carry out normal day-to-day activities.²¹
- 9.45 However, this definition would establish a high threshold for the provision of community care services. For example, in order to qualify under this definition, the long-term effect of the disability must be 12 months.²² Also, this definition has various elements, exceptions and exemptions, which make it difficult to understand and often leads to "extended legal arguments, requiring expensive medical reports and long stressful litigation".²³ There has also been strong criticism of this definition on the basis that it is derived from the medical model of disability and focuses on the functional limitations of an individual.²⁴
- 9.46 There are, of course, other examples of functional definitions. However, in the context of adult social care legislation, most such definitions have a major disadvantage in that they would create an additional and unnecessary barrier to the provision of services. An individual would not only need to have assessed eligible needs for services, they would also need to demonstrate that their condition or disability met the definitional threshold. We consider that this would complicate unnecessarily the community care assessment process.

Leaving user groups undefined

- 9.47 The discussion above raises doubts about the necessity of establishing a central definition of people who are, or may be, eligible for community care services. Arguably, a person should be eligible for services if they have an assessed eligible need, which is determined by a community care assessment and the application of FACS and UFSAMC. To provide a further hurdle based on a legal category, such as a *disabled person*, is unnecessary.
- 9.48 Therefore, an alternative approach would be to remove all user group categories from legislation. Our future adult social care statute would, therefore, contain no central definition of a disabled person or people who can be provided with community care services. In effect, any person who is assessed as having a *social care need* could potentially be provided with a service, subject to that need satisfying the local authority's eligibility criteria.

²¹ Disability Discrimination Act 1995, s 1(1).

²² Disability Discrimination Act 1995, sch 1, para 2(1).

²³ Disability Rights Commission, *Definition of Disability: Consultation Document (2005)* para 28.

²⁴ Disability Rights Commission, *Report on Consultation on Definition of Disability within Anti-Discrimination Law (2006)* p 2.

- 9.49 We recognise that there may be some concerns about the removal of user group categories. In particular, there may be concerns that local authorities would face increased demand for community care services since potentially anyone could be eligible for services. However, this assumes that the existing categories of user groups serve to limit the provision of community care services in any meaningful way. As noted above, most of the existing categories are broad and Government guidance encourages an inclusive approach based on *need* not diagnosis or disability.²⁵ Furthermore, access to services is primarily limited through the application of FACS and UFSAMC rather than by reference to the existing categories of user groups and, therefore, it is unlikely that the removal of the categories would widen entitlement to services in practice.

Provisional view

- 9.50 We provisionally consider that it would be very difficult to consolidate the existing categories of user groups into a single definition, without this definition becoming so broad as to be almost meaningless. A functional definition would narrow eligibility for services but we consider it would create an unnecessary and complicated legal hurdle to the provision of community care services.
- 9.51 We believe that, in principle, a person should be eligible for community care services if they have an assessed eligible need. To provide a further hurdle based on a legal category of *disability*, for example, would be unnecessary. Instead, the provision of community care services would depend entirely upon a community care assessment of need and the eligibility criteria and not a central definition of people who can be provided with services.

Provisional Proposal 9-3: Provisionally, we do not propose that our future adult social care statute should include a central definition of a disabled person or service user.

THE DEFINITION OF CARERS' SERVICES

- 9.52 Community care law does not define the types of services that can be provided to carers. Instead, local authorities are given discretion to provide any services that it "sees fit to provide" and that will "in the local authority's view help the carer care for the person cared for".²⁶ However, the legislation does include a strong emphasis on services that would assist a carer to take part in employment, education, training or leisure activities, as a result of the amendments made by the C(EO)A 2004.²⁷ The breadth of services that can be provided to carers is made clear in the relevant statutory guidance and includes "driving lessons, moving and handling classes, a mobile phone, taxis to work to maximise the carer's time, or a short holiday for the carer".²⁸

²⁵ For example, FACS para 39 and HM Government, *Opportunity Age: Meeting the Challenges of Aging in the 21st Century* (2005) para 5.42.

²⁶ CDCA 2000, s 2(2).

²⁷ These provide that an assessment must consider whether the carer works or wishes to work, and is undertaking, or wishes to undertake, education, training or any leisure activity.

²⁸ Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 65.

Provisional proposal

- 9.53 We propose in Part 5 (Carers' Assessments) that there be a single, separate duty to assess a carer in our future adult social care statute and, in Part 6 (Eligibility for Services), that there be a duty to meet carers' eligible needs with carers' services. Our provisional view is that carers' services should continue to be undefined in the legislation. However, we welcome further views on whether the lack of a definition of carers' services has been a successful innovation in practice.

Provisional Proposal 9-4: We provisionally propose that carers' services should remain undefined in our future adult social care statute.

SHARED LIVES

- 9.54 Shared Lives (SL), formerly known as *adult placements*, is a service that often involves placements of service users in family homes where they have the opportunity to be part of the SL carer's family and support networks. SL does not sit easily within the current legal framework for community care services. Most community care services are easily identified as being either *residential* or *non-residential*. This distinction is important for a number of reasons.
- 9.55 First, a duty to charge arises for residential accommodation and residents are normally left with a *personal expenses allowance*.²⁹ In contrast, charging for non-residential services is discretionary and any charges must ensure that the service user's income does not fall under basic income levels.³⁰ Therefore, for most service users it will be important for SL to be identified as non-residential.
- 9.56 Second, if non-residential services are being provided then direct payments may be available; whereas direct payments cannot be used to fund long-term residential care, and instead the choice of accommodation directions apply. Arguably, therefore, if SL is identified as non-residential then direct payments may be provided and arguably the service user will have a greater degree of choice and control over the services provided.³¹
- 9.57 Finally, the ordinary residence rules differ, depending on whether the service is classed as residential or non-residential. If classed as residential accommodation, the placing authority retains responsibility even if the resident is placed out of the area.³² If classed as a non-residential service, a person is normally ordinarily resident in the local authority in which their household is located. This has important implications for which local authority retains funding responsibility. Thus, if a service user is placed in a SL scheme in a different authority, the original authority will retain funding responsibility if the service is seen as residential, whereas if the service is non-residential, the new authority will take over funding responsibility.

²⁹ NAA 1948, s 22(4).

³⁰ Health and Social Services and Social Security Adjudications Act 1983, s 17(3).

³¹ See Part 10.

³² NAA 1948, ss 24(5) and 24(6).

- 9.58 SL is not easily delineated as a residential or non-residential service. Of course, where the SL does not involve the provision of accommodation, then clearly it will be considered to be a non-residential service. Otherwise, the legal status of SL schemes will depend on the circumstances of the case. If a person is in need of care and attention which can only be met by the provision of SL accommodation, the placement would be under section 21 of the NAA 1948 and would be categorised as residential accommodation.
- 9.59 While some SL schemes may be provided in these circumstances, this is unlikely to be the case for the vast majority. Section 21 is seen as a duty of *last resort*, whereas SL is provided due to the social and other benefits of living as part of a family, and not because the care and attention the person needs is not otherwise available. For example, a service user may already be living in adequate accommodation and their other needs are being addressed through domiciliary services. In these cases, SL will be provided as a non-residential service.

Provisional view

- 9.60 In light of the confusion about the legal status of SL, we propose that our future adult social care statute should provide clarity about the legal status of SL schemes. Whether SL should be defined as a residential or non-residential service is a matter of policy and beyond the remit of our review. The Department of Health has stated its policy position that in most cases it is not necessary to use section 21 to place people in SL schemes. As noted above, we believe that this policy reflects existing practice, since SL placements are in most instances already provided as a non-residential service. We propose that our future adult social care statute should enable regulations to be issued by the Secretary of State and Welsh Ministers prescribing whether SL schemes should be considered to be residential or non-residential services. This would allow flexibility in the law and enable any changes or developments of policy.

Provisional Proposal 9-5: We provisionally propose that our future adult social care statute should allow for regulations to be issued that are capable of defining Shared Lives schemes as being non-residential services in all cases.

STATUTORY PROHIBITIONS ON ADULT SOCIAL CARE SERVICES

- 9.61 Statute law provides a number of prohibitions on the provision of services by local authorities. These help to establish the interface between adult social care and NHS care; housing; and immigration and asylum law. As noted in our scoping report, our review in this area is limited to examining how the existing prohibitions would operate in the context of a single statute and does not attempt to alter the responsibilities of social services or other authorities in any significant way.³³

NHS care

- 9.62 Legislation defines the division between health and adult social care by the use of three statutory bars to the provision of services by local authorities.

³³ Law Commission, *Adult Social Care: Scoping Report* (2008) para 4.259.

Section 21(8) of the NAA 1948

- 9.63 Section 21(8) of the NAA 1948 prohibits local authorities from providing residential accommodation under section 21(1) if this is “authorised or required to be provided under” the NHS Acts 2006.
- 9.64 The word *under* in this context means by way of guidance or directions themselves authorised by the NHS Acts 2006. The mere fact that a service can be provided by means of provisions in the NHS Acts 2006 does not bar a local authority from providing it, if they also have powers to do so. Therefore, the dividing line between health and social care is subject to the policy issued by the Secretary of State and Welsh Ministers. In deciding which services it is *necessary* to provide under the NHS Acts 2006, they “may take into account what services are and can be lawfully provided by local authorities as care provision”.³⁴
- 9.65 According to the relevant guidance “there should be no gap in the provision of care”; people should not find themselves in a situation where neither the NHS nor the relevant local authority (subject to the person meeting the means test and meeting the relevant criteria) will fund care.³⁵ To assist in deciding which health services it is appropriate for the NHS to provide, and to distinguish between those and the services which local authorities must provide under section 21 of the NAA 1948, the “primary health need test” is used.³⁶ This test provides that where a person’s primary need is a health need, the NHS is regarded as responsible for providing for all of their needs, including accommodation.

Section 29(6) of the NAA 1948

- 9.66 Section 29(6) of the NAA 1948 prohibits local authorities from providing any accommodation or services under section 29 if they are “required to be provided” under the NHS Acts 2006. Therefore, the prohibition applies only where there is a *duty* on the NHS to provide a service. It does not extend to services that the NHS has been *authorised* to provide by the Secretary of State or the Welsh Ministers as a matter of policy.³⁷ In such cases, there may be an overlap between health and social care provision. Where disputes have arisen, courts have applied a similar but not identical test to the primary health need test.³⁸

Section 49 of the Health and Social Care Act 2001

- 9.67 Section 49(1) of the Health and Social Care Act 2001 prevents local authorities from providing nursing care by a registered nurse as part of the provision by them of community care services. Where a person does not qualify for NHS Continuing

³⁴ *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213, 235.

³⁵ Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care: July 2009 Revised* (2009) para 26.

³⁶ As above, para 25.

³⁷ L Clements and P Bowen, “NHS Continuing Care and Independent Living” (2007) 10 CCLR 343, 346(C) to 346 (E).

³⁸ *R (T) v Haringey London Borough Council* [2005] EWHC 2235, (2006) 9 CCLR 58 at [62] and [65].

Healthcare but is eligible for care from a registered nurse in a care home, then that care will receive a level of funding from the NHS.³⁹

- 9.68 It may appear strange to have a modality based prohibition, rather than a service-based prohibition. However, the section 49(1) prohibition does not apply to *any* services which are in fact provided by a registered nurse but only those services that are *required* to be provided by a registered nurse.⁴⁰ Whether services must be provided by a nurse is normally decided by an assessment led or informed by a registered nurse.⁴¹

Provisional view

- 9.69 We propose that the existing interface between health and social care should be maintained in our future adult social care statute. This would mean that local authorities would be prohibited from providing residential accommodation, if this is *authorised or required to be provided under the NHS Acts 2006*.
- 9.70 We also propose that local authorities should be prohibited from providing non-residential services that are *required to be provided under the NHS Acts 2006*. This would represent a change from the existing legal position since the existing prohibition only applies to services provided under section 29 of the NAA 1948 and not, for example, the HSPHA 1968. However, we do not believe that this will lead to a change in practice, since it is unlikely that local authorities will make what are often subtle distinctions between services provided under the different statutes and will apply the section 29(6) prohibition to all non-residential services. However, we welcome any further evidence on this point.
- 9.71 We also propose that section 49 of the Health and Social Care Act 2001 should be included in our future adult social care statute.

Provisional Proposal 9-6: We provisionally propose that the existing divide between health and social care service provision should be maintained in our future adult social care statute. This would mean that local authorities would be prohibited from providing residential accommodation, if this is authorised or required to be provided under the NHS Acts 2006; any non-residential services that are required to be provided under the NHS Acts 2006; and nursing care which is required to be provided by a registered nurse.

Housing

- 9.72 Case law has established that a wide range of accommodation can be provided by local authorities under section 21 of the NAA 1948, including care homes, ordinary and sheltered housing and private sector housing.⁴² There is, therefore, a potential overlap between accommodation that can be provided by a local

³⁹ Department of Health, *NHS Funded Nursing Care: Practice Guide (Revised) 2009* (2009) and the NHS (Nursing Care In Residential Accommodation) (England) Directions 2007.

⁴⁰ *R (Grogan) v Bexley NHS Care Trust* [2006] EWHC 44 (Admin), (2006) 9 CCLR 188 at [24].

⁴¹ Department of Health, *NHS Funded Nursing Care: Practice Guide (Revised) 2009* (2009) para 14.

⁴² *R (Batantu) v Islington London Borough Council* (2001) 4 CCLR 445, 451(G).

authority under section 21(1) and that which can be provided by the housing department under the Housing Act 1996.

- 9.73 The division between social care and housing is established by section 21(8) of the NAA 1948, which prohibits a local authority from providing section 21 accommodation if this is “authorised or required” to be provided “by or under” any other enactment. This prohibition is, therefore, wider than the equivalent NHS prohibition, discussed above, which prohibits a local authority from providing section 21 accommodation if this is authorised or required to be made *under* (and not *by*) the NHS Acts 2006. The inclusion of the words *by or under* means anything prohibited by any other enactment, and anything prohibited by way of guidance or directions authorised by other enactments.
- 9.74 In the opinion of the courts, the provision of residential accommodation by a social services authority is only prohibited where the housing authority *has* or *will* provide accommodation under the Housing Act 1996.⁴³ It is a factual test of whether housing is otherwise available than under section 21; for example, an individual who is intentionally homeless can be eligible for accommodation under section 21, even though the housing authority remains *authorised* to provide accommodation but chooses not to under the Housing Act 1996.⁴⁴

Provisional view

- 9.75 We propose that the existing divide between social care and housing authorities should be maintained in our future adult social care statute. This would mean that social services authorities would be prohibited from providing housing if this is *authorised or required to be provided by or under* any other enactments.

<p>Provisional Proposal 9-7: We provisionally propose that social services authorities should continue to be prohibited from providing ordinary housing and connected services, if these services are authorised or required to be provided by or under other legislation.</p>

Immigration and asylum law

- 9.76 As noted in our scoping report, our review does not extend to considering the merits of Government policy in relation to the interface between adult social care law and immigration and asylum law.⁴⁵ Since the dividing line between adult social care and immigration and asylum law is a matter for Government policy, our proposed statute would continue the existing prohibitions. However, this should not be taken as an endorsement of the policy behind these provisions.
- 9.77 Section 21(1A) of the NAA 1948 provides that a person subject to immigration control may not be provided with residential accommodation if their need for care and attention has arisen solely because they are destitute or because of the physical or anticipated physical effects of being destitute. The House of Lords

⁴³ *R (Mooney) v Southwark London Borough Council* [2006] EWHC 1912 (Admin), (2006) 9 CCLR 670.

⁴⁴ Under the Housing Act 1996 local housing authorities almost always have a residual power to provide accommodation should they wish, unless the person is expressly ineligible.

⁴⁵ Law Commission, *Adult Social Care: Scoping Report* (2008) para 4.159.

has confirmed that the word “solely” means that the “able bodied destitute” are excluded from section 21 accommodation, but the “infirm destitute”, whose need for care and attention arises because “they are infirm as well as destitute”, are not so excluded.⁴⁶ Thus, the Home Office is responsible for asylum seekers whose need for care and attention arises solely because they are destitute or from the effects of destitution, while social services are responsible for asylum seekers whose needs are additional to being destitute.

9.78 A similar destitution-plus test also applies to non-residential services provided under section 45 of the HSPHA 1968 and the NHS Acts 2006.⁴⁷ However, the test does not appear in section 29 of the NAA 1948; section 2(1) of the CSDPA 1970; section 117 of the Mental Health Act 1983; or section 2 of the CDCA 2000.

9.79 The following groups are excluded expressly from services provided under nearly all community care legislation by virtue of section 54 of the Nationality, Immigration and Asylum Act 2002: individuals with refugee status in other countries in the European Economic Area; citizens of other countries in the European Economic Area; failed asylum seekers who have not co-operated with removal directions; and those unlawfully in the UK and who are not asylum seekers.⁴⁸

Provisional view

9.80 Current Government policy is to restrict the provision of adult social care services to asylum seekers. In our proposed statute, this would mean that local authorities would be prohibited from providing services to a person subject to immigration control solely because they are destitute or because of the physical or anticipated physical effects of being destitute.

9.81 It is important to note that under our statute, this prohibition would apply to all non-residential services and not just those provided under the HSPHA 1968 and the NHS Acts 2006. It may be the case that in practice this prohibition is applied to the provision of all social care services and services are not being provided to people with solely destitution related needs. We welcome further evidence on this point. However, if services are being provided to asylum seekers with destitution only needs then it may be necessary to retain some legal provision to ensure that such groups do not lose their entitlement to services.

Question 9-2: If Government policy towards asylum seekers continues, what are the likely consequences of retaining the prohibition on adult social care services to those subject to immigration control solely because they are destitute or because of the physical or anticipated physical effects of being destitute?

⁴⁶ *Westminster City Council v National Asylum Support Service* [2002] UKHL 38, [2002] 1 WLR 2956 at [32].

⁴⁷ HSPHA, s 45(A), NHS Act 2006, sch 20, para 2(6) and NHS(Wales) Act 2006, sch 15, para 2(6).

⁴⁸ This excludes services under the Mental Health Act 1983, s 117 and the CDCA 2000, s 2.

PART 10

DELIVERY OF SERVICES

- 10.1 This Part considers how services can be delivered to people, including the mechanisms through which services are provided such as care plans, the choice of accommodation directions and direct payments. It also covers charging for services.

CARE PLANS

- 10.2 While there is no statutory reference to care plans, they are an important aspect of the community care process. Once a local authority has carried out an assessment and identified eligible needs, statutory guidance advises that a care plan must be drawn up.¹ Statutory guidance also sets out minimum requirements for the content of a care plan, such as the services to be provided, preferences of the service user, contingency plans, charges and review date.² There is no requirement in statutory guidance that carers should be provided with a care plan. However, practice guidance does provide some general advice about the provision and the details of care plans for carers.³
- 10.3 The courts have held that a failure to draw up a care plan in accordance with the guidance is unlawful.⁴ Furthermore, since the care plan provides a record of how a local authority will perform its statutory duties, a failure to follow a care plan may provide evidence that the authority has acted unlawfully.⁵ However, while it may be difficult in practice to show that the duties have been complied with without an effective care plan, “if an authority can show that it has complied with these duties, the form in which it does so is not relevant”.⁶ Generally, the courts have adopted a cautious approach to passing adverse judgement upon the content of a care plan; however, this does not mean they have been uncritical.⁷ In other contexts, such as pathway plans under the Children Act 1989 as amended by the Children (Leaving Care) Act 2000, the courts have been prepared to adopt a more critical approach.⁸

Provisional view

- 10.4 Our provisional view is that the clarity of adult social care law would be improved by the introduction of a statutory duty on local authorities to produce a care plan for a person with assessed eligible needs (including carers). This would give additional prominence to the existing requirement to produce a care plan and

¹ Department of Health, *Caring for People: Community Care in the Next Decade and Beyond: Policy Guidance* (1990) para 3.24

² FACS para 47.

³ Department of Health, *A Practitioner's Guide to Carers' Assessments under the Carers and Disabled Children Act 2000* (2001) paras 56 to 59.

⁴ *R v Islington London Borough Council ex p Rixon* (1997-98) 1 CCLR 119.

⁵ As above, 128(D).

⁶ *R (B) v Cornwall County Council* [2009] EWHC 491 (Admin), (2009) 12 CCLR 381 at [49].

⁷ As above, at [67].

⁸ *R (J) v Caerphilly County Borough Council* [2005] EWHC 586 (Admin), [2005] 2 FLR 860.

would underline the importance of such a plan within the community care process. In this consultation paper, our approach to the scope of adult social care has been to emphasise the importance of *process-driven elements* such as the community care assessment process and the application of FACS and UFSAMC. We consider that a statutory care plan would help to underpin the importance of the assessment process and care planning in our proposed legal structure. The duty to produce a care plan would be supported by a duty on the Secretary of State and Welsh Ministers to make regulations concerning the form and content that the care plan must take. We welcome views on whether this is the correct approach and if so, which aspects of the care plan should be specified in the regulations.

- 10.5 Statutory care plans in the form of pathway plans have been introduced in the Children Act 1989, as amended by the Children (Leaving Care) Act 2000, and statements of special educational needs in the Education Act 1996. We welcome views on whether these statutory care plans have been successful in practice and whether they provide a useful model for adult social care law.

Provisional Proposal 10-1: We provisionally propose that our future adult social care statute should place a duty on local authorities to produce a care plan for people who have assessed eligible needs. This would be supported by a duty placed on the Secretary of State and Welsh Ministers to make regulations concerning the form and content that the care plan must take.

THE CHOICE OF ACCOMMODATION DIRECTIONS

- 10.6 When a local authority has decided that residential accommodation should be provided under section 21(1) of the NAA 1948, the choice of accommodation directions require the authority to accommodate that person at the place of his or her choice within England and Wales.⁹ The directions cover both the provision of care homes and accommodation in unregistered settings. The duty applies provided that the accommodation is suitable in relation to the individual's assessed needs; to do so would not cost the authority more than what it would usually expect to pay for accommodation for someone with the individual's assessed needs; the accommodation is available; and the person in charge of the accommodation is willing to provide accommodation, subject to the council's usual terms and conditions.¹⁰
- 10.7 Where a resident chooses accommodation that is more expensive than the local authority would usually expect to pay, the additional payments regulations allow for the resident to be placed in the more expensive accommodation, provided that a third party, such as a relative or friend, is able and willing to top-up the difference.¹¹ Residents who are subject to the 12 week property disregard or have entered into a deferred payments agreement may make top-ups from specified resources on their own behalf.

⁹ National Assistance Act 1948 (Choice of Accommodation) Directions 1992 and in Wales, the National Assistance Act 1948 (Choice of Accommodation) Directions 1993.

¹⁰ As above, para 3 (England) and para 3 (Wales).

¹¹ LAC(2004)20, *Guidance on National Assistance Act (Choice of Accommodation) Directions 1992*, para 3.2 and NAFWC 46/2004 *Guidance on the National Assistance Act 1948 (Choice of Accommodation) Directions 1993*, para 4.2.

The choice of accommodation directions and direct payments

- 10.8 The choice of accommodation directions have been described as “one of the few examples of genuine choice that individuals have in relation to their community care services” and arguably, they are early examples of personalisation and self-directed support.¹² However, there is an awkward relationship between the choice of accommodation directions and other more recent policy developments, such as personal budgets and direct payments. The introduction of direct payments means that there are two parallel legal mechanisms for promoting choice and control. Direct payments can be provided to enable service users to purchase non-residential services and the choice of accommodation directions apply to long-term residential accommodation. The main difference between these mechanisms is that direct payments allow the person to arrange the services themselves but the choice of accommodation directions only enable a local authority to do this on behalf of the person.
- 10.9 This difference becomes more apparent when personal budgets are considered. In relation to non-residential services, a person can take all or part of their personal budget as a direct payment and purchase their own services. However, in relation to residential accommodation, a person cannot do this and must rely on the local authority to use their personal budget to arrange the accommodation on their behalf. Arguably, this gives service users who need residential accommodation less choice and control over service provision. This raises the important issue of whether direct payments should be extended to cover long-term residential accommodation. This would give all service users the option of taking their personal budget as a direct payment and arranging their own services, irrespective of whether they need residential or non-residential services (subject to the conditions on the provision of direct payments).

Government rationale for opposition to direct payments for residential care

- 10.10 Government policy is that direct payments are not an option for people going into residential care. It is argued that the key focus of Government policy is to establish services to help people to remain living in their own homes and to retain independence, dignity and choice, and that direct payments provide the key means of achieving this. By allowing people to have cash in lieu of services, direct payments empower them to shape their own services and make their own decisions about the care they receive. The Government is clear that direct payments offer an alternative to residential care and local authority in-house services, and in policy terms residential care is viewed as an option of last resort.
- 10.11 The Government is not convinced by the argument that extending direct payments will offer greater choice and control to individuals entering residential care, because the choice of accommodation directions already enable people to choose their preferred accommodation. In legal terms, there may seem little difference between extending direct payments to cover residential accommodation and allowing individuals to choose their accommodation under the choice of accommodation directions. However, the Government argues that there is a difference in policy terms, which focuses on direct payments being the tool of independent living and not a means of entering residential care.

¹² L Clements and P Thompson, *Community Care and the Law* (4th ed 2007) para 7.90.

Provisional view

- 10.12 Provisionally, we consider that the most effective way of securing the policy of choice and control would be to extend direct payments to cover residential accommodation. This would allow, where appropriate, service users to arrange and purchase their own accommodation. However, we accept that Government policy is that direct payments are not an option for people going into residential care and it would be going beyond our remit to propose that this policy should be changed. However, we welcome views on this issue and in particular, whether the policy of choice and control would be undermined by extending direct payments in this way.

Question 10-1: Should direct payments be extended to cover residential accommodation?

The status of the choice of accommodation directions

- 10.13 Unlike direct payments, the choice of accommodation directions are not set out in statute law but were issued under section 7A of the Local Authority Social Services Act 1970. It might appear inconsistent to service users and professionals that while direct payments are recognised in statute law, the choice of accommodation directions are not, thus giving rise to uncertainty about the status of the directions. Placing the directions in statute law might, therefore, give the directions additional prominence and emphasise their importance within the overall structure of the law. On the other hand, this may be unnecessary and could mean that the directions become inflexible and difficult to amend.

Provisional proposal

- 10.14 We consider that placing the choice of accommodation directions in statute law would help to ensure legal clarity and would be consistent with the approach that has been adopted for direct payments. Furthermore, the directions are sufficiently short and concise to be suitable for inclusion in statute law. We also propose that the additional payments regulations should be retained in secondary legislation.

Provisional Proposal 10-2: We provisionally propose that the choice of accommodation directions should be placed in statute law and that the additional payments regulations should be retained in secondary legislation.

DIRECT PAYMENTS

- 10.15 Direct payments are cash payments to service users, so that they can buy their own services directly. Section 57 of the Health and Social Care Act 2001 gives the Secretary of State and Welsh Ministers a power to issue regulations requiring or authorising local authorities to make direct payments to a person, with his or her consent, who has been assessed under section 47 of the NHSCCA 1990 as being eligible for a service. Where such a person lacks capacity, then under section 57(1)(1A), the payment can be made to a "suitable person". Carers are also eligible for direct payments where the local authority decides that a service under section 2(2) of the CDCA 2000 should be provided.
- 10.16 In England, the regulations place a duty on local authorities to make direct payments if the person appears to be capable of managing a direct payment alone or with assistance; the person is not subject to certain court orders; the

direct payment is provided to secure the provision of a community care service within the meaning of section 46(3) of the NHSCCA 1990 or a carer's service under section 2 of the CDCA 2000; and the authority is satisfied that the person's need for the service can be met by securing the provision of it by means of direct payment. Under these regulations, the duty to make direct payments extends to most people who are subject to compulsory measures under the Mental Health Act 1983 and there is a power to make direct payments in respect of services which the person is under an obligation to accept as a result of the 1983 Act or certain criminal justice legislation. The equivalent regulations in Wales continue to exclude these groups but are expected to be updated in the near future.¹³

- 10.17 There are various restrictions placed on the provision of direct payments. For example, direct payments cannot be used to purchase services from any close family members or partners who live with the person, except if the local authority is satisfied that securing the service from such a person is necessary to meet satisfactorily the person's need for that service.¹⁴ Direct payments also cannot be used to purchase long-term residential accommodation but can be used to purchase short-term stays of not more than a period of four continuous weeks in any period of 12 months.¹⁵ Statutory guidance in Wales states that direct payments cannot be used to purchase a service from a local authority.¹⁶ Although the equivalent statutory guidance in England does not cover this point expressly, the guide to receiving direct payments states that direct payments cannot be used to purchase local authority services.¹⁷

Provisional view

- 10.18 We provisionally propose to retain the existing content of the direct payments provisions in the Health and Social Care Act 2001. We also do not propose to alter the existing balance between statute law and regulation. Therefore, we envisage that our future adult social care statute would set out the duty to provide direct payments, but most of the detail would be set out in regulations.

Provisional Proposal 10-3: We provisionally propose that the direct payment provisions should be retained in their existing form in our future adult social care statute.

CHARGING FOR SERVICES

- 10.19 Section 22 of the NAA 1948 places a duty on local authorities to recover payments from a person being provided with residential accommodation under the NAA. It also provides that, if a person is unable to pay the full cost, the authority must assess the resident's ability to pay and determine what lower rate

¹³ Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009, SI 2009 No 1887 and Community Care, Services for Carers and Children's Services (Direct Payments) (Wales) Regulations 2004, WSI 2004 No 1748.

¹⁴ As above, reg 11 (England) and reg 7 (Wales).

¹⁵ As above, reg 13 (England) and reg 8 (Wales).

¹⁶ Welsh Assembly Government, *Direct Payments Guidance: Community Care, Services for Carers and Children's Services (Direct Payments) Guidance Wales (2004)* para 95.

¹⁷ Department of Health, *A Guide to Receiving Direct Payments From Your Local Council: A Route to Independent Living (2009)* p 16.

should be paid, and that every resident must be allowed to retain a weekly allowance. If temporary accommodation is being provided for less than eight weeks the local authority has the discretion to limit such charges.

- 10.20 Unlike with residential accommodation, local authorities are not under a duty to charge for non-residential services (including carers' services). Section 17 of the Health Services and Social Security Adjudications Act 1983 provides that a local authority providing such services "may recover such charge (if any) for it as they consider reasonable". Direct payments can be paid as a gross or net payment. When the local authority makes a gross payment it can subsequently seek reimbursement of the assessed charge. Any charge must be an amount that is reasonably practicable for the service user to pay (subject to a means test).¹⁸ Statutory guidance published by the Department of Health sets out how to calculate a service user's contribution to their personal budget.¹⁹
- 10.21 The National Assembly for Wales (Legislative Competence) (Social Welfare) Order 2008 extended the legislative competence of the National Assembly for Wales to pass laws relating to charging for non-residential services, including carers' services and direct payments.²⁰ The proposed Social Care Charges (Wales) Measure 2009 will allow Welsh Ministers to set out, in subordinate legislation and guidance, a framework for charging service users.

Provisional view

- 10.22 As noted in our scoping report, the remit of our review does not extend to altering the rules on charging for services and is limited to determining how best to express the existing statutory provisions.²¹ The vast majority of the detail on charging would continue to be set out in regulations and guidance. One approach would be to replicate the existing framework by setting out a duty to charge for residential accommodation, alongside a power to charge for non-residential services, and provision for direct payments and personal budgets. An alternative option would be to establish a general power to charge for all services. Although this would entail the removal of the duty to charge for residential accommodation and instead give local authorities discretion, it is not put forward with the intention of changing the current charging regime; in practice, it is likely that local authorities would exercise their discretion to charge. However, we acknowledge that Government policy is that residents placed by local authorities must be charged for accommodation and it is important that our proposed adult social care statute does not undermine, or appear to undermine, this policy.
- 10.23 However, it is also important that our proposed statute can cater for any future changes in policy, and any future policy divergence between England and Wales. Therefore, we propose that a regulation-making power should be introduced to

¹⁸ Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009, SI 2009 No 1887, reg 9(2) and the Community Care, Services for Carers and Children's Services (Direct Payments) (Wales) Regulations 2004, WSI 2004 No 1748, reg 6(2).

¹⁹ Department of Health, *Fairer Contributions Guidance: Calculating an Individual's Contribution to their Personal Budget* (2009).

²⁰ WSI 2008 No 1785.

²¹ Law Commission, *Adult Social Care: Scoping Report* (2008) para 4.242.

enable the Secretary of State and the Welsh Ministers to require or authorise local authorities to charge for residential and non-residential services.

Provisional Proposal 10-4: We provisionally propose that our future adult social care statute should include a regulation-making power to enable the Secretary of State or Welsh Ministers to require or authorise local authorities to charge for residential and non-residential services.

SERVICES THAT MUST BE PROVIDED FREE OF CHARGE

- 10.24 Section 15 of the CC(DD)A 2003 gives the Secretary of State the power to issue regulations to require that certain services must be provided free of charge.²² The regulations in England provide that “intermediate care”²³ and “community equipment (aids and minor adaptations) services” must be provided free of charge.²⁴ In addition, the Government is proposing to amend the CC(DD)A 2003 and regulations to provide free personal care to some people living at home who fall within the critical band under FACS and UFSAMC.²⁵ Elsewhere, the law provides that local authorities in England and Wales cannot charge for non-residential services to people with Creutzfeldt Jacob Disease,²⁶ advice about services or an assessment;²⁷ and after-care under section 117 of the Mental Health Act 1983.²⁸

Provisional view

- 10.25 It is beyond our remit to extend the current list of services that can be provided free of charge. However, we would expect that as a minimum the current services that must be provided free of charge should be maintained. We propose that the existing regulation-making power, which enables services to be provided free of charge, should be maintained in our future statute. However, we consider the law should be made clearer about which services are provided for free. To this end, we propose that all free services should be included in this list.

Provisional Proposal 10-5: We provisionally propose that the existing regulation-making power, which enables certain community care services to be provided free of charge, should be retained. All services that must be provided for free should be listed in the regulations.

²² This Act has not been implemented in Wales, although s 16 provides for similar regulation making powers for the National Assembly for Wales.

²³ A structured programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live at home.

²⁴ Community Care (Delayed Discharge etc) Act (Qualifying Services) (England) Regulations 2003, SI 2003 No 1196.

²⁵ Personal Care at Home Bill 2009 and Department of Health, *Personal Care at Home: A Consultation on Proposals for Regulations and Guidance* (2009).

²⁶ Department of Health, *Fairer Charging Policies for Home Care and Other Non-Residential Social Services* (2003) para 75 and Welsh Assembly Government, *Fairer Charging Policies for Home Care and Other Non-Residential Social Services* (2002) para 63.

²⁷ As above, para 8 (England) and para 10 (Wales).

²⁸ *R (Stennett) v Manchester City Council* [2002] UKHL 34, [2002] 2 AC 1127.

PART 11

JOINT WORKING

- 11.1 Adult social care does not exist in a vacuum. The needs of service users frequently cross organisational and legal boundaries. Often the same service or similar services can be provided by different organisations and in recent years, there has also been growing emphasis on achieving greater integration and co-operation between social services and other authorities or agencies. This Part considers how our proposed statute should accommodate the interface between adult social care and other areas of law. This includes children and young people, young carers and parent carers, the well-being power, hospital discharge, prisons, section 117 of the Mental Health Act 1983 and duties to co-operate.

CHILDREN AND YOUNG PEOPLE

- 11.2 Most community care law applies to adults over 18 years of age. However, the following provisions also apply to children and young people: section 2(1) of the CSDPA 1970; section 4 of the DP(SCR)A 1986;¹ section 117 of the Mental Health Act 1983; paragraph 3 of schedule 20 to the NHS Act 2006;² the C(RS)A 1995; and the CDCA 2000. This overlap means that Part 3 of the Children Act 1989 is the primary but not the only source of support for *children in need* and their families, which can produce a complex legal structure. The Children Act allows local authorities to combine assessments under that Act with assessments under other legislation.³ The overlap is most evident for disabled children who are potentially eligible for services under the CSDPA 1970. The advantage of establishing eligibility for services under the CSDPA 1970 is that a specific duty arises, amenable to enforcement by individuals; whereas section 17 of the Children Act is a general duty owed to the population.⁴ The courts have, therefore, held that any choice between providing services under the two Acts should be settled in favour of the CSDPA 1970.⁵
- 11.3 In many cases, disabled children will need continuing services throughout their lives. The importance of an effective transition from children's to adults' services is widely recognised in guidance.⁶ Statute law can also provide a framework to ensure a smooth transition into adult life. For example, the Children Act, as amended by Children (Leaving Care) Act 2000, places duties on local authorities to support young people leaving care up until the age of 21 and in some cases beyond. In addition, the DP(SCR)A 1986 requires the local education authority to consult social services authorities to establish whether a child over the age of 14 who has been provided with a statement of special educational needs by a local

¹ A duty to assess on request by a disabled child or a parent.

² Home help and laundry services in England and Wales.

³ Children Act 1989, sch 2, para 3.

⁴ *R (G) v Barnet London Borough Council* [2003] UKHL 57, [2004] 2 AC 208.

⁵ *R v Bexley London Borough Council ex p B* (2000) 3 CCLR 15.

⁶ For example, Department for Education, Skills and Families and the Department of Health, *Transition: Moving On Well* (2008) and Department for Education, Skills and Families and the Department of Health, *Transition: Getting it Right for Young People* (2006).

authority is likely to require support from the social services department when they leave school. This is reinforced by the Education Act 1996, which requires the social services authority and others to contribute to a transitional plan, which the education department is required to prepare on the annual review of a statement when a child reaches 14.⁷

Provisional view

- 11.4 We provisionally propose that our future statute should apply to those aged 18 and above. In general terms, this would mean that children's services would be provided primarily under the Children Act 1989, and adults' services under our proposed statute. In Part 7 (Section 21 NAA 1948 and Section 2(1) CSDPA 1970), we propose that section 2(1) of the CSDPA 1970 should be removed from adult social care legislation. To ensure that children did not lose their existing enforceable rights to services, it would be necessary to retain and amend this Act, so that it would apply only to those under 18 (or the Children Act could be amended to include similar rights to services). It is important to note that our proposals would not affect the children leaving care provisions under the Children Act or transitional arrangements under the Education Act 1996, which would continue to apply.
- 11.5 In effect, our proposed structure would establish a clear dividing line at the age of 18 between the Children Act (along with the amended CSDPA 1970) and our proposed adult social care statute. While this would establish a greater degree of legal clarity, we also believe that the law should encourage a smooth transition for young people into adult life. Later in this Part we propose the introduction of a general and an enhanced duty to co-operate, both of which will apply when a young person is moving from children's to adults' services.
- 11.6 We also provisionally propose that local authorities should be given the ability to adopt a more flexible approach in individual cases towards young people aged 16 and 17. *First*, local authorities would be given a *power* to assess and provide services to young people aged 16 and 17 under our proposed adult social care statute. For example, in cases where a young disabled person aged 16 or 17 is likely to need services beyond the age of 18, the authority could decide that it would be preferable to assess that person under adult social care legislation rather than the Children Act. Guidance could be issued to assist local authorities in exercising this discretion.
- 11.7 *Second*, young people aged 16 and 17 (and their parents on their behalf) would be given a right to request that they be assessed under adult social care legislation rather than the Children Act and the local authority would then be required to give written reasons if it refuses to carry out the assessment.
- 11.8 It is envisaged that this proposed structure would help to ensure an effective transition from children's to adults' services, since young people could be linked to adult services before they reached 18. It also reflects other areas of law where a more flexible approach is taken in relation to 16 and 17 year olds, such as

⁷ Education (Special Educational Needs) (England) (Consolidation) Regulations 2001, SI 2001 No 3455, reg 21 and the Education (Special Educational Needs) (Wales) Regulations 2002, WSI 2002 No 152, reg 21.

consent to medical treatment under the Family Law Reform Act 1969 and the Mental Health Act 1983.

- 11.9 However, we recognise that there may be concerns that, in practice, this proposal would lead to bureaucratic delays or internal local authority disputes, which would delay the provision of an appropriate assessment. We welcome views on how this proposal might operate in practice and whether there are alternative ways to encourage an effective transition process.

Provisional Proposal 11-1: We provisionally propose that our future adult social care statute should apply to those aged 18 and above, and the Children Act 1989 (and the CSDPA 1970) should apply to those aged 17 and below.

Provisional Proposal 11-2: We provisionally propose that local authorities should have a power to assess 16 and 17 year olds under our proposed adult social care statute and young people aged 16 and 17 (and their parents on their behalf) would have a right to request such an assessment.

YOUNG CARERS AND PARENT CARERS

The legal framework for young carers

- 11.10 The C(RS)A 1995 applies equally to all carers regardless of their age. Under this Act, a young carer is entitled to a carer's assessment where a local authority is carrying out a community care assessment of the cared-for person and the young carer is providing a substantial amount of care on a regular basis to that cared-for person. The results of the carer's assessment must be taken into account when deciding what services, if any, to provide to the cared-for person. In contrast, the CDCA 2000 applies to carers over 16. This means that only young carers aged 16 and 17 (and not those aged under 16) are entitled to a free-standing carer's assessment independent of whether the cared-for person is having their own assessment under the NHSCCA 1990, so long as the local authority is satisfied that the cared-for person is someone for whom it may provide services. Following an assessment, the local authority has a power to provide services to a young carer aged 16 or 17.

- 11.11 Notwithstanding the right to a carer's assessment under these two Acts, statutory guidance emphasises that all young carers should be "routinely assessed under the Children Act 1989".⁸ Similarly, practice guidance states that:

The [CDCA 2000] makes a distinction between young carers under the age of 16 who should be seen as **children in need** under the Children Act 1989 and young carers over the age of 16 who, **in exceptional circumstances**, may be assessed under the [CDCA 2000].⁹

- 11.12 An *exceptional circumstance* might be where a carer aged 17, expresses "a very

⁸ Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 10.

⁹ Department of Health, *A Practitioner's Guide to Carers' Assessments under the Carers and Disabled Children Act 2000* (2001) para 13 (emphasis in original).

strong wish” to be involved in providing care to a parent, but only if it is in the carer’s “best interests to be allowed to continue” in this caring role.¹⁰ In all other cases, the *Framework for the Assessment of Children in Need and their Families* should be the “main source of guidance for local authorities”.¹¹ The reason for assessing young carers under the Children Act is that children should “not be expected to carry inappropriate levels of caring which have an adverse impact on their development and life chances” and in particular, “it should not be assumed that children should take on similar levels of caring responsibilities as adults”.¹²

Provisional proposal

- 11.13 We provisionally propose above that our future statute should apply to those aged 18 and above (except where the local authority is exercising its power to assess and/or provide services to those aged 16 and 17). This would mean it only applies to carers over the age of 18 who care for someone who is 18 or above. Thus young carers would not be entitled to a carer’s assessment under our proposed adult social care statute.
- 11.14 To ensure that young carers did not lose their existing rights, it would be necessary to retain and amend both the C(RS)A 1995 and the CDCA 2000 (including the amendments introduced by the C(EO)A 2004) so that they would apply only to those under 18. This would mean that all young carers who were providing a substantial amount of care on a regular basis would have a right to request a carer’s assessment if the person they were caring for was being assessed under our proposed adult social care statute. Young carers aged 16 and 17 would continue to be eligible for a free-standing assessment which did not depend on the cared-for person being simultaneously assessed and would also continue to be eligible for carer’s services. If the C(RS)A 1995 and the CDCA 2000 were amended in this way, in order to ensure legal clarity there may be advantages to consolidating these statutes so that there is a single carer’s statute for young carers, rather than two separate statutes that must be read in conjunction with each other. However, this question is strictly speaking beyond the remit of our enquiry.
- 11.15 However, the purpose of a carer’s assessment under the C(RS)A 1995 is to inform the outcome of a community care assessment for the cared-for person. By amending it to apply to young carers only, the C(RS)A 1995 would in effect be cut off from adult legislation, and the ability to link the young carer’s assessment with the community care assessment might be more difficult and require a high degree of co-ordination between children’s and adults’ services. This could be addressed by retaining a right for young carers to a carer’s assessment in our proposed statute, as currently provided for in the C(RS)A 1995. This would mean

¹⁰ Department of Health, *A Practitioner’s Guide to Carers’ Assessments under the Carers and Disabled Children Act 2000* (2001) pp 5 to 6.

¹¹ Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 11.

¹² See Department of Health, *Framework for the Assessment of Children in Need and their Families* (2004) para 3.62 and Department of Health, *A Practitioner’s Guide to Carers’ Assessments under the Carers and Disabled Children Act 2000* (2001) para 12.

that all carers, including those aged below 18, would have a right to a carer's assessment under our proposed statute. However, this might undermine the approach emphasised in guidance that young carers should be assessed routinely under the Children Act, rather than adult legislation.

- 11.16 Our preferred approach, therefore, is to amend and retain the C(RS)A 1995 and the CDCA 2000 so that they would apply *only* to young carers and to include a requirement in our proposed adult social care statute that any community care assessment must have regard to the results of any assessment of a young carer under the C(RS)A 1995, the CDCA 2000 and the Children Act. However, we welcome further views on this approach and also on whether young carers should come under adult legislation or not.
- 11.17 We also consider that Provisional Proposal 11-2 – which proposes that local authorities be given a power to assess and provide services to young people aged 16 and 17 under our proposed adult social care statute – should apply to carers aged 16 and 17 who are caring for an individual aged 18 and over. Thus, where a young carer is likely to continue to provide care beyond the age of 18, the authority could decide that it would be preferable to undertake a carer's assessment of that person under adult social care legislation rather than the Children Act (or the amended C(RS)A 1995 or CDCA 2000). This would include a right for young carers aged 16 and 17 (and their parents on their behalf) to request that they be assessed under adult social care legislation rather than the Children Act, and the local authority would then be required to give written reasons if it refuses to carry out the assessment.

Provisional Proposal 11-3: We provisionally propose that the C(RS)A 1995 and the CDCA 2000 should be retained and amended so that they only apply to young carers.

The assessment framework for parent carers

- 11.18 People with parental responsibility for a disabled child are entitled to request a carer's assessment under the C(RS)A 1995 and CDCA 2000.¹³ In order to qualify for an assessment under the C(RS)A 1995, the local authority must be assessing the disabled child under the Children Act 1989 or CSDPA 1970. To qualify under the CDCA 2000, the authority must be satisfied that the disabled child and their family are persons for whom it may provide services under the Children Act.
- 11.19 In both cases, the results of the carer's assessment must be taken into account when deciding what services, if any, to provide under the Children Act. The local authority does not have a power to provide services to parent carers in their own right, since section 6 of the CDCA 2000 only enables the provision of services under the Children Act. However, the parent carer could be provided with a direct payment in order to secure the provision of any of the services that the local authority would have otherwise provided under the Children Act.¹⁴ Parent carers may also have their own needs addressed as part of their child's assessment

¹³ C(RS)A 1995, s 1(2) and CDCA 2000, s 6.

¹⁴ CDCA 2000 ss 6 and 7.

under the Children Act.¹⁵

Provisional proposal

- 11.20 Under our proposed structure, parent carers would continue to have a right to a separate carer's assessment under the C(RS)A 1995 and the CDCA 2000. The results of this assessment must be taken into account when deciding what services, if any, will be provided under the Children Act. Parent carers would also retain their right to have their needs addressed as part of an assessment carried out under section 17 of the Children Act.
- 11.21 As noted above, parent carers who are looking after a young person aged 16 and 17 would be able to request that the young person is assessed under our proposed adult social care statute. If the local authority agrees to this request, then we propose that the parent carer should also be given a carer's assessment under our proposed statute.

Provisional Proposal 11-4: We provisionally propose that parent carers should continue to be eligible for a carer's assessment under the C(RS)A 1995 and the CDCA 2000. We also propose that where a young person aged 16 and 17 is being assessed under our proposed adult social care statute, parent carers should also be given a carer's assessment under this statute.

THE WELL-BEING POWER

- 11.22 Section 2(1) of the Local Government Act 2000 (the well-being power) gives local authorities in England and Wales a wide ranging power to do anything that is likely to promote the well-being of their area. This includes giving financial assistance and providing staff, goods, services or accommodation to any person.¹⁶ In addition to the activities taken within its area, a local authority can use the well-being power in a way that affects areas outside their own boundaries, if that action contributes to well-being in their own area.¹⁷
- 11.23 The statutory guidance stipulates that "the well-being power is an enabling, rather than a regulatory, power".¹⁸ Its scope is not, therefore, limited to that which is already within the powers of local authorities. The breadth of the power removes the need for authorities to rely on other legislation in order to take particular action and can be used instead of existing, more specific powers, for example:

Where an eligible council has a discretionary power to provide a specific service to a defined group of people, or make a grant to a defined type of organisation, the well-being power can be used instead and can also be used to extend the service to other groups or

¹⁵ Department of Health, *Framework for the Assessment of Children in Need and their Families* (2004) para 1.29.

¹⁶ Local Government Act 2000, s 2(4).

¹⁷ Local Government Act 2000, s 2(5).

¹⁸ Department for Communities and Local Government, *Power to Promote Well-Being of the Area: Statutory Guidance for Local Councils* (2009) para 93 and Welsh Assembly Government, *Power to Promote or Improve Economic, Social or Environmental Well-Being* (2009) para 3.8.

make a grant available to other organisations, where it will improve the well-being of individuals, groups or the community as a whole.¹⁹

11.24 In addition, the well-being power contains no restriction or limitation on the amount of money a local authority can spend.²⁰ That said, the possibilities afforded to authorities by this power are not infinite. For example, it must be interpreted in accordance with the general principle of *Wednesbury reasonableness*; the activities undertaken should benefit local people without imposing a disproportionate cost on council's resources; and the well-being power cannot be used to raise money.²¹ In exercising the well-being power the local authority must have prepared and have regard to any sustainable community strategy.²² Also, the well-being power does not enable local authorities to do anything that they are unable to do by virtue of a "prohibition, restriction or limitation" which is contained in any other enactment.²³

11.25 A review of the well-being power found that it was being used mainly to resolve uncertainty where the necessary legal powers already exist, but are not clear; where there is no available legal power, to engage in completely new areas of activity; as a power of first resort, to avoid having to mine and specify all the different pieces of legislation; and as a visible sign that the authority is engaging in new approaches and activities.²⁴ In *R (J) v Enfield London Borough Council* it was held that, in circumstances where the claimant was unlawfully in the UK and the local authority had no power under the Children Act 1989 or NAA 1948 to provide accommodation, the authority must use the well-being power if that is the only way in which it could avoid a breach of the person's article 8 rights under the ECHR.²⁵

The well-being power and adult social care

11.26 It is clear that there is potentially much overlap between adult social care services and the use of the well-being power. This issue, however, is not addressed by any Government guidance. In our view, the well-being power can be used by local authorities to provide social care and other services, including those that do not conform to the traditional model of social care. This can include services to people who fall below the local authority's eligibility threshold. A payment or grant can also be provided under this power, which appears similar but is in legal terms distinct from a direct payment.

¹⁹ Department for Communities and Local Government, *Power to Promote Well-Being of the Area: Statutory Guidance for Local Councils* (2009) para 59.

²⁰ As above, para 65 (England) and Welsh Assembly Government, *Power to Promote or Improve Economic, Social or Environmental Well-Being* (2009) para 2.13.

²¹ As above, paras 56 and 58 (England) and para 3.4 (Wales), and Local Government Act 2000, s 3(2).

²² Local Government Act 2000, s 2(3).

²³ Local Government Act 2000, s 3(1).

²⁴ Department for Communities and Local Government, *Practical Use of the Well-Being Power* (2008) pp 4 to 5.

²⁵ [2002] EWHC 432 (Admin), (2002) 5 CCLR 434.

- 11.27 Any use of the power must promote the well-being of the local area and regard must be had to the authority's sustainable community strategy. Also, it cannot be used as a way of avoiding existing prohibitions, restrictions or limitations on the provision of social care services. Examples could include the requirement of ordinary residence for services provided under section 2(1) of the CSDPA 1970 and restrictions on the use of direct payments under the Health and Social Care Act 2001 (such as purchasing long-term residential care or local authority in-house services). Finally, the well-being power cannot be used to avoid the underlying duties to provide services under adult social care law; for example, while the well-being power can be used as a power of first resort, it could not be used to avoid the duty to assess and meet eligible needs.
- 11.28 Local authorities may but are not required to charge for services provided under the well-being power. There is, however, specific legislation and statutory guidance that applies to charging for community care services and therefore, if the well-being power was being used to provide such services to meet assessed eligible needs, any charges would need to be made in accordance with the relevant guidance.²⁶ In other cases, however, the local authority would not be bound legally by this guidance.

The future role of the well-being power

- 11.29 The potential breadth of the well-being power gives rise to a broad conceptual issue of whether the power could be developed as an alternative to adult social care law. Clearly, this would represent a radical reconceptualisation of adult social care. However, it would be possible for the well-being power to become the vehicle for the provision of all community care services, rather than retaining separate adult social care legislation. As noted above, the well-being power can already be used to provide community care services, as well as services that do not conform to the traditional model of social care. One of the main advantages of using the well-being power in this way is that it could encourage greater flexibility and innovation in the provision of services.
- 11.30 The main difference between the two regimes is that while it is possible to establish strong individually enforceable entitlements to services under adult social care law, the use of the well-being power is discretionary. In order to preserve the existing rights of service users it would therefore be necessary to ensure that strong and enforceable rights to services can be secured through the use of the well-being power. This could be achieved by linking the well-being power to a community care assessment. In effect, our proposed statute would contain the assessment procedures and if the person was assessed under this statute as having *eligible needs*, a duty would arise to provide services to meet those needs by using the well-being power. In this way, the well-being power would become the vehicle through which community care services are provided, rather than adult social care legislation. It follows that if the person does not have assessed *eligible needs*, the authority would retain its existing discretion to provide services under the well-being power.

²⁶ For example, Department of Health, *Charging for Residential Accommodation Guide* (2009).

- 11.31 As noted above, the well-being power does have some restrictions on its use. In particular, it cannot be used by local authorities to do anything that they are unable to do by virtue of a prohibition, restriction or limitation which is contained in any other enactment. In contrast, community care legislation contains a wide range of restrictions, including the statutory prohibitions on the provision of health and housing services, the ordinary residence rules and the limits on the provision and use of direct payments. If the provision of services were left to the well-being power, it would be necessary to retain a separate adult social care statute to set out all of the existing restrictions and prohibitions on the provision of services (alongside the duty to assess).
- 11.32 It is not clear what the advantages would be of such an arrangement. The power to provide services would simply be transferred from one legal provision to another. It would not enable a wider range of community care services to be provided, since as noted in Part 9 (Scope of Adult Social Care Services) the existing definition is already wide. Furthermore, it would be confusing to create a legal structure under which one statute sets out an assessment process and the restrictions on the provision of services, but a different statute enables services to be provided. This would replicate, albeit to a lesser degree, the existing community care legal structure that we have criticised as confusing and complex. As set out in Part 2 (Our Approach to Law Reform), we believe that there are cogent reasons in favour of a single and comprehensive adult social care statute.

Question 11-1: We welcome further comments on how the well-being power is being or should be used in practice.

HOSPITAL DISCHARGE

- 11.33 The CC(DD)A 2003 establishes distinct procedures for community care and carers' assessments in relation to NHS patients who are being discharged from acute medical care. This Act has not been implemented in Wales, and currently does not extend to discharge from mental health, maternity, palliative care, intermediate and rehabilitative or recuperation care.²⁷
- 11.34 The CC(DD)A 2003 places a duty on NHS bodies to give notice to the relevant social services authority if they consider that it is unlikely to be safe to discharge a patient from hospital unless community care services are provided.²⁸ Before issuing this notice, the NHS body must consult both the patient and where appropriate their carer and be satisfied that the patient is not entitled to NHS Continuing Healthcare.²⁹ The notice can be given up to eight days before admission to hospital and up to two days before discharge.³⁰
- 11.35 Once the notice has been given, the social services authority must carry out a community care assessment and where appropriate a carer's assessment, to identify services that need to be available to ensure safe discharge and decide

²⁷ Delayed Discharge (England) Regulations 2003, SI 2003 No 2277, reg 3.

²⁸ CC(DD)A 2003, ss 2(1) to 2(2).

²⁹ Delayed Discharges (Continuing Care) Directions 2009, dir 2.

³⁰ CC(DD)A 2003, s 2(3)(b) and Delayed Discharge (England) Regulations 2003, SI 2003 No 2277, reg 6.

which, if any, services will be provided. Before making this decision, the social services authority must consult with the responsible NHS body. The social services authority is also required to inform the NHS body of its decision whether or not to provide services, and any alterations to that decision.³¹

- 11.36 After an NHS body has given notice, it must consult the social services authority before deciding which health services it will provide on discharge. The NHS body is also required to issue a notice of discharge to the social services authority at least one day before the proposed discharge date. Patients and carers should be informed of the discharge date before the notice of discharge is given to the social services authority.³²
- 11.37 If a patient's discharge from acute services is delayed solely because social services failed to carry out an assessment or failed to provide services to the patient or carer, it must financially reimburse the relevant NHS trust. The current charge, which may be increased by regulations, is £100 per day for most social services authorities but £120 for certain Higher Rate Authorities.³³

Provisional view

- 11.38 We do not propose to amend the content of the CC(DD)A 2003 nor the relevant regulations. Amongst other matters, this would mean that the Welsh Ministers would continue to have the option, but would not be required, to implement these provisions. Although the CC(DD)A 2003 places duties on NHS bodies, as well as social services authorities, we propose that this legislation should be incorporated into our future adult social care statute rather than remaining as a stand-alone statute. This is on the basis that most of the legal requirements in this legislation are placed on local social services authorities. We welcome views or comments on the delayed discharge procedures and, in particular, whether these procedures could be refined or simplified. Government policy has placed a high priority on reducing delayed discharges from NHS hospitals and the CC(DD)A 2003 is the legal means of implementing this policy. We welcome views on whether the delayed discharge procedures are the best way of doing this.

Provisional Proposal 11-5: We provisionally propose that the delayed discharge provisions should be retained in their existing form in our proposed adult social care statute.

PRISONS

- 11.39 Research shows that, relative to the general population, prisoners experience poorer physical and mental health; higher levels of learning difficulties; and

³¹ CC(DD)A 2003, s 4.

³² CC(DD)A 2003, s 5 and Delayed Discharge (England) Regulations 2003, SI 2003 No 2277, reg 5(3).

³³ CC(DD)A 2003, s 6(2) and Delayed Discharge (England) Regulations 2003, SI 2003 No 2277, reg 7 and sch.

poorer social skills.³⁴ The incidence of these needs will continue to rise due, not least, to the increasing number of prisoners and, more specifically, older prisoners.³⁵ Research also shows that some prisoners provide care for disabled prisoners (sometimes paid care), such as assistance with getting dressed, cell cleaning and personal hygiene.³⁶ However, there are few examples of adult social care services being provided for prisoners. The reasons for this are varied but some have pointed to the lack of clarity in the law.³⁷

The legal framework for adult social care in prisons

- 11.40 In most cases, the local authority's duty to assess an individual's needs for community care services under section 47(1) of the NHSCCA 1990 is not affected by the fact of imprisonment. There is nothing in the NHSCCA 1990 or any other community care statutes that excludes prisoners expressly from the class of persons to whom services can be provided. Of course, many services will be irrelevant for meeting the needs of prisoners, such as the provision of residential accommodation under section 21 of the NAA 1948, but as a matter of law, prisoners are not excluded. Furthermore, there is nothing in carers' legislation to exclude carer-prisoners from a local authority's duty to carry out a carer's assessment and power to provide services to carers.
- 11.41 Support for this position can also be found in the analogous case of *R (Howard League for Penal Reform) v The Secretary of State for the Home Department*, which held that the equivalent assessment duty for children does not cease to be owed by reason of the fact that the child is detained in custody; although the functions, duties and responsibilities owed by a local authority to a child in need will be affected by the fact that the child is in custody.³⁸ We see no reason why the same principle would not apply to adult prisoners. In giving judgement, Lord Justice Munby, when he was a High Court judge, recognised that local authorities need to take into account the limitations upon their resources and can lawfully take the view that, whilst a child is detained in custody "his or her needs for services would (at least ordinarily) be adequately met by the facilities provided by the Prison Service".³⁹ This suggests that the duty to carry out a community care assessment in prisons, if implemented lawfully, would not create onerous demands on local authorities.
- 11.42 The possibility that prisoners may be eligible for services raises the further question of whether direct payments can be provided. Recipients must, in the

³⁴ For example: A Bridgwood and G Malbon, *Survey of the Physical Health of Prisoners 1994* (1995); T Marshall and others, *Health Care in Prisons: A Health Care Needs Assessment* (2000); P Mottram, *HMP Liverpool, Styal and Hindley Study Report* (2007); C Smith, "Assessing Health Needs in Women's Prisons" (1998) 118 *Prison Service Journal* 22.

³⁵ Prison Reform Trust, *Doing Time: The Experiences and Needs of Older People in Prison* (2008).

³⁶ HM Inspectorate of Prisons, *'No Problems – Old and Quiet': Older Prisoners in England and Wales: A Thematic Review by HM Chief Inspector of Prisons* (2004) para 1.63.

³⁷ Prison Reform Trust, *Doing Time: The Experiences and Needs of Older People in Prison* (2008) p 5.

³⁸ [2002] EWHC 2497 (Admin), (2003) 6 CCLR 47.

³⁹ As above, at [156].

opinion of the local authority, be capable of managing a direct payment alone or with assistance.⁴⁰ Beyond that, the possibility of receiving direct payments is circumscribed by a number of exclusions, which refer to people who are subject to certain criminal justice community orders, but which do not include prisoners.⁴¹ This appears to be another example of a lack of consideration of the position of prisoners by those drafting the relevant provisions. Of course, the restrictions on prisoners' finances and the practical difficulties in arranging services from prison would make direct payments unsuitable for prisoners. As a matter of law, however, prisoners are not necessarily excluded from direct payments. Nonetheless, the legal framework does provide barriers to the provision of services to prisoners, namely the ordinary residence rules and eligibility criteria.

Ordinary residence

- 11.43 The ordinary residence guidance only covers the position of people leaving prison and not that of prisoners serving sentences. The advice given is that local authorities could reasonably apply the approach set out in section 24 of the NAA 1948 when considering responsibility for people leaving prisons and similar establishments. In effect, a prisoner would be considered to be ordinarily resident in the area in which they were resident before being detained, and if the person was not ordinarily resident in any area prior to detention, the responsible local authority is the one in whose area the prisoner is at the time.⁴²
- 11.44 The Department of Health's draft revised ordinary residence guidance also advises that local authorities could start from the assumption that people who are due for release from prison remain ordinarily resident in the area in which they were living before the start of their sentence. It recognises, however, that this assumption may be rebutted by a number of factors, including the offender's wishes and intentions about where to live, the length of their sentence and remaining ties with their previous area, including whether the nature of their offence precludes a return to their original locality. Where it is not possible for an offender to return to their previous area of ordinary residence, or where an offender was not ordinarily resident in any area prior to being sentenced, then the guidance advises that the authority into which they are moving may have a duty to assess. It is suggested that it would be good practice to initiate joint planning for release at least three months before it is due.⁴³
- 11.45 Although the relevant guidance does not mention explicitly the position of prisoners who are not due for release, it is likely that a similar approach would apply. Thus, local authorities should start from the assumption that prisoners maintain attachment to the local authority of their pre-imprisonment residence. However, this would depend on a number of factors, including the length of the sentence, and should be approached on a case-by-case basis. In cases where

⁴⁰ Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009, SI 2009, No 1887, reg 2(a).

⁴¹ As above, sch 1.

⁴² LAC(93)7, *Ordinary Residence*, para 14.

⁴³ Department of Health, *Ordinary Residence: A Consultation on the Revision of Guidance on the Ordinary Residence Provisions in the National Assistance Act 1948* (2009) paras 99 to 103.

this assumption can be rebutted, there are four possible decisions that could be made concerning the ordinary residence of the prisoner. The outcome of each decision is the same – the prisoner would be the responsibility of the local authority in which the prison is located – but the reasons for each decision differ and have important consequences for the prisoner’s entitlement to services.

- 11.46 *First*, the prisoner could be found to be ordinarily resident in the local authority in which the prison is located and therefore, entitled to services from that authority on the same basis as non-prisoner residents. *Second*, the prisoner could be found to be of *no settled residence*. In strict terms, this applies only to authority liability for the provision of residential accommodation, but if it were applied in these circumstances, the authority in which the prison is located would have a power but not a duty to provide services. *Third*, the prisoner could be in *urgent need* and not ordinarily resident in the area of the authority in which the prison is located. Again, in strict terms this applies only to the provision of residential accommodation, but would mean that the authority in which the prison is located would have a power but not a duty to provide services. *Finally*, the prisoner could be found to be *ordinarily resident elsewhere*, whereby the authority in which the prison is located would retain a power but not a duty to provide services but might still be required to carry out a community care assessment.⁴⁴ The decision as to the ordinary residence status of a prisoner will be resolved in the light of the specific circumstances of the case. However, for present purposes it is important to note that the guidance and the legislation do not cater for the circumstances of prisoners who are not due to be released and this in itself may serve as a barrier to the provision of adult social care services.

Eligibility criteria

- 11.47 It may be the case that prisoners are, in general terms, less likely than non-prisoners to meet the local authority’s eligibility criteria, especially if the eligibility threshold has been set at *critical* or *substantial* needs. One reason is that FACS and UFSAMC were not drafted to take into account the particular circumstances of prisoners and do not mention them as a specific class of people who may be eligible for community care services. Many, although by no means all, of the descriptors used in the eligibility framework are irrelevant to the circumstances of prisoners; for example, a substantial need is described as *partial choice and control over the immediate environment* and/or *vital family or social roles cannot be undertaken*.
- 11.48 However, eligibility criteria can only provide a barrier to the provision of community care services if an assessment has been carried out in the first place. Much of the evidence set out above suggests that community care assessments are rare in prisons. Thus, the operation of eligibility criteria may provide a barrier to the provision of community care services to prisoners but it currently appears to be a largely hypothetical barrier.

Service provision by prison and health authorities

- 11.49 It may be the case that community care services are not being provided in prisons because other organisations provide similar services. The Prison Service

⁴⁴ *R v Berkshire City Council ex p P* (1997-98) 1 CCLR 141.

has responsibility for those in its care, including a common law duty of care.⁴⁵ Protection against inhuman and degrading treatment or punishment is provided by articles 3 and 8 of the ECHR, and a number of positive obligations will be imposed on prison services.⁴⁶ In addition, Part 3 of the Disability Discrimination Act 1995 makes it unlawful for public authorities, including prisons, to discriminate without justification against a disabled person when exercising its functions, which includes a requirement to make “reasonable adjustments” for disabled people. Part 5A of the Disability Discrimination Act 1995 places a duty on public authorities, including prisons, to promote equality of opportunity for disabled people.

- 11.50 A Prison Service Order has been issued outlining Governors’ responsibilities under the Disability Discrimination Act 1995.⁴⁷ This gives examples of reasonable adjustments, including providing a handrail in a cell, a vibrating alarm clock for a prisoner who is deaf, suitable adapted cutlery and eating aids, the use of portable ramps to facilitate access, and user friendly documents and signs.⁴⁸ In addition, the needs of disabled prisoners must be considered and accommodated in any refurbishments undertaken, such as accessible bathing facilities, avoiding steps in favour of ramps, fitting visible as well as audible alarms, clear markings and signs.⁴⁹ In practice, there will be much overlap between these types of adjustments and community care services provision, and it may be the case that many prisoners’ needs that would normally be met by a local authority in the wider community are being met by the prison authorities under the Disability Discrimination Act 1995.
- 11.51 Since 2003, the Secretary of State for Health has assumed responsibility from the Home Secretary for securing a range of health services to prisoners, and responsibility for commissioning services has been delegated to Primary Care Trusts. Since 2006, the responsibility for commissioning prison health services in Wales has been transferred to Local Health Boards. Current government policy on offender healthcare is based on the principle that standards of healthcare for those in custody should be the same as for those in the wider community.⁵⁰ Examples of prison-based healthcare include general medical services, nurse-led healthcare teams and mental health in-reach teams. Some of these services will involve an element of adult social care; for example, some mental health in-reach teams include social workers and some prison-based healthcare assistants undertake “by default” social care tasks such as assistance with bathing and dressing.⁵¹ It might be the case that local authorities assume that a prisoner’s basic social care needs are being addressed by health services (possibly in

⁴⁵ *Racz v Home Office* [1994] 2 AC 45.

⁴⁶ *R (Howard League for Penal Reform) v The Secretary of State for the Home Department* [2002] EWHC 2497 (Admin), (2003) 6 CCLR 47 at [65] to [66].

⁴⁷ HM Prison Service, *Prison Service Order 2855: Prisoners with Disabilities* (2008).

⁴⁸ As above, para 8.2.

⁴⁹ As above, para 6.14.

⁵⁰ Joint Prison Service and National Health Service Executive Working Group, *The Future Organisation of Prison Health Care* (1999) p iii.

⁵¹ CSIP West Midlands Development Centre and University of Birmingham, *Adult Social Care in Prisons: A Strategic Framework* (2007) p 19.

combination with a prison acting under the Disability Discrimination Act 1995), and therefore, prisoners are unlikely to require community care services.

Practice difficulties

- 11.52 It is possible that the law is entirely adequate for the fulfilment of prisoners' care needs but is being undermined in the implementation. Relevant practice difficulties may include the lack of a framework or strategy for the provision of health and social care in prisons;⁵² poor interagency working and gaps between services;⁵³ insufficient resources and lack of staff training or expertise;⁵⁴ practical difficulties associated with providing services to prisoners who are assessed as being a danger to the public;⁵⁵ and some disabled prisoners not being at the correct security level.⁵⁶

Provisional view

- 11.53 For the reasons outlined above, we consider that the current adult social care legal framework does not exclude prisoners. However, this situation does not arise by design or as a result of a clear policy decision but by oversight. Consequently, many of the rules and much of the guidance in this area of law have not been written with prisons in mind, most notably the ordinary residence rules and the eligibility framework. In addition, the provision of services by prisons and health authorities and various non-legal practice issues also provide barriers to the provision of adult social care services.
- 11.54 At this stage, we have only sought to clarify the current legal position. However, in our view the law cannot operate effectively unless a policy decision is made by Government about whether prisons should be included or excluded from adult social care. If it is decided that prisons should be excluded from adult social care legislation, then our future adult social care statute would need to make this clear. If it is decided that prisons should not be excluded, then it will be necessary to ensure that the legal framework facilitates this policy. We welcome comments on any aspects of the analysis provided above, and on whether adult social care services should be provided in prisons.

Question 11-2: We welcome comments about whether prisons should be included or excluded from adult social care.

SECTION 117 OF THE MENTAL HEALTH ACT 1983

- 11.55 Section 117 of the Mental Health Act 1983 requires health authorities and local

⁵² The Government has announced the introduction of such a plan: see, Department of Health, *Offender Health and Social Care Strategy Data Report* (2008) and Welsh Assembly Government and others, *Joining Together in Wales: An Adult and Young Person's Strategy to Reduce Re-Offending* (2006).

⁵³ J Talbot, *No-one Knows: Identifying and Supporting Prisoners with Learning Difficulties and Learning Disabilities* (2007).

⁵⁴ As above.

⁵⁵ J Reed, "Delivering Psychiatric Care to Prisoners: Problems and Solutions" (2002) 8 *Advances in Psychiatric Treatment* 117.

⁵⁶ Sainsbury Centre for Mental Health, *London's Prison Mental Health Services* (2006).

social services authorities, in co-operation with voluntary agencies, to provide after-care to patients detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Act, who then cease to be detained and leave hospital. It originated as an opposition amendment to the Mental Health (Amendment) Bill 1981, which was initially opposed by the Government but then accepted based on the mistaken belief that it merely duplicated the general duty to provide health services under section 3 of the NHS Act 1977 (which has since been incorporated into the NHS Acts 2006).⁵⁷ Case law has confirmed that section 117 goes much further by placing an enforceable joint duty on local authorities and health bodies to consider the after-care needs of each individual to whom it relates.⁵⁸ Furthermore, responsible authorities cannot charge for services provided under section 117.⁵⁹

11.56 After-care services are not defined in the legislation. The Code of Practice in England does not give any specific examples but states that they can include services provided directly by Primary Care Trusts and local social services authorities, as well as services they commission from other providers, and it sets out a broad list of potential needs that an assessment for services might address.⁶⁰ However, the *National Framework for NHS Continuing Healthcare*, suggests that after-care services must be provided for a reason related to mental disorder and may not include services to meet physical health problems.⁶¹ The Code of Practice in Wales defines after-care as services provided to meet an assessed need “arising from the patient’s mental disorder” and are aimed at “reducing the likelihood of the patient being readmitted to hospital for treatment for that disorder”; examples include social work assistance and the administration and monitoring of medication.⁶² The definition of after-care services has also been developed through case-law, which has established a broad definition that includes social work, assistance with problems of employment, accommodation or family relationships, domiciliary services, day centre and residential facilities.⁶³

11.57 In our scoping report, we set out our view that section 117 should remain as a standalone community care provision in the Mental Health Act 1983 and would not, therefore, be brought into our proposed adult social care statute.⁶⁴ The main reason for this is that section 117 applies to a specific group of former mental health patients whose needs are linked directly to the 1983 Act, since services are required in order to reduce their chance of being readmitted to hospital. Furthermore, section 117 cannot be described as a pure social care enactment, since it establishes a joint duty on social services *and* the NHS, and would not fit

⁵⁷ *Hansard* (HL), 23 February 1982, vol 427, col 913 (Lord Elton).

⁵⁸ *R v Ealing District Health Authority ex p Fox* [1993] 1 WLR 373.

⁵⁹ *R (Stennett) v Manchester City Council* [2002] UKHL 34, [2002] 2 AC 1127.

⁶⁰ Department of Health, *Code of Practice: Mental Health Act 1983* (2008) paras 27.4 and 27.13.

⁶¹ Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care: July 2009 Revised* (2009) paras 115 to 116.

⁶² Welsh Assembly Government, *Mental Health Act 1983: Code of Practice for Wales* (2008) para 31.2.

⁶³ *Clunis v Camden and Islington Health Authority* [1998] QB 978, 992.

⁶⁴ Law Commission, *Adult Social Care: Scoping Report* (2008) para 4.192.

easily into our proposed statute. However, we consider below whether section 117 could or should be more fully integrated within the legal framework for the provision of adult social care services.

The choice of accommodation directions

- 11.58 As discussed in Part 10 (Delivery of Services), when a local authority has decided that residential accommodation should be provided, the choice of accommodation directions require the authority to accommodate that person at the place of his or her choice within England and Wales. These directions apply only to accommodation provided under section 21 of the NAA 1948. In *R (Stennett) v Manchester City Council*, the House of Lords held that section 117 imposes a free-standing duty to provide after-care services and is not a gateway provision that leads to services being provided under other statutes.⁶⁵ As a consequence of this decision, the choice of accommodation directions do not apply to residential accommodation provided under section 117.
- 11.59 This means that, at least in law, the choice of accommodation of a section 117 service user is given less recognition than a service user who is being provided with accommodation under the NAA 1948. However, it is not the case that a section 117 service user's preference is irrelevant. It has been held that the preference of a person must be taken into account and given appropriate weight by the local authority when undertaking an assessment and any care and support planning.⁶⁶ This holds for all services users, including those being provided with accommodation under section 117. However, a requirement to *take into account* and give *appropriate weight* to a service user's choice is not as strong as the requirement contained in the choice of accommodation directions.

Provisional view

- 11.60 We provisionally consider that the choice of accommodation directions should apply to accommodation provided under section 117 of the Mental Health Act 1983. In principle, service users should be given the right to choose the accommodation that is being provided by a local authority, irrespective of whether or not section 117 applies. This principle is already established in relation to non-residential services, since all service users, including section 117 service users, are potentially eligible for the provision of direct payments. The directions are an important aspect of community care law and the inability of a section 117 service user to access the same rights through legislation creates an anomaly in the law.

Provisional Proposal 11-6: We provisionally propose that the choice of accommodation directions should cover residential accommodation provided under section 117 of the Mental Health Act 1983.

The additional payments regulations

- 11.61 As noted in Part 10 (Delivery of Services), the additional payment regulations provide that, where a resident chooses accommodation that is more expensive than the local authority would usually expect to pay, the resident can be placed in

⁶⁵ [2002] UKHL 34, [2002] 2 AC 1127.

⁶⁶ *R v North Yorkshire County Council ex p Hargreaves* (1997-98) 1 CCLR 104.

the more expensive accommodation, provided that a third party, such as a relative or friend, is able and willing to top-up the difference.⁶⁷ These regulations apply to residential accommodation provided under section 21 of the NAA 1948 and, again as a consequence of the decision in *Stennett*, do not extend to accommodation provided under section 117.

- 11.62 However, there is uncertainty over whether, outside of the regulations, a section 117 service user or a third party can make payments in order to procure more expensive accommodation than the local authority would normally expect to pay. There is no express statutory prohibition on making such payments and this issue has not been addressed by case law or guidance. Furthermore, the Local Government Ombudsman has found nothing wrong with arrangements that enable section 117 service users to make payments to meet the additional costs of a care home.⁶⁸
- 11.63 However, in the absence of any power to charge for section 117 services, it is difficult to argue that there is a power for a local authority to accept voluntary payments towards the cost of a service. This concern, however, may be less relevant where a section 117 service user or a third party makes the top-up payment directly to the care home. Also, it may be the case that the well-being power, under section 2 of the Local Government Act 2000, could be used in these circumstances to enable section 117 service users or third parties to make additional payments. In any event, it is likely that the lack of certainty on this point will mean that local authorities are taking different approaches.

Provisional view

- 11.64 We propose that the additional payments regulations should apply to section 117 after-care. In principle, service users and third parties should be given the right to make additional payments, irrespective of whether or not section 117 applies. This proposal would introduce greater clarity and certainty regarding the ability to make additional payments.

Provisional Proposal 11-7: We provisionally propose that the additional payments regulations should cover residential accommodation provided under section 117 of the Mental Health Act 1983.

Ordinary residence

- 11.65 The concept of *ordinary residence* does not apply to section 117 after-care services. Instead, section 117(3) of the Mental Health Act 1983 states that the duty to provide after-care services falls on the authorities "for the area in which the person concerned is resident or to which he is sent on discharge by the hospital in which he was detained". Lord Justice Scott Baker, when he was a High Court judge, held that the relevant after-care bodies for the purposes of

⁶⁷ National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Amendment) (England) Regulations 2001, SI 2001 No 3441 and the National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Wales) Regulations 2003, WSI 2003 No 931.

⁶⁸ Local Government Ombudsman, Complaint No 05/C/13158 against North Yorkshire County Council, 24 July 2007.

section 117(3) were those for the area in which the patient was resident before being detained in hospital and this was the case notwithstanding that the patient can be discharged to a different part of the country and is not likely to return.⁶⁹ Where a patient has no place of residence, the relevant bodies will be those to which the patient is sent on discharge by the hospital.⁷⁰ This position has subsequently been reflected in Department of Health guidance.⁷¹

- 11.66 Thus, the term *resident* in section 117 is given a different meaning to *ordinary residence* under the NAA 1948 and CSDPA 1970, which can lead to a number of difficulties in practice. Confusion can arise because different rules will apply to individual mental health patients depending on whether or not section 117 applies. The problem is compounded by the fact that there is far less guidance or case law to assist with determining the meaning of residency under section 117(3), compared to ordinary residence, and disputes between authorities may be more likely. Furthermore, disputes over the residency of a section 117 patient cannot be referred to the Secretary of State or Welsh Ministers for determination under section 32(3) of the NAA 1948 and consequently, if the dispute cannot be resolved locally, it is necessary to involve the courts.

Extending ordinary residence to section 117

- 11.67 In considering whether the concept of ordinary residence could or should apply to section 117, we are not seeking to alter the existing responsibilities for providing after-care services to any given patient. That is a policy question and beyond our remit. We are, instead, concerned with applying ordinary residence to section 117 and retaining the *effect* of the existing rules under section 117(3).
- 11.68 If the ordinary residence rules were extended to cover section 117, then the responsible social services authority would be the authority for the area in which the patient was resident at the time of admission. Where residential accommodation is being provided on discharge, the patient would retain their prior ordinary residence, even if they were placed out of the area. If the patient has *no settled residence* then responsibility would lie with the authority for the area where the hospital is located. In all of these examples, there would be no change from the current position that exists under section 117(3).
- 11.69 The main change that would occur would be in relation to section 117 patients who are discharged to a new local authority and residential care is *not* being provided. Under section 117(3), the patient would remain the responsibility of the authority in which they were resident at the time of admission. Under the ordinary residence rules, the patient would be the responsibility of the new authority. This would not only change the current position but it could undermine the ability to plan after-care services. The section 117 duty only crystallises once a patient has left hospital;⁷² therefore, the new authority would become responsible *post discharge*. This could result in stalemate and unnecessary delay if a patient cannot be discharged unless the authority puts after-care services in place, but

⁶⁹ *R v Mental Health Review Tribunal ex p Hall* [1999] 2 CCLR 361, 371(J).

⁷⁰ As above.

⁷¹ HSC 2000/003 and LAC(2000)3, *After-Care Under the Mental Health Act 1983*, para 5.

⁷² *R v Ealing District Health Authority ex p Fox* [1993] 1 WLR 373.

the authority will not accept responsibility until the patient has been discharged.

- 11.70 It would, however, be possible to maintain the existing legal position by creating different ordinary residence rules for section 117 patients, which provide that the patient would remain the responsibility of the local authority in which the patient was ordinarily resident before being detained in hospital. The effect would be to retain the current position under section 117(3), but to bring section 117 after-care under the umbrella of ordinary residence. Since the ordinary residence rules already establish a special case for people placed in residential accommodation, it would not be difficult to also establish section 117 as special case.
- 11.71 These separate rules could apply to all section 117 services. This would mean that the *effect* of the existing rules under section 117(3) would continue, and that section 117 patients would benefit from access to the dispute resolution procedures. Alternatively, the separate rules could apply *only* in circumstances where a section 117 patient is discharged to a new authority and residential care is not being provided. Again, this would mean that the effect of section 117(3) would be retained, and that all patients would gain access to the dispute resolution procedures. Also, most section 117 patients gain from the existing guidance and case law for determining the meaning of ordinary residence.

Provisional view

- 11.72 We provisionally propose that the concept of ordinary residence should be extended to apply to section 117 after-care services and that the effect of the existing rules under section 117(3) should be retained. This would mean that the patient would remain the responsibility of the local authority in which they were resident at the time of admission. In order to achieve this, separate rules will need to be introduced for some or all section 117 patients. We welcome views on whether these separate rules should apply to all section 117 services, or only in circumstances where a section 117 patient is being discharged to a new local authority and residential care is not being provided.

<p>Provisional Proposal 11-8: We provisionally propose that the concept of ordinary residence should be extended to apply to after-care services provided under section 117 of the Mental Health Act 1983.</p>

The nature of the joint duty

- 11.73 Section 117 is a joint duty placed on health and social services authorities but it is not clear from the statute whether the duty falls jointly and severally on health and social services authorities, in that both are responsible for the entire duty, or whether the duty falls primarily on health authorities to provide *health care after-care* and social services authorities to provide *social care after-care*. Arguably, the wording of section 117 suggests the former interpretation, but it may be the case that many authorities use the latter interpretation, on the basis that this often makes organisational sense. In our view it is unlikely that a court would regard a health body as being accountable for the provision of *social care after-care*, or a social services authority as being accountable for *health care after-care*. However, the position is not clear in law and this could cause difficulties; for example, where a PCT and local authority are in dispute over who should provide a specific service, or where a service user is seeking to secure the provision of a specific service and is not clear who is responsible for providing it.

11.74 In addition, the section 117 duty is to “provide” after-care but apart from the reference to doing so “in co-operation with relevant voluntary agencies”, there is nothing stating that health and social services authorities may commission services from other providers. In practice, however, most authorities commission section 117 services and it is likely that a court would agree that *provide* must imply *commission*. However, section 117 leaves room for doubt, in contrast to most health and social care statutes, where the power to commission is explicit.

Provisional view

11.75 We propose that section 117 should be amended to state expressly that the duty falls on health authorities to provide *health care after-care*, and on social services authorities to provide *social care after-care*. This would establish legal clarity and is likely to reflect how section 117 is interpreted in practice. However, we welcome any further evidence on this point. We also welcome views on whether splitting the joint duty in this way might undermine the operation of existing NHS and local authority partnership arrangements, which enable some degree of flexibility on how the joint duty is implemented.

11.76 If this proposal were implemented, it would be necessary to be clear when the section 117 duty is to end. The existing duty to provide after-care continues until such time as the health *and* social services authority are satisfied that the person concerned is no longer in need of such services. We welcome views on whether the termination of the duty should also be split so that, for example, *social care after-care* ceases when the social services authority is satisfied that the person no longer needs social care after-care; or whether both authorities should be involved in the decision.

11.77 Finally, we also propose that section 117 should be amended to clarify that health and social services authorities can commission after-care services.

Provisional Proposal 11-9: We provisionally propose that section 117 should be amended to clarify that the duty falls on health authorities to provide *health care after-care*, and on social services authorities to provide *social care after-care*. We also propose that section 117 should be amended to clarify that health and social services authorities can commission after-care services.

Question 11-3: If the section 117 duty should be split between health and social services authorities, should the termination of the duty also be split so that, for example, *social care after-care* ceases when the social services authority is satisfied that the person no longer needs social care after-care; or should both authorities be involved in the decision?

Section 117 as a free-standing duty

11.78 Much of the preceding discussion raises fundamental questions about the nature of section 117 as a free-standing duty, rather than a gateway provision. The decision in *Stennett* had one significant policy effect, namely preventing responsible authorities charging for section 117 services. However, the confirmation that section 117 is a free-standing duty also brings with it many complications and anomalies, mainly because the rules that govern the provision of section 117 services are different to the rules that apply to services provided under other legislation. As discussed above, *after-care* is not defined in the

Mental Health Act 1983 and can include a wide range of services that are related to a person's mental disorder and aimed at reducing the chances of readmission to hospital. In practice, there will be little qualitative difference between the *kinds* of services provided under section 117 and those that are provided to people with mental health problems under other legislation.

- 11.79 This might lead to the conclusion that the rules which govern service provision should be the same, regardless of whether services are provided under section 117 or some other power. One possibility, therefore, would be to recast section 117 as a duty to provide services to individuals which health and social services authorities already have a power to provide under other legislation. Thus, section 117 after-care services would be provided through other legal powers available to health and social services authorities, such as the NHS Acts 2006, the Children Act 1989 and adult social care legislation. An existing example of such a gateway provision is section 2 of the CSDPA 1970, which places a duty on local authorities to provide certain services in the exercise of their functions under section 29 of the NAA 1948 and Part 3 of the Children Act 1989. Thus when local authorities are exercising their functions under section 2 of the CSDPA 1970, they are making arrangements for the provision of services under different legislation.⁷³ If section 117 became a gateway duty, it would operate as an enforceable individual duty that is carried out through the provision of services under other legislation, such as the NHS Acts 2006 and our proposed adult social care statute. Furthermore, other matters such as ordinary residence and the respective responsibilities of health and social services authorities would then flow automatically from the other legislation in question. However, to preserve the existing position in relation to charging, the power to charge for community care services would be disapplied in the case of section 117 after-care services.

Provisional view

- 11.80 The main advantage of recasting section 117 as a gateway duty would be that the rules that apply to a person's care package would be the same, irrespective of whether the services in question are being provided under section 117 or some other power. In effect, the current uncertainties, complications and anomalies would be removed. It is also important to emphasise that section 117 would continue to be an enforceable individual duty and the power to charge for section 117 services would be disapplied.

Question 11-4: Should section 117 be recast from a free-standing duty to a gateway provision?
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DUTIES TO CO-OPERATE

- 11.81 Statute law can and has been used to encourage co-operation between social services, the NHS and other organisations. The following provides an analysis of existing duties to co-operate and whether such a duty should be included in our proposed adult social care statute. It is important, however, to recognise the limitations of a legal analysis of duties to co-operate. The extent of co-operation between agencies will depend on a wide range of factors, such as resources,

⁷³ *R v Kirklees Metropolitan Borough Council ex p Daykin* (1997-98) 1 CCLR 512.

social circumstances and personal relationships. Many of these issues apply irrespective of the law or whether duties can be enforced. Therefore, the law is only one factor in ensuring greater co-operation between different agencies. We welcome further evidence on the existing levels of co-operation between social services and other bodies, and where the main problems, if any, arise.

Existing statutory duties to co-operate

- 11.82 Section 82 of the NHS Act 2006⁷⁴ provides an example of a general duty to co-operate. The duty is to a target since it is not expressed as being owed to any specific individual nor does it specify what actions constitute co-operation.⁷⁵ This is significant in legal terms because general duties are difficult to enforce and it is generally left to the authority in question to decide when, and to what extent, the duty comes into being. It is likely that a court would only find a breach of this general duty in extreme circumstances, such as where there has been an express refusal to co-operate on unreasonable grounds. By way of contrast, section 10 of the Children Act 2004 also provides a general duty to co-operate but its terms are far more specific; for example, it requires arrangements to be made to promote co-operation, gives examples of such arrangements, identifies a lead organisation and provides a list of partner agencies.⁷⁶
- 11.83 Section 47(3) of the NHSCCA 1990 is an example of an *invitation to co-operate*. If a community care assessment discloses a possible housing or medical need, the local authority is required to notify the relevant housing or health authority and invite them to assist. This duty applies only *during* the assessment and after its completion.⁷⁷ There is no requirement for the health or housing authority to co-operate with the local authority, but a failure to respond, or a failure to respond within a reasonable time or in a reasonable manner, may be vulnerable to judicial review. In contrast, the equivalent duty in section 27 of the Children Act 1989 enables a local authority to request the help of another organisation and specify the action in question. A requested authority must comply with the request if it is compatible with its own duties.
- 11.84 Section 3 of the C(EO)A 2004 provides an example of an *enhanced duty to request*. Where a local authority requests another authority to assist it in planning the provision of services to a carer or cared-for person, the requested authority must give *due consideration* to the request. In addition, if a local authority has undertaken a carer's assessment and forms the view that the carer's ability to provide and to continue to provide care for the person cared for might be enhanced by the provision of services by another authority, the assessing authority can request that authority to provide any such services and the requested authority must give *due consideration* to the request.
- 11.85 As discussed above, the CC(DD)A 2003 sets out detailed requirements to ensure co-operation between health and social services when NHS patients are being discharged from acute medical care, including requirements for giving notice of

⁷⁴ This also applies in Wales.

⁷⁵ *R v Secretary of State for Social Services ex p Hincks* [1980] 1 BMLR 93.

⁷⁶ Children Act 2004, s 10(4).

⁷⁷ *R (Batantu) v Islington London Borough Council* (2001) 4 CCLR 445, 452(B).

discharge, communication between health and social services and time scales for the completion of assessments. However, this legislation is specific to the unique circumstances of a hospital discharge and is, therefore, unlikely to provide a useful model in other situations. Also as noted above, section 117 of the Mental Health Act 1983 places a joint duty on health and social services to provide after-care services to certain former mental health patients. The primary goal of section 117 is to require health and social services to provide after-care services; it does not set co-operation as a goal in itself, and does not prescribe who should be responsible for providing these services nor the necessary arrangements between health and social services.

Analysis of duties to co-operate

- 11.86 It appears from the above that there are certain characteristics that help to define an effective duty to co-operate. *First*, it must be clear to whom the duty applies. Almost all the legislation discussed above is clear about which bodies the duty to co-operate applies to and establishes a clear lead agency or agencies, which other agencies must co-operate with, rather than requiring organisations to co-operate generally with each other.
- 11.87 *Second*, the duty should have wide coverage. Some of the duties to co-operate are targeted at a handful of organisations; for example, the NHS Act 2006 and the CC(DD)A 2003 apply only to the NHS and local authorities. The advantages of this approach are that it clearly identifies the responsible agencies and prevents the duty becoming diluted amongst a larger number of organisations. However, most legislation recognises that multi-agency co-operation is vital for effective care provision and, therefore, provides an extensive list of relevant organisations. However, it is important that wide coverage is balanced with the first characteristic, which is being clear about to whom the duty applies.
- 11.88 *Third*, it should be clear when the duty applies. Some statutes are unclear on this point. For example, the NHS Act 2006 duty applies when the NHS and local authorities are “exercising their respective functions” and the purpose of co-operation must be to “secure and advance the health and welfare of people in England and Wales”. This can be described as *high-level* and difficult to tie to specific actions. In contrast, the C(EO)A 2004 is more specific, in that the duty applies when a local authority is making plans for or delivering services. Similarly, section 47(3) of the NHSCCA 1990 is activated by the identification of a health or housing need during a community care assessment.
- 11.89 *Fourth*, some form of action should be required by all bodies. Duties that require a two-way flow of obligations appear to be more effective than those that require no response. Thus, section 47(3) of the NHSCCA 1990 is weakened by the absence of any requirement that the invited authority respond to an invitation to assist, whereas the C(EO)A 2004 requires some degree of reciprocity by mandating that the requested authority must give *due consideration* to the request. Section 27 of the Children Act 1989 goes further and requires requested authorities to comply with the request if it is compatible with its own duties.
- 11.90 Finally, the action that is required must be as specific as possible. The CC(DD)A 2003 provides the best example of specific actions but is unlikely to provide a useful model other than in the specific circumstances of hospital discharge. Section 27 of the Children Act 1989 also links the duty to co-operate with

specified actions, since the authority can request the help of another authority “specifying the action in question”.

Provisional view

- 11.91 An important aspect of Government policy in both England and Wales is to encourage joined-up services.⁷⁸ We consider that our proposed statute could facilitate this approach by setting out two duties to co-operate. First, we propose that a general duty should be imposed on each social services authority to make arrangements to promote co-operation with other relevant organisations. The legislation could then provide a list of *relevant organisations*, such as housing, education and health authorities. Like section 10 of the Children Act 2004, the statute could provide examples of arrangements that could be made under this duty, such as sharing information, pooling budgets or staff, or providing types of goods or services. This duty would help to encourage local authorities to be proactive in establishing a general framework that will encourage joint working.
- 11.92 Second, we propose that there should be a specific duty to co-operate, which applies when an assessment is taking place and in other specific circumstances, such as when providing services to an individual. It would also extend to circumstances where a service user is moving from one local authority area to another and safeguarding adults at risk of abuse and neglect. This duty would apply to education, housing, health and other local authorities. As is the case in section 3 of the C(EO)A 2004, the requested authority should be required to give due consideration to the request. We welcome views on this proposal, and whether there are any other circumstances in which this duty should apply and whether the duty should apply to any other bodies.

Provisional Proposal 11-10: We provisionally propose that our future adult social care statute should place a general duty on each social services authority to make arrangements to promote co-operation between the local authority and specified relevant organisations.

Provisional Proposal 11-11: We provisionally propose that our future adult social care statute should specify that a local authority can request certain authorities to assist in a number of circumstances, including when an assessment of a service user or carer is taking place and in providing services to a service user or a carer. In such cases, the requested authority would be under a duty to give due consideration to the request.

⁷⁸ For example, *Shaping the Future of Care Together* (2009) Cm 7673, p 55 and Welsh Assembly Government, *Paying for Care in Wales* (2009) pp 15 to 16.

PART 12

SAFEGUARDING ADULTS AT RISK

- 12.1 For both policy makers and practitioners, there is a difficult balance to be struck between maximising autonomy and ensuring adequate protection for those who need it. Public intervention in the lives of children is often based on the assumption that they lack competence, but with adults a contrary assumption applies. Where an adult lacks capacity and is placed at risk as a result, the need for intervention may be heightened. However, the need for intervention can, in some cases, extend to those with decision-making capacity.
- 12.2 In recent years there have been growing calls for the introduction of new adult protection powers and duties on local authorities. Frequently, the question has been posed as: should there be new legislation? Our view is that looking at the question in this way can obscure rather than elucidate the issues. The primary policy question is about whether there should be new, more intrusive and in some cases compulsory powers aimed at safeguarding adults, including those with mental capacity. Of course, adopting this line would require new legislation. Other policy options, including tidying up the existing law, might also include legislative change but would not imply the new powers sought by some.
- 12.3 It is for the Government to determine the policy of what powers and rules should apply in adult protection cases. The role of the Law Commission is to consider this policy and how the law can facilitate it. It is also within our remit to consider the existing legal framework and how this can be expressed in our proposed structure. However, Government policy in this field is uncertain. The public consultation on the review of the legal framework for safeguarding adults in England closed in January 2009. At the time of writing, there has been one policy announcement; a ministerial statement in January 2010 that adult safeguarding boards will be placed on a statutory footing and, amongst other matters, new guidance will be published in the autumn.¹ It is not clear whether any further legislative reforms will be announced or what changes will be made to the substance of the existing guidance *No Secrets*. The Welsh Assembly Government is also reviewing safeguarding policy and is not expected to set out its policy position until the summer of 2010.²
- 12.4 In light of this uncertainty, we believe that our review can add to the ongoing debate in two ways: *first*, by considering the existing legal framework for safeguarding adults and how this could be expressed in our proposed statute and *second* by considering developing policy and how this could be facilitated in our proposed statute.

A DUTY TO INVESTIGATE AND TAKE APPROPRIATE ACTION

- 12.5 When discussing a duty to *investigate* it is important to be clear about what is

¹ Department of Health, *Written Ministerial Statement: Government Response to the Consultation on Safeguarding Adults: The Review of the No Secrets Guidance* (2010), http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_111286 (last visited 4 February 2010).

² Welsh Assembly Government, *Paying for Care in Wales* (2009) p 21.

meant by this term. Many different bodies have a statutory investigative function. For example, the police have a duty to investigate crime and indeed, the word *investigation* has, for some, become synonymous with a criminal inquiry. However, there are different types of investigation, the precise nature of which will vary according to the powers and role of the relevant organisation. For example, where a service user is at risk of abuse or neglect, the social services authority will normally need to make enquiries in order to decide what action, if any, it *can* and *should* take. The nature of the investigation will, therefore, be circumscribed by the powers available to the authority and a social services investigation is not the same as a criminal investigation.

Does a duty to investigate already exist?

- 12.6 The following section considers the *existing* legal framework for safeguarding adults and whether this amounts to a duty to make enquiries. A crucial aspect of any such duty is the definition of who should be investigated. We have used the term *adult at risk* and we discuss how this term might be defined later in this Part.

Statute law

- 12.7 Social services authorities have a number of statutory powers and duties in adult protection cases. Some concern the provision of services, while others are more intrusive. Where an authority has such existing powers, it may have to explain any failure to investigate the case or use those powers, particularly where that failure has led to a situation where a person suffers harm. For example, the authority could face a claim in damages by the victims or an investigation of maladministration by the Local Government Ombudsman.
- 12.8 As noted in Part 4 (Community Care Assessments), the NHSCCA 1990 establishes the core duty to carry out an assessment. In some circumstances, this can be regarded as amounting to a statutory duty to investigate. Where a local authority becomes aware that a person may be in need of services due to actual or potential abuse or neglect, the duty to assess will be triggered. This assessment will need to establish the facts of the case, and may prompt referrals to other services and organisations, such as local safeguarding teams, mental health services, the police and the Public Guardian.
- 12.9 Following an assessment, the local authority must decide whether community care services should be provided, and in many cases such services will be an important part of safeguarding a person from abuse and neglect. The importance of service provision in such cases is recognised by the eligibility framework in FACS and UFSAMC, which provide that the occurrence, or likely occurrence, of abuse and neglect should be taken to indicate that the person has *critical* or *substantial* levels of needs. For example, FACS describes critical needs as including those where “life is, or will be threatened” and cases of “serious abuse or neglect”, and describes substantial needs as where “abuse or neglect has occurred or will occur”.³ UFSAMC describes critical needs as including where “life is, or could be, threatened” or “abuse or neglect (self or other) have occurred or are likely to occur”.⁴ Thus the Welsh guidance, unlike FACS, requires all potential

³ FACS para 16.

⁴ UFSAMC para 5.16.

abuse to be recorded as critical.

- 12.10 Local authorities are also given statutory powers to take more coercive action in order to protect certain adults at risk. For example, the Mental Health Act 1983 enables the detention of mentally disordered people in hospital if this is in the interests of the person's "health and safety" or the protection of others.⁵ The 1983 Act also provides regimes, which include coercive elements, to enable people to be cared for in the community, such as guardianship and Supervised Community Treatment.⁶ Finally, section 135(1) enables a person to be removed from their home to a place of safety where it is believed that they are being ill-treated or neglected. The role of the social services authority is central to the use of these powers through the role of the Approved Mental Health Professional, who acts on behalf of the authority but exercises independent professional judgment, and has powers to make applications for detention and the other powers.
- 12.11 The Mental Capacity Act 2005 allows certain decisions or actions (including the use of restraint) to be taken on behalf of a person who lacks capacity where it is considered to be in their "best interests".⁷ The Act also enables local authorities and NHS bodies to appoint an Independent Mental Capacity Advocate where it is alleged that a person who lacks capacity is or has been abused or neglected by another person, or the person is abusing or neglecting another person.⁸ Furthermore, applications can be made to the Court of Protection where an alleged victim lacks capacity. Schedule 1A to the Mental Capacity Act 2005 enables care homes and hospitals to take action that amounts to a deprivation of a person's liberty, within the meaning of article 5 of the ECHR, where this is necessary to protect the person from harm and is in their *best interests*. In most cases, the deprivation of liberty must first be authorised by the local social services authority or PCT, following a series of six assessments.

Local authority guidance

- 12.12 The statutory guidance *No Secrets* and *In Safe Hands* provide for the development of local inter-agency policies, procedures and joint protocols for the purposes of safeguarding adults, and establish the local social services authority as the lead agency.⁹ They state that an investigation is normally justified on the basis of "harm", which includes ill treatment, impairment of or avoidable deterioration in physical or mental health and impairment of physical, intellectual, emotional, social or behavioural development. All staff have the responsibility to act if there is a suspicion or evidence of abuse or neglect and in most cases there should be a joint investigation rather than a series of separate investigations.¹⁰ It is therefore clear that *No Secrets* and *In Safe Hands* require social services authorities in England and Wales to investigate cases of actual or alleged abuse

⁵ Mental Health Act 1983, ss 2 and 3.

⁶ Mental Health Act 1983, ss 7 and 17A.

⁷ Mental Capacity Act 2005, ss 4 and 5.

⁸ Mental Capacity Act 2005 (Independent Mental Capacity Act Advocates) (Expansion of Role) Regulations 2006, SI 2006 No 2883.

⁹ Department of Health and Home Office, *No Secrets* (2000) para 3.3 and National Assembly for Wales, *In Safe Hands* (2000) para 1.1.

¹⁰ As above, paras 2.18, 6.2 and 6.10 (*No Secrets*) and para 1.1 (*In Safe Hands*).

and neglect, and to coordinate any appropriate action.

Common law duty of care

- 12.13 In *X v Hounslow London Borough Council*, the Court of Appeal held that a local authority did not owe a common law duty of care to protect tenants living in one of its flats by moving them into alternative accommodation in response to “the unusual but dangerous situation which had developed”.¹¹ The couple, who had learning difficulties, lived in local housing authority accommodation with their children, and local youths had taken to using the couple’s flat for illicit activity, including taking drugs, underage sexual activity and storing stolen goods, and on several occasions the couple had been subjected to threatening and abusive behaviour. The local social services authority had referred them to the housing department to be re-housed, but the local authority failed to do so before the youths imprisoned the couple in their home for the duration of a weekend and subjected them to serious and degrading sexual and physical assaults. The Court of Appeal held that in order to establish a duty of care to protect one party against the criminal acts of a third party, something more than reasonable foreseeability of harm was needed. Examples of the necessary further ingredients include where: the defendant creates the source of danger to the claimant; the third party who causes damage is under the control or supervision of the defendant; and the defendant has assumed a responsibility to the victim.¹²
- 12.14 The claimants argued that the local authority had assumed a responsibility for the family because it had assumed the task of providing social work support to them, as well as providing suitable and safe housing. The claimants also argued that, given the vulnerability of the couple, they could only live in the community with the assistance of the authority and there was a heavy degree of reliance by the vulnerable adults on the authority. The Court of Appeal, however, was not persuaded that those considerations led to the assumption of responsibility or some other factor which might give rise to the imposition of a duty of care on the local authority. The Court found that the local authority was seeking to carry out their statutory functions and no more; a complaint that the authority was not exercising its statutory duties and powers properly is not sufficient to give rise to a parallel common law duty of care.¹³
- 12.15 The point at which a local authority will be held to have assumed responsibility towards an individual to protect them from harm caused by a third party is not capable of being defined precisely but it is more than merely providing services and other support to individuals; some other *special factor* is required. While the common law has not yet recognised a duty of care, if a local authority assumes a responsibility over an individual or increases or causes the danger they face, such a duty may be found in the future.

Public law

- 12.16 Local authorities must act in accordance with the requirements of public law,

¹¹ [2009] EWCA Civ 286, (2009) 12 CCLR 254 at [33].

¹² *X v Hounslow London Borough Council* [2009] EWCA Civ 286, (2009) 12 CCLR 254 at [55].

¹³ As above, at [65] and [90].

including the Human Rights Act 1998. In relation to adults at risk, public law does not impose specific obligations on public bodies to take particular action. Rather, it ensures that authorities act within the powers granted to them, and act fairly and rationally in the exercise of those powers. Remedies available for breach of these powers include orders requiring the public body to do or refrain from doing certain activities, or orders quashing the original decision.

- 12.17 Section 6 of the Human Rights Act 1998 provides that it is unlawful for a public body to act, or fail to act, in a way that is incompatible with those ECHR rights listed in section 1 of the Act. In some circumstances, positive obligations arise under the ECHR requiring a public body to investigate and protect people. It should be borne in mind, however, that the primary function of the ECHR is to prevent the state from actively interfering with people's rights and freedoms. Positive obligations are accordingly limited in range and scope.
- 12.18 In *Re Z (Local Authority: Duty)* it was held a local authority is under a duty to "investigate the position of a vulnerable adult" if there is a real risk to their life from suicide or the welfare of the individual is threatened by the criminal or other wrongful act of another.¹⁴ The duty arose in this case because the authority owed the person certain duties under community care law, and taking into account the guidance contained in *No Secrets*. The common law duties owed by the local authority did not extend the scope of the statutory duties, but once the authority had been informed of the concerns, it could not ignore them. While article 2 was engaged, in the context of a person with full decision making capacity it does not assume primacy over rights of autonomy and self-determination.¹⁵
- 12.19 In addition, a positive duty can arise under article 3 to take measures, including carrying out an investigation, to prevent the ill-treatment of children and other vulnerable persons in circumstances where the authorities "had or ought to have had knowledge".¹⁶ However, the scope of this duty is limited; for example, the degree of potential harm must be of such gravity that it amounts to inhuman and degrading treatment within the meaning of article 3.¹⁷ Positive obligations may also arise under article 8 to intervene in a person's life if this is necessary to secure the rights of another, but such action can be justified only in exceptional circumstances and if what it offers is better than was previously on offer.¹⁸

Provisional view

- 12.20 We provisionally consider that in certain circumstances local authorities are already under a duty to investigate an *adult at risk* and consider whether services are necessary and what, if any, further action should be taken. This duty arises from the existing statutory duties and powers to assess and provide community care services, and by taking into account the statutory guidance *No Secrets* and *In Safe Hands*. Indeed, this argument appears to have been accepted by the Government during the Parliamentary debates on the Mental Capacity Bill

¹⁴ [2004] EWHC 2817 (Fam), [2005] 1 WLR 959 at [19].

¹⁵ As above, at [18].

¹⁶ *Z v United Kingdom* (2001) 34 EHRR 97 (App No 29392/95) at [73].

¹⁷ *Ireland v United Kingdom* (1979-80) 2 EHRR 25 (App No 5310/71).

¹⁸ *Local Authority X v MM* [2007] EWHC 2003 (Fam), (2008) 11 CCLR 119.

2004.¹⁹ However, this only takes the argument so far. Once account is taken of the other elements of the current legal framework – such as the compulsory and other powers available under the Mental Health Act 1983 and the Mental Capacity Act 2005, the requirements of the common law and the ECHR – then it becomes clear that a different context often applies when an adult is at risk of abuse and neglect, to which an express investigation duty is appropriate.

12.21 The community care assessment duty was not framed primarily with adult protection cases in mind, and it is often an unsatisfactory mechanism for dealing with them. It is true that section 47(5) of the NHSCCA 1990 allows urgent temporary services to be provided in lieu of an assessment, but this will not be an appropriate intervention where the risks require immediate and sometimes compulsory intervention. Enquiries into abuse and neglect often amount to a more formal process than a community care assessment, and may trigger operational procedures, such as strategy meetings, case conferences, adult protection plans, sharing information protocols, disciplinary action and inter-agency working agreements. The investigation may need to focus less on the need for services, and more on establishing the facts and validity of the allegations, especially if police inquiries are also taking place. The most common outcome for the victim is increased monitoring by a care manager, which is not an outcome often associated with community care assessments.²⁰ This is not to say that an assessment and an investigation are separate entities. The same core assessment will apply in all cases, but where suspicions of abuse or neglect arise, there will be a different focus for the assessment, different procedures and outcomes, and a change in the pace and scope of the assessment.

12.22 We therefore propose that our future adult social care statute should clarify the existing legal position and establish a duty to make enquiries and take appropriate action in adult protection cases. This proposal is made in the context of the *existing* powers of social services authorities to take action. It does not necessarily follow that the introduction of a statutory duty to investigate is a prelude to new compulsory and emergency powers. The introduction of such powers is a separate debate and is considered below. Our proposed duty would operate in conjunction with the community care assessment duty by enabling *explicitly* a formal process to be initiated in adult protection cases. The duty to investigate would be triggered if the authority has *reasonable cause* to suspect abuse or neglect, which would not be the case, for example, if the authority did not have and could not be expected to have full knowledge of the relevant facts.

Provisional Proposal 12-1: We provisionally propose that our future adult social care statute should place a duty on local authorities to make, or cause to be made, such enquiries as it considers necessary where it has reasonable cause to suspect that a person appears to be an *adult at risk* and consider whether there is a need to provide services or take any other action within its powers in order to safeguard that person from harm.

¹⁹ *Hansard* (HC) Standing Committee A, 2 November 2004, col 325 (Rosie Winterton MP).

²⁰ Care and Social Services Inspectorate Wales, *Protection of Vulnerable Adults Monitoring Report 2007-2008* (2009) p 19.

DEFINING WHO IS AT RISK

- 12.23 The use of legal categories, such as *vulnerable adults* or *adults at risk*, is an attempt to move beyond mental incapacity as a means of defining a cohort of people who are or may be unable to protect themselves from abuse or neglect. These categories can be broken down into two elements. The first element describes in general terms a person who may fall within the definition by reference to their situation (for example, where they live or receipt of services) and/or condition (for example, mental disorder, disability or age). Second, there is a description of what the person is at risk from, for example *harm* or *exploitation*. The inclusion of both elements ensures that the fact of a diagnosis or that a person is in a particular situation, does not mean they should be automatically considered *at risk*.

A “vulnerable adult”

- 12.24 A “vulnerable adult” is defined in the statutory guidance *No Secrets* and *In Safe Hands* as a person aged 18 years or older who:

is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.²¹

- 12.25 This definition has in recent years been the subject of increasing criticism. In 2004, the Health Committee noted that it excludes people who do not require or qualify for community care services, and is based on a “health/social care model” which “assumes that the vulnerable person must be in need of external support”.²² The Committee recommended that the definition should be broadened to include, for example, “older people living in their own homes without the support of health and social services, and those who can take care of themselves”.²³
- 12.26 The term *vulnerable adult* has also been criticised for locating “the cause of abuse with the victim, rather than placing responsibility with the actions or omissions of others”.²⁴ Furthermore, it suggests that vulnerability is an inherent characteristic of a person, and does not recognise that it might be the context, the setting or the place which makes a person vulnerable.²⁵
- 12.27 Guidance issued by the Association of the Directors of Adult Social Services emphasises that there has been a shift in philosophy since *No Secrets*:

In particular, Fair Access to Care ... stresses “risk to independence

²¹ Department of Health and Home Office, *No Secrets* (2000) para 2.3 and National Assembly for Wales, *In Safe Hands* (2000) para 7.2.

²² Elder Abuse, Second Report of the House of Commons Health Committee (2003-04) HC 111-I, para 8.

²³ As above, para 14.

²⁴ Association of Directors of Adult Social Services, *Safeguarding Adults: A National Framework of Standards* (2005) p 4.

²⁵ Commission for Social Care Inspection, *Raising Voices: Views on Safeguarding Adults* (2008) para 3.5.

and well being” as the key criteria for determining eligibility for care services, and therefore replaces the concept of “vulnerable adult” with an assessment of the risk posed by the abuse and neglect to the quality of life of the individual adult concerned. Furthermore, the emphasis is now on supporting adults to access services of their own choosing, rather than “stepping in” to provide protection.²⁶

“Adults at risk”

- 12.28 More recent definitions have adopted the term *adults at risk* because it focuses attention on the risk rather than any inherent vulnerability. An “adult at risk” has been defined as any person “who is or may be eligible for community care services” and “whose independence and wellbeing is at risk due to abuse or neglect”.²⁷ However, this definition is not entirely satisfactory because arguably it excludes people who have been assessed as having social care needs but do not qualify for services under the local authority eligibility criteria.
- 12.29 The Adult Support and Protection (Scotland) Act 2007 also refers to “adults at risk”, who are defined as those unable to safeguard their own well-being, property, rights or other interests; at risk of harm; and because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected. The Act provides a detailed and broad definition of harm. Thus, section 3(2) specifies that an adult is “at risk of harm” as a result of the actual or likely conduct of a third party or self harm. Section 53(1) also states that “harm” includes all harmful conduct and, in particular that which causes physical and psychological harm; unlawful conduct which appropriates or adversely affects property, rights or interests (for example: theft, fraud, embezzlement or extortion); and conduct which causes self-harm. The Act, therefore, adopts a broad and complex definition of *adults at risk*, based on the fact of “disability, mental disorder, illness or physical or mental infirmity” and a judgement that the person is unable to safeguard their own interest, is at risk of harm and is more vulnerable to being harmed than other adults.

Situational definition

- 12.30 An alternative approach is taken in the Safeguarding Vulnerable Groups Act 2006 whereby vulnerability is understood purely through the situation in which an adult is placed. Thus, a “vulnerable adult” is defined as a person aged 18 or over and:
- (1) is in residential accommodation;
 - (2) is in sheltered housing;
 - (3) receives domiciliary care;
 - (4) receives any form of health care;
 - (5) is detained in lawful custody;

²⁶ Association of Directors of Adult Social Services, *Safeguarding Adults: A National Framework of Standards* (2005) p 5.

²⁷ As above, p 5.

- (6) is in contact with probation services;
- (7) receives a welfare service;
- (8) receives any service or participates in any activity which is targeted at people with age-related needs, disabilities, or prescribed physical or mental health conditions, or expectant or nursing mothers living in residential care;
- (9) receives direct payments in lieu of social care services; or
- (10) requires assistance in the conduct of his or her affairs.²⁸

12.31 This definition is almost entirely objective and it is, therefore, clear who falls within it; the mere fact that a person is receiving a service will mean that they are classified as a *vulnerable adult*. This helps to ensure consistency in practice and that people are not stigmatised as vulnerable or even at risk on the basis of a diagnosis or condition. However, the definition does label people on the basis of their situation; for example, a disabled person who attends a training centre would become automatically an adult *at risk*. For that reason, while a situational definition may be useful in the context of vetting and barring care workers, it is of less use as a definition of who is potentially at risk from abuse and neglect. It would need an additional subjective element.

“Vulnerable adults” and the inherent jurisdiction of the High Court

12.32 The court’s powers when exercising the inherent jurisdiction are wide and can include declaratory relief and the use of injunctions. Although the High Court has traditionally used its inherent jurisdiction to intervene in the lives of adults who lack capacity, a number of cases have broadened the scope of intervention to include those who have capacity but are “vulnerable”.²⁹

12.33 Lord Justice Munby, when he was a High Court judge, described a “vulnerable adult” for the purposes of the inherent jurisdiction as a person who is not necessarily lacking mental capacity but is reasonably believed to be:

- (1) under constraint;
- (2) subject to coercion or undue influence; or
- (3) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.³⁰

12.34 While emphasising that this was intended to be descriptive and not definitive, his

²⁸ Safeguarding Vulnerable Groups Act 2006, s 59(1).

²⁹ See: *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam), (2007) 10 CCLR 193; *G (An Adult) (Mental Capacity: Court’s Jurisdiction)* [2004] EWHC 2222, [2004] All ER (D) 33; and *Sunderland City Council v PS* [2007] EWHC 623 (Fam), (2007) 10 CCLR 295.

³⁰ *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam), (2007) 10 CCLR 193 at [77] by Munby J.

Lordship went on to describe a “vulnerable adult” as including someone who:

is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind or dumb, or who is substantially handicapped by illness, injury or congenital deformity.³¹

- 12.35 However, this approach can be viewed as similar to, and has been subject to the same criticism as, the definition of a “vulnerable adult” contained in *No Secrets* and *In Safe Hands*.³²

Provisional view

- 12.36 In our view, the term *vulnerable adults* should be replaced by *adults at risk* to reflect the need to focus on the risks that a person faces rather than the characteristics of the person concerned.
- 12.37 Our statute would need to define adults at risk for the purpose of the duty to make enquiries. In our view, an *adult at risk* should be defined by adopting a two-limbed approach. The first limb needs to describe in general terms who would fall within the remit of the definition. There would be advantages to adopting a situational definition similar to that contained in the Safeguarding Vulnerable Groups Act 2006. It would be clear to whom the duty to investigate applies and it would ensure that people are not labelled or stigmatised as *vulnerable* or even *at risk* on the basis of a diagnosis or condition (although arguably it does so on the basis of service provision). However, most of the *situations* listed in the Act are based on the receipt of services and if this were applied to an adult social care context, then adult protection would depend on local authority eligibility criteria, creating geographical variation in the duty to investigate. This approach may also exclude self-funders from the duty to investigate. Furthermore, the list covers some people – such as those with health needs only – who could not reasonably be seen as being the responsibility of a social services authority.
- 12.38 Our provisional view is that the first limb of the definition of an *adult at risk* should be based on a person’s *social care needs*, rather than being in receipt of services or diagnosed with a particular condition or disability. Thus, any person who has or may have social care needs – whether or not they fall within the local authority eligibility criteria – should be included within the first limb of the definition. This would ensure that the duty to investigate would be wide ranging (and would include self-funders), while also ensuring that local social services responsibilities do not extend to, for example, those with health needs. We also consider that there should be an ability for the Secretary of State or Welsh Ministers to extend the definition to include other groups of people in the future.

³¹ *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam), (2007) 10 CCLR 193 at [82].

³² M Dunn and others, “To Empower or to Protect? Constructing the ‘Vulnerable Adult’ in English Law and Public Policy” (2008) 28 *Legal Studies* 234.

- 12.39 The second limb of the definition would need to set out what the person is at risk from. Our provisional view is that the threshold *significant harm*, which is currently used in *No Secrets, In Safe Hands* and the Children Act 1989, should be retained. This should be a concept that social services authorities are familiar with and ensures that the focus is on the most critical cases. However, we welcome views on whether this term is useful in practice or whether the threshold it establishes is too high. An alternative would be to use the threshold *harm*, which appears in the Adult Support and Protection (Scotland) Act 2007.
- 12.40 Furthermore, we consider that the term *harm* should be defined in legislation but that *significant* should continue to be left undefined and left to interpretation. In our view the definition of *harm* provided in the Adult Support and Protection (Scotland) Act 2007 has a number of merits but it is multi-layered and difficult to understand, and may be interpreted inconsistently by practitioners. We consider that any definition should be simple and capable of being understood easily. We therefore suggest that *harm* could be defined as ill-treatment or the impairment of health or development, or unlawful conduct, including specifically financial abuse.
- 12.41 Putting these two limbs together, an *adult at risk* could be defined as:
- (1) a person aged 18 or over and who:
 - (a) is eligible for or receives any adult social care service (including carers' services) provided or arranged by a local authority; or
 - (b) receives direct payments in lieu of adult social care services; or
 - (c) funds their own care and has social care needs; or
 - (d) otherwise has social care needs that are low, moderate, substantial or critical; or
 - (e) falls within any other categories prescribed by the Secretary of State or Welsh Ministers; *and*
 - (2) is at risk of *significant harm*, where harm is defined as ill-treatment or the impairment of health or development or unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion).
- 12.42 We welcome views on this definition or any other suggestions on how an *adult at risk* could be defined in legislation. In considering this issue, it is important to recognise that the Welsh Assembly Government may decide on a different definition to that adopted in England. If this is the case, then our statute would include both definitions.

Provisional Proposal 12-2: We provisionally propose that the term *vulnerable adult* should be replaced by *adult at risk* for the purposes of the duty to make enquiries.

Provisional Proposal 12-3: We provisionally propose that an *adult at risk* should be defined in our statute as anyone with social care needs who is or may be at risk of significant harm.

EMERGENCY AND COMPULSORY POWERS

- 12.43 As noted previously, local authorities have a number of existing powers and duties to act in safeguarding cases. In most cases, this will involve the provision of community care services. In a small number of cases, it will require the use of emergency and compulsory powers, most of which are contained in the Mental Health Act 1983 and the Mental Capacity Act 2005.
- 12.44 In 1995, the Law Commission recommended the introduction of a number of new compulsory intervention powers aimed specifically at adults at risk of abuse and neglect. These included a power for a local authority officer to enter premises and interview a vulnerable adult; an order to allow a local authority officer to enter premises, by force if necessary, where a vulnerable adult may be at risk; a court order to allow the authority to assess whether a person is at risk; and a compulsory removal power.³³ Since then, the Adult Support and Protection (Scotland) Act 2007 has been implemented, which includes a number of compulsory powers, including a power for a council officer to visit premises to determine whether or not further action is needed, for a sheriff to issue an assessment order or an order to remove the adult at risk to a specified place; and the power to ban abusers from a specified place for up to six months.
- 12.45 The report on the responses to the safeguarding adults consultation in England showed that, while there was quite high support for a power of entry where it is suspected that a vulnerable adult is being abused (60% of respondents), the level of support significantly reduces in response to more invasive powers (for example, only 13% supported a power to remove an adult who is being harmed from their home). There was also less support for compulsory powers in situations where the relevant person has decision-making capacity.³⁴

Provisional view

- 12.46 As stated previously, it is for the Government to determine policy and consequently our proposed statute will only include new compulsory or emergency orders if they are proposed by the Government. There is a possibility that policy in this area may diverge between England and Wales. This may require our statute to include a separate part that applies to England only or to Wales only, and contains compulsory and emergency powers.

Provisional Proposal 12-4: We provisionally propose that if the Government in England or the Welsh Assembly Government decides to introduce new compulsory or emergency powers to safeguard adults from abuse and neglect then these will be included in our future adult social care statute.

SECTION 47 OF THE NATIONAL ASSISTANCE ACT 1948

- 12.47 Section 47 of the NAA 1948 provides an example of an existing compulsory power available to local authorities where a person is at risk of abuse and neglect. It enables an authority to apply to a magistrates' court for an order to remove a person from their home into a hospital, or other place, who is:

³³ Mental Incapacity (1995) Law Com No 231.

³⁴ Department of Health, Home Office, and the Ministry of Justice, *Safeguarding Adults: Report on the Consultation on the Review of "No Secrets"* (2009) pp 122 to 124.

- (1) suffering from grave chronic disease, *or* being aged, infirm or physically incapacitated, are living in insanitary conditions; *and*
 - (2) unable to devote to themselves, and are not receiving from other persons, proper care and attention.
- 12.48 The order can only be granted if a *medical officer of health* certifies that removal is necessary in the interests of the person or for the prevention of injury to the health of or serious nuisance to, other persons. The person must be given seven days' notice of the application. The order can authorise the person's detention for up to three months, renewable for further periods of up to three months.
- 12.49 The National Assistance (Amendment) Act 1951 introduced an emergency procedure whereby, if it is certified by a medical officer of health and another doctor that it is necessary to remove an individual without delay, an order can be made without notice, by a single justice and without the person being present. The maximum period of detention is three weeks and the person cannot challenge the order during this period. Research suggests that a large proportion of section 47 orders have been made using the emergency procedure.³⁵
- 12.50 Section 47 has been the subject of widespread criticism on the basis that it is incompatible with human rights law, has operational concerns and that it is obsolete in practice. The following discussion considers these criticisms and whether, as a result, section 47 should be repealed.

Human rights concerns

- 12.51 Article 5(1) provides that no one shall be deprived of their liberty except in six defined circumstances. The most relevant category for section 47 orders is "for the prevention of spreading diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants".³⁶ Section 47 can be used to satisfy this requirement, for example if the detained person has a chronic (and infectious) disease. However, section 47 could extend beyond these categories to detain people of *sound mind* who are simply suffering from *grave, chronic disease* (without being infectious); or infirm, aged or physically incapacitated (without being alcoholics, drug addicts or vagrants) and living in insanitary conditions. Detentions made in these cases would, therefore, breach the ECHR.
- 12.52 Article 5(1) also provides that no one shall be deprived of their liberty except in accordance with a procedure prescribed by law. Section 47 orders can be issued for a set period of up to three months. During this period the conditions justifying detention under section 47 may cease; for example, the person may regain physical capacity or their living conditions may improve. As noted in *Winterwerp v Netherlands*, the validity of continued confinement depends on the persistence of the disorder that warranted compulsory detention.³⁷ The only way that section 47

³⁵ P Nair and J Mayberry, "The Compulsory Removal of Elderly People in England and Wales under Section 47 of the National Assistance Act" (1995) 24 *Age and Ageing* 180 and J A Muir, "Section 47: Bradford 1925 – United Kingdom 1988" (1990) 12 *Journal of Public Health Medicine* 28.

³⁶ ECHR, art 5(1)(e).

³⁷ *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) para 39.

can be ended is by the detained person making an application to the court to have the order revoked, which can take place six months after detention. Section 47 contains no provision for the authority responsible for the detention to discharge the order; for example if the person's situation improves. It may be that section 3 of the Human Rights Act 1998 enables the court to insert into orders the discretion to discharge the order and therefore, provided that the order is discharged at the appropriate time, there need not be a breach of article 5. We are not, however, aware of any evidence of the courts adopting this practice. We believe, therefore, that in many cases section 47 detentions will be arbitrary and, therefore, unlawful for the purposes of article 5(1).

- 12.53 Article 5(4) provides that anyone deprived of liberty "shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court". When the decision to detain is taken by a court, as is the case under section 47, the requirements of article 5(4) may be satisfied by that initial decision; but only on condition that the procedure followed has a "judicial character and gives to the individual concerned guarantees appropriate to the kind of deprivation of liberty in question".³⁸ Such guarantees can include the right to be heard in person or through a suitable representative.³⁹ There is no ability, under the emergency section 47 procedure, for the person to contest the application or to appeal to a court against their detention. In our view, the emergency procedure is, therefore, incompatible with article 5(4).⁴⁰
- 12.54 Furthermore, article 5(4) requires a review of the lawfulness of the deprivation of liberty to be "available at reasonable intervals" in cases where the reasons warranting confinement may cease to exist, for example if the person is mentally disordered. This applies irrespective of whether the initial detention was ordered by a court or a non-judicial body.⁴¹ What constitutes a "reasonable interval" for the purposes of holding periodic reviews will vary on the facts of each case.⁴² We believe that section 47, which sets a six-week time limit in all cases before a detained person is able to initiate a challenge, is arbitrary and likely in many cases to be incompatible with article 5(4).
- 12.55 Article 5(4) does not guarantee an automatic review of detention,⁴³ but in cases where the person lacks capacity to decide to instigate a review, procedures should be available to enable a review to be initiated on their behalf (where there is reason to believe that they would wish to do so).⁴⁴ Section 47, however, contains no such safeguard and in such cases will breach article 5(4).
- 12.56 Article 5(4) also requires that once instigated, the review must itself be made "speedily".⁴⁵ The meaning of "speedily" should be determined in the light of the

³⁸ *De Wilde v Belgium* (1972) App No 2832/66; 2835/66; 2899/66 para 76.

³⁹ *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) para 60.

⁴⁰ As above, para 60.

⁴¹ As above, para 55.

⁴² *Oldham v United Kingdom* App No 36273/97 para 30.

⁴³ *Rakevich v Russia* App No 58973/00.

⁴⁴ *R (H) v Secretary of State for Health* [2005] UKHL 60, [2006] 1 AC 441.

⁴⁵ *Luberti v Italy* (1984) 6 EHRR 440 (App No 9019/80).

circumstances of each case.⁴⁶ Section 47 is not, in itself, incompatible with this particular requirement, since reviews could be determined sufficiently speedily and individual cases of excessive delay can be challenged under section 6 of the Human Rights Act 1998.

- 12.57 Article 8 guarantees respect for private and family life, home and correspondence. Section 47 orders are clearly capable of interfering with this right and must be justified as “necessary in a democratic society” for, amongst other things, “the protection of health or morals”.⁴⁷ Most detentions under section 47 will be capable of being justified under this exception, but it will need to be demonstrated that the action taken is proportionate. We believe that section 47 can be applied in a way that is compatible with article 8 and individual cases of abuse can be challenged using section 6 of the Human Rights Act 1998.

Operational criticisms

- 12.58 Section 47 presents a number of definitional problems for those responsible for administering this power. The main difficulty is that section 47 is one of the few principles of the old poor law that remain in place and its wording is based on local legislation drafted in Bradford in 1925, designed to assist in slum clearance.⁴⁸ As one commentator suggests, it is open to question whether the “premises of the legislation (which derived from nineteenth century views of continency and “proper” conduct) are concordant with modern values”.⁴⁹ The language used in section 47, such as “infirm” and “being aged”, can be seen as outdated and stigmatising but there are also difficulties associated with the interpretation of some of the terms, such as “insanitary conditions”, and “chronic disease”. Magistrates’ courts are not courts of record, which may increase the likelihood of different approaches being taken to the meaning of section 47. Furthermore, review by the higher courts of section 47 orders is rare. Magistrates, therefore, have little guidance to assist them in issuing orders.
- 12.59 Difficulties may also occur for practitioners implementing a section 47 order. Section 47(11) of the NAA 1948 provides that it is an offence to willfully disobey or obstruct the execution of an order but there is no explicit power to force entry into people’s homes or override a refusal of permission to enter. The extent to which subjects of section 47 orders can be compelled to obey the orders is not, therefore, clear and may cause confusion in practice.
- 12.60 Furthermore, the section 47 power is given to the “appropriate authority”, which is a district council or London Borough Council, or in Wales, the councils of counties and county boroughs.⁵⁰ In practice, the power is carried out by environmental health departments. However, environmental officers may not be best suited for this role, particularly in cases where section 47 is needed to safeguard adults from abuse or neglect, as opposed to environmental health grounds. This has

⁴⁶ *Sanchez-Reisse v Switzerland* (1986) 9 EHRR 71 (App No 9862/82).

⁴⁷ ECHR, art 8(2).

⁴⁸ See J A Muir, “Section 47: Bradford 1925 – United Kingdom 1988” (1990) 12 *Journal of Public Health Medicine* 28, 29 to 30.

⁴⁹ E Counsell, “Compulsory Removal and Medical Discretion” (1990) 140 *New Law Journal* 750, 750.

⁵⁰ NAA 1948, s 47(12).

resulted in calls for a greater role for social services in such cases.⁵¹

- 12.61 Concerns have also been raised about the quality of the medical certificate upon which section 47 applications are based. In many cases, it is provided by a consultant in communicable disease control, even though a section 47 order does not require the risk of communicable disease or infection. This has led to concerns of an inappropriate focus on public health risk when assessing whether it is necessary to remove the person.⁵² It has also been suggested that the certificate is sometimes provided by public health specialists who are not medically qualified or have not conducted clinical examinations for some time.⁵³

Is section 47 obsolete in practice?

- 12.62 There is little reliable evidence on the use of section 47. There is survey-based evidence that in England, in the 1970s and early 1980s, section 47 orders were made around 200 times per year.⁵⁴ In Leeds, in a five-year period during the 1980s, 17 orders were made, which would tend to support the national picture.⁵⁵ The use of section 47 in England may have begun to drop by the mid-to-late 1980s to less than 100 per year.⁵⁶ Figures gathered for 1988 and 1989 in England and Wales would support this conclusion.⁵⁷
- 12.63 The only national statistics available in relation to section 47 concern people admitted to hospitals. On average, between 1997 and 2008, 43 people were detained in hospital each year under legislation other than the Mental Health Act 1983 in England.⁵⁸ This legislation includes (amongst five other Acts) section 47. The figure only represents detention in hospitals (as opposed to care homes or other places) and no indication is given as to the division between the different Acts. Nonetheless, the figure is low and in contrast over 45,000 people are detained under the Mental Health Act 1983 each year. In 2000, the Department of Health estimated that some authorities use section 47 orders “perhaps once or twice a year as a last resort”.⁵⁹ We welcome any further information on how often section 47 orders are used in practice.
- 12.64 Although the limited evidence available suggests that section 47 is rarely used, it does not appear to be entirely obsolete. The question, therefore, arises as to why

⁵¹ Welsh Local Government Association, *WLGA Briefing – The National Assistance Acts 1948 and 1951 – Section 47 Removals* (2005).

⁵² As above.

⁵³ Welsh Local Government Association, *WLGA Briefing – The National Assistance Acts 1948 and 1951 – Section 47 Removals* (2005).

⁵⁴ J A Muir, “Section 47: Bradford 1925 – United Kingdom 1988” (1990) 12 *Journal of Public Health Medicine* 28.

⁵⁵ J D Fear and others, “Section 47 of the National Assistance Act: A Time for Change?” (1988) 296 *British Medical Journal* 860.

⁵⁶ J A Muir, “Section 47: Bradford 1925 – United Kingdom 1988” (1990) 12 *Journal of Public Health Medicine* 28.

⁵⁷ P Nair and J Mayberry, “The Compulsory Removal of Elderly People in England and Wales under Section 47 of the National Assistance Act (1995) 24 *Age and Ageing* 180.

⁵⁸ Information Centre, *In-patients Formally Detained Under the Mental Health Act 1983 and Other Legislation, England: 1997-1998 to 2007-2008* (2008) p 20.

⁵⁹ Department of Health, *Letter to the Regional Directors of Public Health* (2000).

it is used at all. The answer may be that the alternative legislative powers that provide for compulsory care and treatment fail to cover all people who can be dealt with under section 47.

- 12.65 As noted above, the Mental Health Act 1983 contains civil powers to detain people in hospital, community powers and powers to remove people to a place of safety. There is, therefore, significant overlap between people who could be dealt with under the 1983 Act and those who could come under section 47. Indeed, some evidence suggests that section 47 is being used in cases where the 1983 Act should have been used instead.⁶⁰ However, people who do not suffer from a mental disorder, or whose disorder is not of a sufficient nature or degree, will fall outside the scope of the 1983 Act. Some of these people may potentially meet the criteria for section 47 and therefore, there remains a gap between the scope of the 1983 Act and the wider remit of section 47.
- 12.66 As noted earlier, the Mental Capacity Act 2005 provides a statutory framework for decision-making on behalf of adults who lack capacity, and in some cases this Act can be used to authorise deprivations of liberty. There is much overlap between the 2005 Act and section 47. The key difference, however, is that the person must lack the relevant decision-making capacity before the 2005 Act can be used, while section 47 can be used to detain people who have capacity. Thus, section 47 covers potentially a wider cohort of people.
- 12.67 The Public Health (Control of Disease) Act 1984 allows a local authority to apply to a magistrate for an order to remove a person from a house where an infectious disease has occurred, and to place or detain a person in hospital if they are suffering from a notifiable disease. There is further power for a magistrate to order the removal of people who are or may be infected or contaminated in such a way that presents a significant risk of harm to human health. Section 47 can be used to detain a person with “a grave chronic disease”, while the 1984 Act requires the presence of an infectious disease or contamination. Therefore, section 47 covers potentially a wider group whose chronic illness is not infectious or capable of contamination.
- 12.68 Under the Public Health Act 1936 there are powers to temporarily remove people from their homes where fumigation of the premises is required because there is a risk to health. There is a further power to remove people from their homes and detain them for the purpose of cleaning them or their clothing, where either are *verminous*. Under the Environmental Health Act 1990 a local authority has powers of entry in order to determine if a statutory nuisance exists or to take action or execute work. This includes premises that are in a state prejudicial to health or a nuisance or any accumulation or deposit prejudicial to health or a nuisance. Section 47 allows a person to be removed if they are living in insanitary conditions but it also requires additional factors, such as physical incapacity. Therefore, environmental health powers are potentially wider than section 47.
- 12.69 Finally, the inherent jurisdiction of the High Court can be used to remove and detain people who lack capacity and, in limited circumstances, those who retain

⁶⁰ P Wolfson and others, “Section 47 and its Use with Mentally Disordered People” (1990) 12 *Journal of Public Health Medicine* 9, 13.

capacity.⁶¹ Although this remains a power of last resort, many cases could be dealt with under the inherent jurisdiction if section 47 were repealed.

- 12.70 In summary, if section 47 is repealed, the overwhelming majority of people who could conceivably come under this power would be covered by alternative powers. The gap would consist of adults with full mental capacity and no significant mental problems, who have a non-infectious grave chronic illness but who are not receiving proper care and attention, and need to be detained in the interests of themselves or others. Furthermore, in order to be compliant with article 5(1) of the ECHR, such a person could only be detained for the prevention of spreading disease or if they are an alcoholic, drug addict or vagrant. Such a group, if it exists at all, is likely to be very small and it is at the very least questionable whether the state should be given the power to detain such people in order to secure care and attention.

Provisional view

- 12.71 We propose that section 47 should be repealed. It has the potential to breach the ECHR, specifically article 5, and there are also several general concerns regarding its use. If it were repealed then in the overwhelming majority of cases other powers could be used in its place. To put the point more broadly – *if* the Government wants to introduce new restrictions on liberty to safeguard adults from abuse and neglect, then section 47 is not the way to do this.

<p>Provisional Proposal 12-5: We provisionally propose that section 47 of the National Assistance Act 1948 should be repealed.</p>

POWERS TO PROTECT PROPERTY

- 12.72 Section 48 of the NAA 1948 places a duty on local authorities to prevent the loss or damage of a person's property when he or she is admitted to hospital, provided with accommodation under Part 3 of the NAA 1948 or removed under section 47 of the NAA 1948. This applies when it appears to the local authority that "there is danger of loss of, or damage to, any movable property of his by reason of his temporary or permanent inability to protect or deal with the property, and that no other suitable arrangements have been or are being made".⁶² Authorities are empowered to enter premises in order to protect property and recover any reasonable expenses incurred.

Provisional view

- 12.73 Our provisional view is that the section 48 duty should be retained in our proposed adult social care statute. This provision appears to provide an important safeguard where a person's property is at risk. However, we welcome further views on whether this is useful in practice.

⁶¹ *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam), (2007) 10 CCLR 193.

⁶² NAA 1948, s 48(1).

Provisional Proposal 12-6: We provisionally propose that a local authority should continue to be under a duty to prevent the loss or damage of a person's property when they have been admitted to hospital or provided with residential accommodation.

ADULT SAFEGUARDING BOARDS

- 12.74 Local adult safeguarding boards are multi-agency partnerships, made up of a wide range of statutory, independent and voluntary agencies and organisations. They are aimed at facilitating joint working in adult protection and their responsibilities include ensuring multi-agency policies and procedures are in place, conducting serious case reviews, and providing training and information.
- 12.75 Currently, adult safeguarding boards are not provided for in statute law, although they are referred to briefly in the guidance.⁶³ However, as noted earlier, the Department of Health has announced that new legislation will be introduced “to strengthen the local governance of safeguarding by putting Safeguarding Boards on a statutory footing”.⁶⁴
- 12.76 An example of how this policy could be achieved is provided by the Adult Support and Protection (Scotland) Act 2007, which places a duty on each local council to establish an Adult Protection Committee and specifies the following functions:
- (1) to keep under review the procedures and practices of public bodies which relate to safeguarding adults at risk;
 - (2) to give information or advice, or make proposals, to any public body on the exercise of functions which relate to adult protection; and
 - (3) to improve the skills and knowledge of professionals who have responsibilities relating to safeguarding adults.⁶⁵
- 12.77 The Adult Support and Protection (Scotland) Act 2007 also provides that certain specified bodies must nominate a representative to be a committee member who has the appropriate skills and knowledge⁶⁶ and (along with certain other bodies) must provide the committee with any information that the committee may reasonably require in order to carry out its functions.⁶⁷ Section 46 requires the convener to produce a report every two years on the exercise of the committee's functions.

⁶³ Department of Health and Home Office, *No Secrets* (2000) para 3.4 and National Assembly for Wales, *In Safe Hands* (2000) para 5.5.

⁶⁴ Department of Health, *Written Ministerial Statement. Government Response to the Consultation on Safeguarding Adults: The Review of the No Secrets Guidance* (2010), http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_111286 (last visited 4 February 2010).

⁶⁵ Adult Support and Protection (Scotland) Act 2007, s 42(1).

⁶⁶ Adult Support and Protection (Scotland) Act 2007, s 43(2). These bodies are: the council, the health board; the police; and any other body specified by the Scottish Ministers. In addition the Care Commission may nominate a representative (s 43(3)).

⁶⁷ Adult Support and Protection (Scotland) Act 2007, s 45(2). The bodies in addition to those above listed in s 43(2) are: the Care Commission; the Mental Welfare Commission for Scotland and the Public Guardian.

- 12.78 The consultation paper on safeguarding adults in England also raised for discussion the possibility that the safeguarding board should commission serious case reviews and that there should be a duty to contribute to these reviews.⁶⁸

Provisional view

- 12.79 We provisionally propose that our future statute should place adult safeguarding boards on a statutory footing by placing a duty on each social services authority to establish a safeguarding board, and by setting out the functions and membership of the board, requirements to share information, and a duty to contribute to serious case reviews. We welcome views on whether the functions and membership of Adult Protection Committees, as set out in the Adult Support and Protection (Scotland) Act 2007, should be adopted in our proposed statute. We also invite comments on whether there are other ways that adult safeguarding boards could be placed on a statutory footing.

Provisional Proposal 12-7: We provisionally propose that our future statute should place a duty on each social services authority to establish an adult safeguarding board and should specify the functions and membership of the board, the requirement to share information and a duty to contribute to serious case reviews.

A DUTY TO CO-OPERATE

- 12.80 Currently there is no express duty on agencies to co-operate in cases of abuse and neglect. The need for multi-agency co-operation in adult protection cases is noted in *No Secrets* and *In Safe Hands*, which set out a framework for inter-agency arrangements.⁶⁹ The lead agency is identified as the local social services authority and the partner organisations include health, social care and housing service providers, regulators, law enforcement departments, service user groups, support organisations, legal advice centres and welfare agencies.
- 12.81 A report commissioned by the Department of Health into the effectiveness of multi-agency working found that the benefits of partnership working in adult protection services included the sharing of information, knowledge, skills and expertise, and the “fostering of shared decision making, shared ownership and shared responsibility”.⁷⁰ The report also found a number of barriers to partnership working including lack of clarity as to the roles and responsibilities of the various bodies, inconsistent policy priorities and delay. The lack of adequate resources and the absence of specific legislation to protect vulnerable adults were also cited as significantly inhibiting effective working arrangements in this area.

Provisional view

- 12.82 In Part 11 (Joint Working), we provisionally propose that our future adult social care statute should introduce a general duty and an enhanced duty to co-operate.

⁶⁸ Department of Health, Home Office, and the Ministry of Justice, *Safeguarding Adults: A Consultation on the Review of the ‘No Secrets’ Guidance* (2008) pp 44 to 45.

⁶⁹ Department of Health and Home Office, *No Secrets* (2000) para 4.3 and National Assembly for Wales, *In Safe Hands* (2000) paras 1.1, 3.1 and 3.2.

⁷⁰ University of Sheffield, King’s College London and Staffordshire University, *Partnership and Regulation in Adult Protection: Final Report* (2007) pp 6 and 7.

It is envisaged that the general duty would require local authorities to make arrangements to promote co-operation between the authority and other organisations. Although the duty would not mention safeguarding adults expressly, many of the specified organisations will be those with legal responsibilities to safeguard adults at risk. The enhanced duty would provide that an authority can request certain bodies to provide assistance during an assessment and in providing services. In such cases, the requested body would be under a duty to give *due consideration* to the request. We envisage that this duty would apply expressly in adult protection cases.

Provisional Proposal 12-8: We provisionally propose that the enhanced duty to co-operate, as proposed in Part 11 of this consultation paper, should include specific provision to promote co-operation between the organisations in safeguarding adults from abuse and neglect.

THE LEGAL BASIS OF NO SECRETS AND IN SAFE HANDS

- 12.83 Both *No Secrets* and *In Safe Hands* were issued under section 7 of the Local Authority and Social Services Act 1970, which gives the Secretary of State and Welsh Ministers power to issue guidance to assist local authorities “in the exercise of any discretion conferred by any relevant enactment”. Any guidance issued under section 7 must, therefore, be linked to a local authority’s functions that are conferred by statute law. However, *No Secrets* and *In Safe Hands* cover an area of law where there is currently no specific statute that confers powers and duties on local social services authorities.
- 12.84 Accordingly, *No Secrets* and *In Safe Hands* will be effective in guiding local authorities in the exercise of their existing statutory functions but the guidance cannot provide a free-standing justification for any act. It may be that some parts of *No Secrets* and *In Safe Hands* appear to give local authorities greater powers than they actually have in law. We are not aware, however, that this is the case. However, we understand that some local authorities may be relying on *No Secrets* and *In Safe Hands* to justify their actions, rather than referring to the underlying legal power. We welcome any further evidence on this issue.

Provisional view

- 12.85 It is important that local authorities are clear about the legal basis for any decision taken, especially where the decision relates to safeguarding an adult from abuse and neglect. We believe that the current lack of clarity would be addressed, at least in part, by the introduction of legislation setting out the duties and responsibilities of local authorities in relation to safeguarding adults. In this way, our proposed adult social care statute would provide the necessary authority through which statutory guidance could be issued in England and Wales.

Provisional Proposal 12-9: We provisionally propose that *No Secrets* and *In Safe Hands*, or their successors, are linked clearly to a local authority’s statutory functions to safeguard adults from abuse and neglect, as set out in our future adult social care statute.

PART 13

STRATEGIC PLANNING

- 13.1 Strategic planning concerns the obligations on local authorities to ensure that appropriate services are available to meet local need. There are three main elements to strategic planning: the register of disabled people; strategic plans; and the provision of information.

THE REGISTER OF DISABLED PEOPLE

- 13.2 Section 29(4)(g) of the NAA 1948 and the relevant directions¹ place a duty on local authorities to compile and maintain registers of persons to whom section 29 “relates” and who are ordinarily resident in their area. Section 29 *relates* to disabled people, who are defined as people aged 18 and over who are:

blind, deaf or dumb, or who suffer from mental disorder of any description and ... who are substantially and permanently handicapped by illness, injury, or congenital deformity.

- 13.3 This duty in section 29 is supplemented by section 1 of the CSDPA 1970, which requires local authorities to “inform themselves” of the number of persons in their area to which section 29 “applies”. The directions state that the register should include both those who are receiving services and those who may require help in the future.² However, all of the local authority registers that we have reviewed allow registration for people that fall within the section 29 definition of disability, whether or not they are eligible for services. The directions and guidance state that the purpose of the register is to assist local authorities to plan services and to prove eligibility for certain benefits unconnected with section 29.³

Does the register assist planning services?

- 13.4 In order to assist in planning services, the register would need to provide an accurate record of disabled people with social care needs living in a local area. However, the accuracy of the register is limited because few disabled people choose to register. It is estimated that there are ten million disabled adults in the UK,⁴ but only between one and two million people register.⁵ In relation to sight impaired people, however, the proportion who register is higher; perhaps as many as 80%.⁶ On this basis, VISION 2020 argues that the register does provide useful assistance in the planning and delivery of local services, at least for sight impaired people.⁷

¹ LAC(93)10, appendix 4.

² As above, appendix 4, para 2.

³ As above, appendix 4 and DHSS Circular 12/70, *Chronically Sick and Disabled Persons Act 1970*, para 5.

⁴ Department for Work and Pensions, *Family Resources Survey 2007-08* (2009).

⁵ Written Answer, *Hansard* (HC), 28 February 2006, vol 443, col 690W (Mrs McGuire).

⁶ R Tate and others, *The Prevalence of Visual Impairment in the UK* (2005).

⁷ Letter from Lesley-Anne Alexander on behalf of the VISION 2020 Executive Committee, dated 14 January 2009 (available from the Law Commission).

- 13.5 The accuracy of the register is limited by the definition of disabled people provided in section 29 of the NAA 1948. This definition excludes disabled people who are substantially but not *permanently handicapped*; for example, people whose disabilities may improve and those with fluctuating disability, people with a less than substantial but permanent disability, and people with developing disabilities or problems which, if left unattended, may develop into a substantial disability. Nonetheless, all of these people may, and in some cases will, need community care services.
- 13.6 Furthermore, the provision of services to disabled people under section 29 of the NAA 1948 and the CSDPA 1970 is only one aspect of local authorities' responsibilities; services can also be provided to older people under the HSPHA 1968; to certain former mental health patients under section 117 of the Mental Health Act 1983; on the basis of illness under the NHS Acts 2006; and to carers under the CDCA 2000. Whilst there is much overlap between these groups and the section 29 definition, a significant number of service users will not be covered by the definition. One might reasonably question, therefore, why there is a register of disabled people under section 29, but not other services users.
- 13.7 A register is only an indicator of the number of people in an area that fall into a particular category (in this case *disabled people*). This data will be of limited use to local authorities when commissioning services, since effective commissioning will depend on an understanding of the needs that arise from, for example, disability or age.⁸ Arguably, even if the register did record accurately the number of disabled people in an area, it remains a blunt tool for the purposes of strategic planning. It is noteworthy that none of the commissioning guidance or toolkits that we have seen reviewed mention the disability register as an element of strategic planning; as opposed to, for example, joint strategic needs assessments. This suggests that, for the purposes of strategic planning, the register is largely irrelevant. However, we welcome further views on this point.

Does registration establish entitlement to certain benefits?

- 13.8 It was never envisaged that registering as disabled would be a pre-requisite for receiving all the assistance and services available for disabled people in the local area. The vast majority of services or welfare benefits that can be provided to disabled people are done so irrespective of whether the person is registered. In particular, registration is not required in order to access assistance under section 29 of the NAA 1948 or the CSDPA 1970, or indeed any other community care services. However, a small number of benefits can be obtained by people who are registered as blind or hearing impaired. The main examples are:
- (1) the blind person's income tax allowance, which is granted only to persons registered as blind;⁹
 - (2) the *Blue Badge* scheme for parking concessions, which is available

⁸ Department of Health, *Valuing People Now: From Progress to Transformation: A Consultation on the Next Three Years of Learning Disability Policy* (2007) para 5.1.1.

⁹ Income and Corporation Taxes Act 1988, s 265 (as amended).

automatically to people registered as blind;¹⁰

- (3) the disabled person's railcard, which is available to people registered as partially sighted, blind or deaf;¹¹ and
- (4) a reduced cost TV licence, which is available to people registered as blind.¹²

13.9 Only one of the benefits listed above (the blind person's income tax allowance) depends entirely on the fact of registration. The other benefits can be accessed in alternative ways.

13.10 In addition to the above benefits, there are often concessions available locally for disabled people. Examples include reduced or free entrance to museums, cinemas, galleries and other leisure facilities. Evidence of registration as disabled is sometimes used as a way of proving entitlement to these concessions.¹³ However, this is not always the case; many such concessions are on the basis that the person is in receipt of certain welfare benefits. Furthermore, a person who is registered as blind or partially sighted is deemed to be a disabled person for the purposes of the Disability Discrimination Act 1995.¹⁴

Provisional view

13.11 We propose that the disability register should be abolished. It does not appear to provide an accurate record of the overall numbers of disabled people and is of limited utility as a strategic planning tool for local authorities. Even in the case of services for partially sighted people, where the register is more accurate, we have seen no evidence that the registers are used for planning services.

13.12 The vast majority of services or welfare benefits that can be provided to disabled people are done so irrespective of whether the person is registered. However, for a small number of benefits, registration appears to provide a convenient way of establishing eligibility, and in the case of the blind person's tax allowance it is the only way. We provisionally consider that there are alternative and more efficient ways in which disabled people could establish entitlement to benefits. For example, the Certificate of Visual Impairment might provide an alternative in the case of sight impaired people. This certificate is normally required in order for people to register and therefore, the additional requirement of evidence of registration over and above the production of the certificate appears to be an unnecessary formality. In addition, evidence of receipt of certain welfare benefits could be used to establish entitlement, rather than the local authority register. We welcome further views on the viability of these and any other options. If the register were abolished, then legislation currently using registration as a way of

¹⁰ CSDPA 1970, s 21 and the Disabled Persons (Badges for Motor Vehicles) (England) Regulations 2000, SI 2000 No 682, reg 4(2)(c).

¹¹ Railways Act 1993, s 28. See also <http://www.disabledpersons-railcard.co.uk/buying-your-railcard> (last visited 4 February 2010).

¹² Communications (Television Licensing) Regulations 2004, SI 2004 No 692.

¹³ See, for example, <http://www.ceacard.co.uk/> (last visited 4 February 2010).

¹⁴ Disability Discrimination (Blind and Partially Sighted Persons) Regulations 2003, SI 2003 No 712.

proving entitlement would be amended to allow for other methods of proof. In the case of local concessions and other non-statutory benefits, the various bodies would be required to develop practices to take into account the changes.

- 13.13 We also welcome views on whether the disability register could be retained but only in respect of people who are blind or partially sighted. Most of the benefits linked to registration are directed at these groups and it may make sense to continue with a more restricted register on this basis, which would reduce the administrative costs for local authorities.

Provisional Proposal 13-1: We provisionally propose that the disabled persons register should be abolished.
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STRATEGIC PLANS

- 13.14 As noted in our scoping report, responsibility for the strategic planning of adult social care services was placed squarely on local social services authorities until the early 1990s.¹⁵ However, the period since then has seen a proliferation in the number of local strategic plans and a broadening of their focus to cover the wider responsibilities of local authorities and joint working with other local agencies, including health and emergency services. Accordingly, the overall responsibility for these plans has shifted from social services to a more collaborative approach whereby the various bodies comprising the local authority work together.
- 13.15 Some of these plans have been issued under the Local Government Act 2000 or other statutes, while others are non-statutory in origin, and the requirements to produce them are contained in a range of circulars and guidance. Furthermore, some of the plans have been abandoned but others have not, so it is not immediately clear which plans are still in use. There is also a great deal of overlap and repetition of obligations and information.

The main planning requirements currently in force in England

- 13.16 The Health Act 1999 and associated regulations allowed for partnership arrangements to be made between health and local authority bodies to improve NHS and health related services. Section 28 requires strategic health authorities to prepare plans setting out their strategy for improving the health of people within their area. This was modified in 2002 to take into account the NHS modernisation agenda, resulting in health improvement and modernisation plans.¹⁶ In addition, joint investment plans focus on the development and improvement of services at the interface of health and social care.¹⁷
- 13.17 Section 116 of the Local Government and Public Involvement in Health Act 2007 requires all responsible local authorities in England with their partner Primary Care Trusts to prepare and publish an assessment of the “health and well-being” needs of people within their local area (the joint strategic needs assessment). The members of the local strategic partnership contribute to this, as well as

¹⁵ Law Commission, *Adult Social Care: Scoping Report* (2008) para 4.130.

¹⁶ Department of Health, *The NHS Plan: A Plan for Investment, A Plan for Reform* (2000) and Department of Health, *Health Improvement and Modernisation Plans* (2001).

¹⁷ Department of Health, *Guidance on Joint Investment Plans* (2000).

employment, education, housing, and environmental bodies.¹⁸ The social services element of this assessment requires data to be provided on the number of people receiving services, the standard of services and service users' perceptions of the services they are receiving. The joint strategic needs assessment should be used as a part of the evidence base for drawing up sustainable community strategies and local area agreements.

- 13.18 In 2007, a local performance framework came into force in England with the publication of a set of around 200 national performance indicators to assist local government in setting its local priorities and targets.¹⁹ The new framework replaced all previous nationally set targets in this area, such as best value performance indicators and associated plans. The indicators focus on outcomes for service users and cover "health, welfare, housing, employment, education, communities, economic development, policing and community safety, the environment and beyond".²⁰ Local authorities are required to report annually on their performance against each of the indicators, and to use them to help create their sustainable community strategies and local area agreements.
- 13.19 Section 4 of the Local Government Act 2000 introduced community strategies, which later became sustainable community strategies under the Sustainable Communities Act 2007. The Local Government and Public Involvement in Health Act 2007 established local strategic partnerships in order to help create and implement the sustainable community strategies and local area agreements. These partnerships are led by the responsible local authority and include the police, fire services, NHS and arts and sports councils.²¹ The sustainable community strategies are aimed at promoting or improving "the economic, social and environmental well-being of their area and contributing to the achievement of sustainable development in the United Kingdom".²²
- 13.20 The Local Government and Public Involvement in Health Act 2007 introduced local area agreements in England. These are described as a local "to-do" list in relation to social and health care, the content of which is negotiated and agreed with central government to "balance local priorities and levels of performance with national improvement priorities".²³ There are generally around 35 local priorities and related improvement targets selected from the 200 national indicators, along with a number of targets set by the Department for Education and Skills.²⁴ Like sustainable community strategies, the responsibility for local area agreements lies with the local strategic partnership.

¹⁸ Department of Health, *Guidance on Joint Strategic Needs Assessment* (2007).

¹⁹ Department for Communities and Local Government, *The New Performance Framework for Local Authorities & Local Authority Partnerships* (2007).

²⁰ Department for Communities and Local Government, *National Indicators for Local Authorities and Local Authority Partnerships: A Handbook of Definitions* (2008) p 8.

²¹ Local Government and Public Involvement in Health Act 2007, s 104.

²² Local Government Act 2000, s 4(1).

²³ Department for Communities and Local Government, *Strong and Prosperous Communities – the Local Government White Paper, Vol 1* (2006) para 6.39.

²⁴ Department for Communities and Local Government, *National Indicators for Local Authorities and Local Authority Partnerships: A Handbook of Definitions: Draft* (2007) p 21.

- 13.21 The local performance framework in England saw the introduction of comprehensive area assessments. These cover the full range of services provided in the community and are completed by a number of inspectorate organisations. Comprehensive area assessments contain two assessments: area assessments focus on the extent to which councils and their partners are delivering improvements to the services that are most important to the local area, and organisation assessments focus on the various public bodies themselves and whether they are performing efficiently.²⁵

The main planning mechanisms currently in force in Wales

- 13.22 Section 46 of the NHSCCA 1990 and associated directions established a duty to create community care plans (termed social care plans in Wales) as the primary local strategic planning tool.²⁶ These plans provide information to the public about available services and assist local authorities in organising their own finances. From 1997, social services departments in Wales were required to produce community care charters.²⁷ These should include a list of services provided in the local area (including health and housing services), together with the expected standard of service delivery. Community care charters contain considerable duplication of information contained in social care plans, and hence the obligation appears to have been subsumed into the social care plans in many areas.
- 13.23 Corporate strategic planning and service improvement is a devolved matter in Wales and local authorities in Wales are thus not subject to the Local Government Act 2000 as regards community strategies or to any of the provisions of the Sustainable Communities Act 2007 or the Local Government and Public Involvement in Health Act 2007. Instead, the Local Government (Wales) Measure 2009 creates a duty on authorities and other agencies (principally, NHS bodies, the police, the fire service, national parks and community councils) to participate in a process of community planning. The outcomes of that must be captured in a community strategy. The Local Government (Wales) Measure 2009 also repealed most of the Local Government Act 1999, and the related “best value” regime, as regards Wales. From 2010 to 2011, local authorities will be required each year to determine and publish their own priorities for improvement (“improvement objectives”) in consultation with local interests, to collect and use data allowing them to monitor delivery of those objectives, and to account publicly for progress.
- 13.24 Since 2002, Welsh local authorities and the relevant local health board have been under a duty to “formulate and implement a strategy for the health and well-being of members of the public in the local authority’s area”.²⁸ These should address how well the existing provision of services address local need, and identify risks to the health and well-being of the population and how they will be reduced. The duty to create social care plans, amongst other planning requirements, should be co-ordinated or integrated into the health and well-being strategy process.

²⁵ Audit Commission, *Comprehensive Area Assessment Framework Document* (2009).

²⁶ Community Care Plans Directions 1991 and WOC 79/94, *Guidance on the Framework for Social Care Planning*. The duty to produce these plans was abolished in England in 2003.

²⁷ WOC 9/96, *Framework for Local Community Care Charters*.

²⁸ NHS Reform and Health Care Professions Act 2002, s 24; NHS (Wales) Act 2006, s 40.

- 13.25 Wales does not use the new local performance framework or produce comprehensive area assessments. Instead, the Care and Social Services Inspectorate Wales conducts various reviews of community service provision and produces reports accordingly. The Welsh Assembly Government has produced a number of regulations governing minimum care standards to be achieved.²⁹

Provisional view

- 13.26 The strategic planning legal framework is complex and often confusing. There is continuing lack of clarity as to what obligations are currently in force and how they work. In addition, the purpose behind the various planning obligations and instructions on how to construct the plans are outlined in a plethora of policy documents, local authority circulars, legislation and guidance. It is almost impossible for members of the public to understand exactly what obligations their local authority has, and hence what they can reasonably expect in terms of published strategies and plans. In our view, this calls for the existing planning requirements to be streamlined and for clear information to be provided about what obligations are in force, the standards to be achieved and where to look to find the relevant information.
- 13.27 The strategic planning responsibilities of local authorities are, however, wider than those of adult social care services. The various plans include the range of local authority services, for example housing and children services, as well as joint working with other organisations, such as health, emergency services and voluntary groups. It appears to make little sense and goes beyond the remit of our review to try and address this complexity by proposing a duty on the local social services department alone to provide strategic plans in the local area.

Provisional Proposal 13-2: Provisionally, we do not propose to include any strategic planning provisions in our future adult social care statute.

INFORMATION ABOUT SERVICES

- 13.28 For many potential and actual service users, it will be important to know what services are available in their local area and how to go about accessing them. The Government's personalisation policy and the increased use of direct payments and individual budgets, heightens the need for detailed and accurate information about services and how to access them, as in some cases the individual will be arranging the service, rather than the local authority.
- 13.29 There are a number of existing legal requirements on local authorities to provide information about services. Section 29(4) of the NAA 1948 and associated directions gives local authorities the power to inform disabled people about the services available to them under that section.³⁰ This was strengthened by section 1(2) of the CSDPA 1970, which requires local authorities to publish information about the services available under section 29 of the NAA 1948, as well as any other relevant services available to disabled people, including those provided by other local authorities or private organisations. The need to publicise available

²⁹ For example the Care Homes (Wales) Regulations 2002, WSI 2002 No 324.

³⁰ LAC(93)10, appendix 2, para 2(1).

services is also mentioned in various pieces of community care guidance³¹ and strategic planning guidance.³² The importance of providing information is endorsed in the 2009 Green Paper, *Shaping the Future of Care Together*.³³

- 13.30 The main body responsible for disseminating information about available social care services will be the local authority. In addition, however, other bodies such as the Care Quality Commission and charities and voluntary organisations distribute information about services and how to access them.
- 13.31 There has been a move away from locally produced information-based plans, such as community care plans and community care charters, in favour of agreements or plans produced in collaboration with various local bodies and the central government.³⁴ These plans tend not to be as focused on what services are available and how to access them but on setting agreed targets and improvement outcomes. The duty to provide information is often eclipsed by the pursuit of specific performance targets.

Provisional view

- 13.32 The duties to provide information outlined above appear in a variety of different sources. Where it is contained in guidance, the requirement can easily become out of date and fall into disuse, or be replaced or superseded by further guidance that fails to reflect the preceding duty to provide information in the same way or at all. This creates confusion about whether and in what circumstances information should be provided. For example, the requirement to provide information about services contained in the 1990 statutory guidance, *Community Care in the Next Decade and Beyond* refers primarily to community care plans; however these have since been abolished but the guidance remains in force. In practice, this makes it difficult for services users and their representatives to refer to a specific duty when demanding access to information.
- 13.33 We provisionally consider that a statutory duty to provide information will create a clearer and more robust requirement, to which people would be able to refer and enforce if necessary. Some of the strategic plans, discussed above, place requirements to provide information on the local authority as a whole or on the local authority and other organisations, such as health. This may mean that there is less need for a specific duty on local social services authorities to provide information. However, we believe that such a duty would provide a useful mechanism that could be carried out in conjunction with other bodies, and would ensure that the core need to provide information about adult social care services is not lost within a more general obligation on the local authority as a whole. However, we welcome views and comments on this point.

Provisional Proposal 13-3: We provisionally propose that our future adult social care statute should place a duty on a local social services authority to provide information about services available in the local area.

³¹ Department of Health, *Caring for People: Community Care in the Next Decade and Beyond: Policy Guidance* (1990) paras 2.25 and 3.56, and FACS para 29.

³² LAC(2001)6 and HSC 2001/006, *Better Health Higher Standards: Guidance for 2001-02*.

³³ *Shaping the Future of Care Together* (2009) Cm 7673, pp 55 to 57.

³⁴ See discussion above of the existing planning requirements in England and Wales.

PART 14

SUMMARY OF PROPOSALS AND QUESTIONS

- 14.1 This Part brings together all of the provisional proposals made and questions asked in this consultation paper. We note that the provisional proposals and questions have their own numbering system, consisting of two numbers separated by a dash. The first number indicates the Part number and the second number represents the number of the proposal or question as made in that Part.

PART 1: INTRODUCTION

- 14.2 There are no provisional proposals made in this Part.

PART 2: OUR APPROACH TO LAW REFORM

- 14.3 **Provisional Proposal 2-1:** We provisionally propose that there should be a single adult social care statute for England and Wales, unless policy in Wales diverges enough to require separate statutes for England and Wales.
- 14.4 **Question 2-1:** Is our proposed three-level structure for the regulation of adult social care law (consisting of primary legislation, statutory instruments and guidance) appropriate?
- 14.5 **Question 2-2:** Should there be a duty on the Secretary of State and Welsh Ministers to prepare a code of practice to bring together statutory guidance?
- 14.6 **Question 2-3:** Is our process-driven approach to adult social care (a prescribed assessment and eligibility process, with support from prohibitions, a broad list of services, care plans and statutory principles) sufficient to determine the scope of adult social care, or is further definition required?

PART 3: STATUTORY PRINCIPLES

- 14.7 **Provisional Proposal 3-1:** We provisionally propose that our future adult social care statute should include a statement of principles.
- 14.8 **Question 3-1:** Should there be a principle in our proposed adult social care statute which provides that decision-makers must maximise the choice and control of service users?
- 14.9 **Question 3-2:** Should there be a principle in our proposed adult social care statute based on person-centred planning – or should this be incorporated into other provisions of the legislation?
- 14.10 **Question 3-3:** Should there be a principle in our future adult social care statute which provides that a person's needs should be viewed broadly?
- 14.11 **Question 3-4:** Should there be a principle in our proposed adult social care statute based on the need to remove or reduce future need?
- 14.12 **Question 3-5:** Should there be a principle in our proposed adult social care statute based on the concept of independent living?

- 14.13 **Question 3-6:** Should there be a principle in our proposed adult social care statute based on an assumption of home-based living?
- 14.14 **Question 3-7:** Should there be a principle in our proposed adult social care statute based on dignity in care?
- 14.15 **Question 3-8:** Should there be a principle in our proposed adult social care statute based on the need to safeguard adults at risk from abuse and neglect?
- 14.16 **Question 3-9:** Should any one principle in adult social care be given primacy over all other principles?

PART 4: COMMUNITY CARE ASSESSMENTS

- 14.17 **Provisional Proposal 4-1:** We provisionally propose that there should be a duty to undertake a community care assessment in our future adult social care statute, triggered where a person appears to the local authority to have social care needs that can be met by the provision of community care services (including a direct payment in lieu of services) and where a local authority has a legal power to provide or arrange for the provision of community care services (or a direct payment) to the person.
- 14.18 **Question 4-1:** Should our proposed adult social care statute include a right to have an assessment on request?
- 14.19 **Provisional Proposal 4-2:** We provisionally propose that the focus of the community care assessment duty should be an assessment of a person's social care needs and the outcomes they wish to achieve, and should not focus on the person's suitability for a particular service.
- 14.20 **Question 4-2:** Should our proposed adult social care statute recognise co-produced self-assessments as a lawful form of assessment?
- 14.21 **Question 4-3:** Should our proposed adult social care statute allow for a pure self-assessment for certain people or groups of people?
- 14.22 **Provisional Proposal 4-3:** We provisionally propose that our future adult social care statute should place a duty on the Secretary of State and Welsh Ministers to make regulations which prescribe details of the assessment process. The statute should specify the areas which these regulations must cover.
- 14.23 **Provisional Proposal 4-4:** We provisionally propose that local authorities should retain the ability to provide temporary services in urgent cases.

PART 5: CARERS' ASSESSMENTS

- 14.24 **Provisional Proposal 5-1:** We provisionally propose that there should be a duty to undertake a carer's assessment in our future adult social care statute.
- 14.25 **Provisional Proposal 5-2:** We provisionally propose that the duty to assess a carer should apply to all carers who are providing or intend to provide care to another person, not just those providing a substantial amount of care on a regular basis.

- 14.26 **Provisional Proposal 5-3:** We provisionally propose that the duty to assess a carer should not be triggered by the carer making a request, but should be triggered where a carer appears to have, or will have upon commencing the caring role, needs that could be met either by the provision of carers' services or by the provision of services to the cared-for person.
- 14.27 **Provisional Proposal 5-4:** We provisionally propose that our future adult social care statute provides that the following carers are not excluded from the definition of a carer for the purposes of a carer's assessment: (1) a previously unpaid carer who now receives payment for their services through direct payments received by the cared-for person; (2) a carer who is paid for some but not all of the care they provide; and (3) a carer where the local authority believes the caring relationship is not principally a commercial one.
- 14.28 **Question 5-1:** Should our proposed adult social care statute encourage a more unified assessment process for carers and cared-for people?
- 14.29 **Question 5-2:** Do you think the carers' assessment duty should be merged with the community care assessment duty in our proposed adult social care statute?

PART 6: ELIGIBILITY FOR SERVICES

- 14.30 **Provisional Proposal 6-1:** We provisionally propose that our future adult social care statute should place a duty on local authorities to: (1) determine whether a person's social care needs are eligible needs, using eligibility criteria; and (2) provide or arrange community care services (including a direct payment in lieu of services) to meet all eligible needs.
- 14.31 **Provisional Proposal 6-2:** We provisionally propose that our future adult social care statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the risks to independence that will call for the provision of services and the objectives that are to be achieved by the provision of services.
- 14.32 **Provisional Proposal 6-3:** If a right to re-ablement services is introduced, we provisionally propose this should be accommodated in our future adult social care statute.
- 14.33 **Provisional Proposal 6-4:** If the eligibility criteria are to be set at a national level in England and in Wales, we provisionally propose that the eligibility criteria should be prescribed in regulations issued by the Secretary of State and Welsh Ministers respectively.
- 14.34 **Provisional Proposal 6-5:** We provisionally propose that our future adult social care statute should prescribe that the Secretary of State or Welsh Ministers may by regulations require that a local authority must allocate a personal budget in fulfilling the duty to meet all needs that are eligible.
- 14.35 **Provisional Proposal 6-6:** We provisionally propose that there be a mandatory national eligibility framework which local authorities must use to decide whether or not to provide services to carers, and a duty to meet the eligible needs of carers.

PART 7: SECTION 21 OF THE NATIONAL ASSISTANCE ACT 1948 AND SECTION 2(1) OF THE CHRONICALLY SICK AND DISABLED PERSONS ACT 1970

- 14.36 **Provisional Proposal 7-1:** We provisionally propose that section 21 of the National Assistance Act 1948 should be repealed and that the Government should ensure a proper scheme for the provision of residential accommodation to those people who might lose their entitlement.
- 14.37 **Provisional Proposal 7-2:** If the Government does not introduce a proper scheme for residential accommodation, we propose that section 21 should be retained but *only* in relation to those people who would otherwise lose their entitlement.
- 14.38 **Question 7-1:** If section 21 of the National Assistance Act 1948 were repealed, do you think that any groups would lose their entitlement to accommodation under our proposed structure?
- 14.39 **Provisional Proposal 7-3:** We provisionally propose that section 2(1) of the Chronically Sick and Disabled Persons Act 1970 should be removed from adult social care legislation.

PART 8: ORDINARY RESIDENCE AND PORTABILITY

- 14.40 **Provisional Proposal 8-1:** We provisionally propose that the local authority be placed under a *duty* to provide services for people ordinarily resident in their area and have the *power* to provide services for people who are not ordinarily resident in their area. In cases of urgent need of residential accommodation, there should be a duty to provide accommodation to those people not ordinarily resident in the authority's area. Assessments of need and the provision of temporary urgent services should not be limited by the ordinary residence rules.
- 14.41 **Provisional Proposal 8-2:** We provisionally propose that the local authority in which the cared-for person lives should be given responsibility for providing carers' services.
- 14.42 **Provisional Proposal 8-3:** We provisionally propose that our future adult social care statute should enable the portability of services by the introduction of: (1) an enhanced duty to co-operate when service users move areas; and (2) if these policies are implemented, a national portable needs assessment and national eligibility criteria.

PART 9: SCOPE OF ADULT SOCIAL CARE SERVICES

- 14.43 **Provisional Proposal 9-1:** We provisionally propose that community care services should be defined by a short and broad list of services.
- 14.44 **Provisional Proposal 9-2:** We provisionally propose that the list of community care services should be set out on the face of our future adult social care statute.
- 14.45 **Question 9-1:** Do you think that community care services should be undefined in our future adult social care statute?

- 14.46 **Provisional Proposal 9-3:** Provisionally, we do not propose that our future adult social care statute should include a central definition of a disabled person or service user.
- 14.47 **Provisional Proposal 9-4:** We provisionally propose that carers' services should remain undefined in our future adult social care statute.
- 14.48 **Provisional Proposal 9-5:** We provisionally propose that our future adult social care statute should allow for regulations to be issued that are capable of defining Shared Lives schemes as being non-residential services in all cases.
- 14.49 **Provisional Proposal 9-6:** We provisionally propose that the existing divide between health and social care service provision should be maintained in our future adult social care statute. This would mean that local authorities would be prohibited from providing residential accommodation, if this is authorised or required to be provided under the NHS Acts 2006; any non-residential services that are required to be provided under the NHS Acts 2006; and nursing care which is required to be provided by a registered nurse.
- 14.50 **Provisional Proposal 9-7:** We provisionally propose that social services authorities should continue to be prohibited from providing ordinary housing and connected services, if these services are authorised or required to be provided by or under other legislation.
- 14.51 **Question 9-2:** If Government policy towards asylum seekers continues, what are the likely consequences of retaining the prohibition on adult social care services to those subject to immigration control solely because they are destitute or because of the physical or anticipated physical effects of being destitute?

PART 10: DELIVERY OF SERVICES

- 14.52 **Provisional Proposal 10-1:** We provisionally propose that our future adult social care statute should place a duty on local authorities to produce a care plan for people who have assessed eligible needs. This would be supported by a duty placed on the Secretary of State and Welsh Ministers to make regulations concerning the form and content that the care plan must take.
- 14.53 **Question 10-1:** Should direct payments be extended to cover residential accommodation?
- 14.54 **Provisional Proposal 10-2:** We provisionally propose that the choice of accommodation directions should be placed in statute law and that the additional payments regulations should be retained in secondary legislation.
- 14.55 **Provisional Proposal 10-3:** We provisionally propose that the direct payment provisions should be retained in their existing form in our future adult social care statute.
- 14.56 **Provisional Proposal 10-4:** We provisionally propose that our future adult social care statute should include a regulation-making power to enable the Secretary of State or Welsh Ministers to require or authorise local authorities to charge for residential and non-residential services.

14.57 **Provisional Proposal 10-5:** We provisionally propose that the existing regulation-making power, which enables certain community care services to be provided free of charge, should be retained. All services that must be provided for free should be listed in the regulations.

PART 11: JOINT WORKING

14.58 **Provisional Proposal 11-1:** We provisionally propose that our future adult social care statute should apply to those aged 18 and above, and the Children Act 1989 (and the CSDPA 1970) should apply to those aged 17 and below.

14.59 **Provisional Proposal 11-2:** We provisionally propose that local authorities should have a power to assess 16 and 17 year olds under our proposed adult social care statute and young people aged 16 and 17 (and their parents on their behalf) would have a right to request such an assessment.

14.60 **Provisional Proposal 11-3:** We provisionally propose that the C(RS)A 1995 and the CDCA 2000 should be retained and amended so that they only apply to young carers.

14.61 **Provisional Proposal 11-4:** We provisionally propose that parent carers should continue to be eligible for a carer's assessment under the C(RS)A 1995 and the CDCA 2000. We also propose that where a young person aged 16 and 17 is being assessed under our proposed adult social care statute, parent carers should also be given a carer's assessment under this statute.

14.62 **Question 11-1:** We welcome further comments on how the well-being power is being or should be used in practice.

14.63 **Provisional Proposal 11-5:** We provisionally propose that the delayed discharge provisions should be retained in their existing form in our proposed adult social care statute.

14.64 **Question 11-2:** We welcome comments about whether prisons should be included or excluded from adult social care.

14.65 **Provisional Proposal 11-6:** We provisionally propose that the choice of accommodation directions should cover residential accommodation provided under section 117 of the Mental Health Act 1983.

14.66 **Provisional Proposal 11-7:** We provisionally propose that the additional payments regulations should cover residential accommodation provided under section 117 of the Mental Health Act 1983.

14.67 **Provisional Proposal 11-8:** We provisionally propose that the concept of ordinary residence should be extended to apply to after-care services provided under section 117 of the Mental Health Act 1983.

14.68 **Provisional Proposal 11-9:** We provisionally propose that section 117 should be amended to clarify that the duty falls on health authorities to provide *health care after-care*, and on social services authorities to provide *social care after-care*. We also propose that section 117 should be amended to clarify that health and social services authorities can commission after-care services.

- 14.69 **Question 11-3:** If the section 117 duty should be split between health and social services authorities, should the termination of the duty also be split so that, for example, *social care after-care* ceases when the social services authority is satisfied that the person no longer needs social care after-care; or should both authorities be involved in the decision?
- 14.70 **Question 11-4:** Should section 117 be recast from a free-standing duty to a gateway provision?
- 14.71 **Provisional Proposal 11-10:** We provisionally propose that our future adult social care statute should place a general duty on each social services authority to make arrangements to promote co-operation between the local authority and specified relevant organisations.
- 14.72 **Provisional Proposal 11-11:** We provisionally propose that our future adult social care statute should specify that a local authority can request certain authorities to assist in a number of circumstances, including when an assessment of a service user or carer is taking place and in providing services to a service user or a carer. In such cases, the requested authority would be under a duty to give due consideration to the request.

PART 12: SAFEGUARDING ADULTS AT RISK

- 14.73 **Provisional Proposal 12-1:** We provisionally propose that our future adult social care statute should place a duty on local authorities to make, or cause to be made, such enquiries as it considers necessary where it has reasonable cause to suspect that a person appears to be an *adult at risk* and consider whether there is a need to provide services or take any other action within its powers in order to safeguard that person from harm.
- 14.74 **Provisional Proposal 12-2:** We provisionally propose that the term *vulnerable adult* should be replaced by *adult at risk* for the purposes of the duty to make enquiries.
- 14.75 **Provisional Proposal 12-3:** We provisionally propose that an *adult at risk* should be defined in our statute as anyone with social care needs who is or may be at risk of significant harm.
- 14.76 **Provisional Proposal 12-4:** We provisionally propose that if the Government in England or the Welsh Assembly Government decides to introduce new compulsory or emergency powers to safeguard adults from abuse and neglect then these will be included in our future adult social care statute.
- 14.77 **Provisional Proposal 12-5:** We provisionally propose that section 47 of the National Assistance Act 1948 should be repealed.
- 14.78 **Provisional Proposal 12-6:** We provisionally propose that a local authority should continue to be under a duty to prevent the loss or damage of a person's property when they have been admitted to hospital or provided with residential accommodation.

- 14.79 **Provisional Proposal 12-7:** We provisionally propose that our future statute should place a duty on each social services authority to establish an adult safeguarding board and should specify the functions and membership of the board, the requirement to share information and a duty to contribute to serious case reviews.
- 14.80 **Provisional Proposal 12-8:** We provisionally propose that the enhanced duty to co-operate, as proposed in Part 11 of this consultation paper, should include specific provision to promote co-operation between the organisations in safeguarding adults from abuse and neglect.
- 14.81 **Provisional Proposal 12-9:** We provisionally propose that *No Secrets* and *In Safe Hands*, or their successors, are linked clearly to a local authority's statutory functions to safeguard adults from abuse and neglect, as set out in our future adult social care statute.

PART 13: STRATEGIC PLANNING

- 14.82 **Provisional Proposal 13-1:** We provisionally propose that the disabled persons register should be abolished.
- 14.83 **Provisional Proposal 13-2:** Provisionally, we do not propose to include any strategic planning provisions in our future adult social care statute.
- 14.84 **Provisional Proposal 13-3:** We provisionally propose that our future adult social care statute should place a duty on a local social services authority to provide information about services available in the local area.

APPENDIX A

CORE IMPACT ASSESSMENT ANALYSIS

BASIS OF ANALYSIS

- A.1 As noted in the consultation paper, the aim of our review is to provide a resource-neutral system for adult social care. Our intention is that the proposed legal structure set out in the consultation paper should be capable of operating at any given level of resources; it would not *require* any greater or reduced level of expenditure. This does not mean that the system would not require services to be provided for a particular person with social care needs or that services may not be provided in general. It will ensure both of these. But the system allows the relevant policy makers to make separate policy decisions on the rationing of the resources available to the system as a whole. The costs and savings relevant to this impact assessment, therefore, are the costs and savings of introducing and running the new legal system, not providing services under it.
- A.2 We emphasise that our purpose here is to identify the value of savings and costs of our reform. We do not say anything about how the value of such savings should be deployed. Whether the savings we identify are used to improve services for clients or whether they are used to reduce the overall cost of adult social care is a policy choice for Government to make.
- A.3 As with the rest of the consultation paper, we welcome comments from consultees on this impact assessment analysis.

THE DATA

- A.4 In compiling this information we have drawn on such published data as we were able to access. In addition, some of the figures are based on small, exploratory surveys we have undertaken, and on our own estimates. We intend to improve the reliability of these figures by conducting some further limited research during the consultation period.
- A.5 *First*, we will send a questionnaire to social services authorities, which will include questions to establish:
- (1) the number of full-time equivalent legal staff working on adult social care;
 - (2) the costs to local authorities of litigation relating to adult social care (excluding employed lawyers, but including particularly counsel's brief fees, court fees and other non-salary disbursements); and
 - (3) the costs of complaints relating to adult social care (preferably discounting the cost of legal services provided by the authorities' legal departments).
- A.6 *Second*, we will review a time-limited sample of cases involving adult social care law in the Administrative Court, and take a view as to whether the legal question would have arisen under our proposed new system. This will enable us to provide a more robust figure for savings on litigation.

BENEFITS OF OUR PROVISIONAL PROPOSALS

A.7 We consider the benefits of our provisional proposals under the following headings:

- (1) training costs;
- (2) complaints and legal costs; and
- (3) savings in relation to the everyday activities of social workers.

Training costs

A.8 A simpler legal structure will take less time to teach to social workers than a complicated one. This will be true for both initial training and continuing professional training. We consider these in turn.

Initial social work training

- A.9 Since 2003, the professional qualifying award for social workers has been a degree in social work, the content of which is regulated by the General Social Care Council. A typical social work law course would cover an introduction to social work law, anti-discrimination law, the Children Act 1989, the criminal justice system, community care law and mental health and mental capacity law. Assignments need to be completed on most or all of these topics. This means that community care law will typically take up a quarter of all course work. In addition, there will be an exam, which will often focus more on the Children Act and community care law. Therefore, overall we estimate that community care takes up a third of social work law training. The law course itself constitutes, we estimate, about 10% of the degree as a whole.
- A.10 Teaching community care law by considering a single, comprehensive, rational statute will clearly be possible in less time than the current multiplicity of statutes and other sources of law. We estimate that our new system could be taught to the same level as the current law is taught in 60% of the time necessary to teach the current law. We therefore propose that the percentage saving in relation to a whole degree would be about 2%.
- A.11 In 2007 to 2008, 5,221 students enrolled on regulated social work degrees in England. During the period from 2003 to 2007, the completion rate was 73.6%. The proportion of graduates who registered with the General Social Care Council as qualified social workers was 90%. This includes those working in all sectors.¹ There is a case for counting the saving in teaching time to all students. But if we confine ourselves to the savings in respect of those completing the course and working as qualified social workers, then, using the 2007 to 2008 figure for students and the figures for completion and registration over the longer period, we are considering an annual total of about 3,500 relevant students. We have not found data on the costs of the social work degree. However, the total cost (including central funding and tuition fees) of degrees in the relevant category

¹ General Social Care Council, *Raising Standards: Social Work Education in England 2007-2008* (2009).

(health and community studies) is £8,347.² A saving of 2% of the annual cost would therefore amount to about £200,000.

- A.12 This represents only the direct cost of the teaching of the degree. It is clear that a significant proportion of students on the degree course are supported financially by their employers. A study in 2005 to 2006 found that 11% of students were “seconded”, and another 13% were “sponsored”.³ We would be grateful for clarification of the amount of support implied by these terms. In order to arrive at some quantification for these costs, we will assume that the seconded students were full time but on a lower than average salary for social workers (£28,000 including the costs to the employer of the employment), and will make no assumption in relation to sponsorship. The overestimate implied by the assumption that seconded students are full time will be compensated for by discounting sponsorship. On this basis (and using our figure of 3,500 for the number of relevant students), the saving under this heading would be £215,000.
- A.13 In Wales, 161 students gained social work qualifications in 2007. Of those students, 138 have registered as qualified social workers with the Care Council for Wales.⁴ We do not have figures for the costs of social work initial training in Wales, but if we assume the cost is the same as that in England (£8,347) then the total cost of training 138 social workers would be £1,151,886. A saving of 2% of the total cost would therefore amount to £23,038. As in England, a number of students received some level of financial support during their training from their employers. This amounted to 23% of students, although we do not have information about the level of support in these cases.⁵
- A.14 These figures may be an underestimate, as they do not include costs to students of undertaking training. But it may be argued that students benefit in financial terms from the training over time, so it would not be appropriate to include the costs for them. We would be grateful for views on this issue.
- A.15 We recognise that it is hardly plausible in this context that there would be a 2% cut in social work courses. However, the saving we have identified is a real benefit accruing from our proposed reforms. Even if it is “spent” on better training in community care or other aspects of the law, or other components of the degree, it is nevertheless a benefit which should be properly costed.

On-going training

- A.16 The current requirement for continuing professional education for social workers is for a minimum of 90 hours of post registration training in every three year registration period.⁶ Continuing education therefore comprises a little under 2% of social workers’ time. There are about 8,800 social workers in adult social care,

² Higher Education Funding Council for England, *Review of the Subject Price Groups Using TRAC(T) Data* (2009) annex B.

³ J Harris and others, *What Works in ‘Grow Your Own’ Initiatives for Social Work?* (2008) p 31.

⁴ Care Council for Wales, *Social Work Qualifying Training: Annual Review of Trends 2007/2008* (2009) pp 7 to 8.

⁵ As above, p 3.

⁶ General Social Care Council, *UK Post Qualification Matrix* (2009).

and their average cost (salary plus employment on-costs) is £35,629.⁷ Assuming the same proportion of community care law to total training, this would amount to a saving of about £125,000 a year.

Complaints and legal costs

A.17 We divide consideration of the possible savings in terms of legal costs into the following parts:

- (4) complaints;
- (5) local authority legal advisors' time; and
- (6) other costs of litigation.

Complaints

LOCAL AUTHORITIES

A.18 Adult social care complaints cost local authorities an estimated £13 million in 2006 to 2007.⁸ This figure relates to the internal costs to local authorities of dealing with complaints, and excludes the costs of complaints to the ombudsman (including the cost to a local authority of dealing with an ombudsman's complaint), and any litigation costs.

A.19 Since this research was conducted, the complaints systems for both health and adult social care have been reformed in England. The impact assessment prepared in relation to this reform, which has been effective since April 2009, estimated an increase in costs to local authorities of £2 million.⁹ We therefore proceed on the basis of an overall cost of £15 million.

A.20 It is likely that a simpler and more modern legal structure will reduce the number of complaints. We do not think that there will be fewer complaints because of a significant difference in the decisions made about service provision under our proposed system (that is, that more services will necessarily be offered to more people). Rather, we consider the reason why there may be fewer complaints is that there will be fewer mistakes. Clearer and simpler law, which allows for clearer and simpler practice guidance, will mean better decisions.

A.21 We think that the reduction in complaints is likely to be moderate. Research conducted by the National Audit Office breaks down complaints as follows:¹⁰

⁷ Personal Social Services Research Unit, *Unit Costs of Health and Social Care 2008* (2008) p 114.

⁸ National Audit Office, *Feeding Back? Learning from Complaints Handling in Health and Social Care* (2008) p 6.

⁹ Department of Health, *Impact Assessment of the Reformed Complaints Regulations for Health and Social Care* (2009) para 9.

¹⁰ National Audit Office, *Feeding Back? Learning from Complaints Handling in Health and Social Care* (2008) p 33.

Reason for dissatisfaction with adult social care services	%
Bad standard of treatment/not treated properly	26
Uncaring attitude/being fobbed off	13
Inaccurate/mis-diagnosis, bad/wrong advice	10
Patronising/rude/intimidating attitude	9
Not being listened to/not being understood	7
Expense/payment/costs	6
Lack of information/bad communication	5

A.22 It seems unlikely that improved law will have a great effect on most of these categories of complaints. We might expect, however, a significant improvement in relation to “inaccurate/mis-diagnosis, bad/wrong advice” and “lack of information”, and some impact on “expense/payment/costs”. Together, these categories represent 21% of complaints. We therefore suggest that it would be appropriate to suggest a savings range of between 5% to 15%. Applying that to our overall figure of £15 million gives an annual saving of £750,000 to £2.25 million.

THE OMBUDSMAN

A.23 The latest figures from the Local Government Ombudsman show that the ombudsman considered 599 complaints on adult social care in 2008 to 2009 (the total number of complaints received was 909, but of these 310 were sent back as prematurely made).¹¹ Of these, 444 were passed on to an investigative team. In this period, the average cost for a complaint forwarded to an investigative team was £719, whilst the cost of giving advice without forwarding the complaint was £23.¹² Combining these figures gives a total figure spent on adult social care complaints of £322,801. However, the reforms in England referred to above will significantly increase the burden on the ombudsman (because the top internal tier of complaint handling has been transferred from local authorities to the Local Government Ombudsman). The impact assessment prepared in relation to those reforms estimated additional costs of £1 million for the ombudsman service.¹³

A.24 Applying the same assumptions as for local authority-handled complaints would give a potential saving in the range of £66,000 to £198,000. It is likely, however, that the figure for the ombudsman will be towards the bottom of this range, because the more clearly mistaken decisions, which, we suggest, are less likely

¹¹ Local Government Ombudsman, *Annual Report 2008/2009: Delivering Public Value* (2009) p 17.

¹² As above, p 31.

¹³ Department of Health, *Impact Assessment of the Reformed Complaints Regulations for Health and Social Care* (2009) para 9.

to have been wrongly made under our proposals, are more likely to have been corrected earlier in the process.

Local authority legal advisors' time

- A.25 An analysis of figures provided by the Law Society shows that there are 3,372 solicitors working for local authorities with social services functions.¹⁴ This is a count of people, so includes both full and part timers. A workforce survey of local government lawyers found that about 80% were full time.¹⁵ A full time equivalent figure could be derived from the part timers by applying a ratio of 1.8:1. This would give an overall figure of 3,072 for full time equivalents.
- A.26 We have not been able to ascertain the number of employed barristers working for such authorities. However, comparable figures are available for the Government Legal Service, which provides legal services to central Government departments and other national public bodies. These show that about 25% of their lawyers are employed barristers and 75% are solicitors. We do not think it is likely that there are more employed barristers in local government, and there may be somewhat less. We will therefore assume that the ratio of employed barristers to solicitors is 20% to 80%. This gives a figure of 3,840 for the total number of local authority lawyers in these authorities.
- A.27 An exploratory survey by the Law Commission of local authority legal departments indicates that perhaps 5% of the workload of lawyers in local authorities with social services responsibilities relates to adult social care.¹⁶ That would give a total of the equivalent of 192 lawyers working full time on adult social care. The average annual salary range of local government lawyers is £29,700 to £39,900.¹⁷ In the absence of more detailed information, we will assume that the mean is in the middle of this range, at £34,800.
- A.28 Unlike children's services, the process of discharging adult social care services does not routinely involve litigation. Therefore the bulk of the time spent on adult social care by social services lawyers will be dealing with genuine legal problems about the powers or duties of the authority. By no means will all of these simply disappear as a result of the changes we propose. Issues such as disputes about ordinary residence will remain. However, in line with our assumptions about public law litigation (see below), we think a substantial proportion of the advisory legal role in relation to adult social care will be removed by our proposals. We therefore suggest something in the range of 30% to 40%.
- A.29 Applying the figure above for the average salary of local authority lawyers, this would give savings in a range of about £2 million to £2.7 million.

¹⁴ Based on unpublished figures provided by the Law Society of England and Wales (November 2009).

¹⁵ Conducted by Local Government Analysis and Research, see D Wilks, "Legal Workforce Survey 2005" (2006) 43 *NOTERup* 16, 16.

¹⁶ Telephone survey conducted in 2009. The authorities surveyed were Kent County Council, Newcastle City Council, Somerset County Council, Waltham Forest County Council, Warwickshire County Council and Vale of Glamorgan Council.

¹⁷ See, <http://www.lgcareers.com/career-descriptions/supporting-your-community/solicitor/> (last visited 5 February 2010).

- A.30 We intend to ask about social services authorities' adult social care legal workload as part of our questionnaire. We would also be grateful for comments about the assumptions we make here.

Other costs of litigation

COSTS INCURRED BY SOCIAL SERVICES AUTHORITIES

- A.31 A significant proportion of adult social care litigation costs generally will comprise social services authorities' legal advisor costs, which are considered above. On the other hand, the figure given there does not include other substantial direct costs of litigation to social services authorities. In particular, it does not cover counsel's fees, court fees and other disbursements.
- A.32 We have estimated these costs by considering the costs of adult social care litigation in the Administrative Court. Figures show that in 2007 to 2008 the Legal Services Commission paid out £1,047,512 in costs to local authorities in cases in which the defendant authority was successful or partially successful in litigation (not including cases that were concluded before issue). This figure does not include litigation costs of social services authorities where the claimant was not legally aided. There were 96 cases concluded after issue of the case in that period in which authorities were at least partially successful, giving an average cost to them in relation to these cases of £10,911.¹⁸
- A.33 This figure does not include the costs to defendant local authorities of cases in which they are ultimately unsuccessful, meaning that their costs will not be met by the legally aided claimant. Figures from the Administrative Court show that in 2007, there were 139 community care cases received by the court. Multiplying this by the average cost of £10,911 gives an approximate total cost to social services authorities of £1,516, 629. These figures can only be approximate as only a small proportion of cases will be substantively determined at trial; the majority will drop out of the system before this because, for example, they have been withdrawn or refused at the permission stage.
- A.34 Under Part 44 of the Civil Procedure Rules, the costs awarded by the court will not usually be the full costs of the successful party. Therefore the actual costs of litigation before the courts for social services authorities may be higher than our estimate.¹⁹

THE COSTS TO CLAIMANTS

- A.35 Figures produced by the Legal Services Commission give the total cost paid out in legal aid. The figure given for 2007 to 2008 for community care (which we think

¹⁸ Lord Justice Jackson, *Review of Civil Litigation Costs: Final Report* (2009) p 55, http://www.judiciary.gov.uk/about_judiciary/cost-review/jan2010/final-report-140110.pdf, (last visited 5 February 2010). The figures cover the period 1 January 2007 to 31 March 2008.

¹⁹ Under the Civil Procedure Rules, r 44.4, the court has discretion over the amount of costs awarded to the successful party, and may, for example, make an order for part payment only of costs. The court will usually assess costs on the standard basis, and will award only costs that are proportionate to the matters in issue.

constitutes most of adult social care litigation and does not include anything that is not adult social care litigation) was £1,887,386.²⁰

REDUCTION IN CASES ISSUED AND HEARD AS A RESULT OF PROPOSALS

- A.36 We estimate that fewer legal cases can be assumed to arise under our proposals than the number of general complaints that might arise. For a case to be taken to court, the claimant's legal advisors must be satisfied that there is a reasonable legal issue to be considered. This is a much narrower test than will operate in relation to an individual's complaint on the merits, which may not constitute an actionable legal issue. It is also our impression that the problematic parts of adult social care law generate much more case law than the mainstream, FACS/UFSAMC assessment based system for the allocation of adult social care resources. It must be acknowledged, however, that some areas that we are not reforming substantially, such as the relationship between adult social care and health care and the ordinary residence rules, also generate a significant amount of litigation. During the consultation period, it is our intention to conduct a study of transcripts of cases heard to consider how many would not have arisen under our proposed system. In advance of that information, our estimate is necessarily speculative. Nevertheless, we consider that there will be a reduction in cases issued and consider this to be in the order of 50%. To reflect the sensitivity of this estimate, we will therefore proceed on the basis of a range of 45% to 55%.
- A.37 On the basis of this estimate, the potential savings under this heading are between £850,000 and £1,050,000.

Savings in relation to everyday activities of social workers

- A.38 We have not been able to find much significant data expressly on the time spent by social workers considering legal issues. For reasons we will come on to, this is not surprising. However, in recent times, a significant amount of work has been done to analyse what social workers do spend their time on, and to identify trends within that.
- A.39 Research shows that social workers currently spend a great deal of time on administrative work and less time on face to face contact with service users. A recent UNISON survey indicated that 96% felt that too much of their time was spent with paper work. Of those surveyed, 73% felt the time they had available to spend with service users was "insufficient" or "very insufficient".²¹
- A.40 Similarly, research from 2003 found that three of the activities most frequently reported by social workers was office-based paperwork relating to caseload, negotiating and arranging social services for users, and completing assessment documentation in the office. The research found that face to face contact with service users and carers combined represented a little over one-fifth of the working week of sampled care managers working with older people, and

²⁰ Lord Justice Jackson, *Review of Civil Litigation Costs: Final Report* (2009) p 55, http://www.judiciary.gov.uk/about_judiciary/cost-review/jan2010/final-report-140110.pdf, (last visited 5 February 2010).

²¹ UNISON, *Not Waving But Drowning: Paperwork and Pressures in Adult Social Work Services* (2009), <http://www.unison.org.uk/acrobat/B4710a.pdf> (last visited 5 February 2010).

accounted for 50% of face to face contact time. Assessment activity accounted for 27% of time. The research noted that “emotional and psychological needs were often missed in assessments and one possible explanation could be the relatively low level of face to face contact recorded”.²²

- A.41 When it comes to legal knowledge, there is also some evidence in the literature to suggest that social workers are generally lacking in legal knowledge, and do not devote much, if any, of their working time to legal matters. One survey suggested that many social workers do not use law (or feel they use law) at all in practice. They report that law has a “low profile in daily practice” and that the lack of “overt use of the law to inform practice” results in a dependency on policy and procedure rather than professional discretion.²³
- A.42 It may be that the current legal framework increases the administrative burden on social workers, even where the administrative work itself is not of a legal character. In particular, it has been suggested by some researchers that the uncertainty created by the complexity of the law may cause more defensive administrative practices in response to the threat of litigation. Professional discretion is substituted for a “checklist” approach, which leads to an increased emphasis on paperwork and less time for direct contact with service users and carers.²⁴
- A.43 It has been suggested that the lack of legal knowledge results in increased delays (and therefore costs) in these processes. This may be due to social workers’ lack of knowledge of possible alternative solutions for difficulties (for example, whether a family member or a donee of an Enduring Power of Attorney has authority to arrange an older person’s admission to residential care), or where a social worker lacks sufficient confidence in their knowledge to assert themselves when consulting with other professionals.²⁵ Similarly, a lack of legal knowledge can lead to an over-reliance on limited statutory powers or local authority policies. Research suggests this could cause additional hostility from service users, where they view the legal system as operating against them. Antagonistic practice is likely to cause additional delays in the assessment and care planning process.²⁶
- A.44 The National Occupational Standards for social workers published in 2002 highlight the significance of legal information and skills in the working practices of

²² A Weinberg and others, “What Do Care Managers Do? A Study of Working Practice in Older Peoples’ Services” (2003) 33 *British Journal of Social Work* 901, 914.

²³ S Braye and others, “Beyond the Classroom: Learning Social Work Law in Practice” (2007) 7 *Journal of Social Work* 322, 330.

²⁴ K Postle, “Working ‘Between the Idea and the Reality’: Ambiguities and Tension in Care Managers’ Work” (2002) 32 *British Journal of Social Work* 335.

²⁵ A McDonald and others, “Barriers to Retaining and Using Professional Knowledge in Local Authority Social Work Practice with Adults in the UK” (2008) 38 *British Journal of Social Work* 1370, 1379.

²⁶ S Braye and others, “Beyond the Classroom: Learning Social Work Law in Practice” (2007) 7 *Journal of Social Work* 322.

social workers. Sixteen of the 21 practice units identified by these Standards contain at least one legal element.²⁷

- A.45 These results present a contradiction. On the one hand, there is an apparent blindness to a legal dimension in their work by social workers. On the other, we conclude that there is a substantial legal input into everyday tasks. But the contradiction, we consider, is illusory. The reason is that the comparatively high level of legal input into social work is mediated by training and guidance which presents itself as “social work practice” rather than “social work law”. The law is there, but hidden behind the everyday processes and the associated documents used by social workers. This means, however, that it would be artificial to single out particular elements in social workers’ daily tasks, and persuasively claim that a certain percentage of time spent on that task will henceforth be saved.
- A.46 We think, therefore, that the appropriate way to attempt to quantify the savings in social workers’ daily tasks is to make a global estimate of what sort of overall time savings a clearer and simpler legal structure (enabling clearer and simpler practice guidance) might be expected to deliver. We fully accept that this is a speculative endeavour. Our hope is that our speculation will be endorsed or corrected through our consultation.
- A.47 With those caveats as to the significance of the figures, we have adopted a conservative approach. We consider that overall, it would be reasonable to suggest that social workers will save between fifteen and thirty minutes a week, on average. No doubt this is comparatively crude. In particular, the time saving for front-line social workers might be towards the bottom of this range, whereas that for more senior managers (who cost more) might be higher. Nevertheless, it appears to us a realistic approach to take in the absence of more detailed data.
- A.48 In proportionate terms, fifteen minutes to thirty minutes is about 0.75% to 1.5% of adult social workers’ contracted weekly hours. Using 2008 figures, there are about 8,800 adult social care social workers. Their average salary is £28,494.²⁸ Allowing for on-costs of employment (at £7,135), that gives a savings range of about £2,350,000 to £4,700,000.

COSTS OF OUR PROVISIONAL PROPOSALS

- A.49 We consider that the costs of our provisional proposals arise from the costs of change. These fall into three categories: training costs; dissemination costs; and the costs to central Government/Parliament of legislation. We have assumed that our proposed legal framework reflects to a considerable extent what is already being done in practice by social workers and others, and that this should reduce the costs of change in terms of training costs and some dissemination costs.

Training costs

- A.50 There will be initial training costs in the new system for social workers and others. The duration of such costs will depend to a degree on the length of transitional arrangements in relation to the implementation of our proposals. We think it

²⁷ Topps UK Partnership, *National Occupational Standards for Social Work* (2002).

²⁸ Personal Social Services Research Unit, *Unit Costs of Health and Social Care 2008* (2008) p 114.

would be prudent to assume extra expenditure on training for two years. We suggest that the costs of extra training for these years will be about the same as the on-going savings we have identified. The costs would therefore be £415,000 (for degree level training) and £125,000 (for post-qualification training) per year.

Dissemination costs

- A.51 There will be some costs to central and local government, and other agencies such as voluntary organisations and private companies, in disseminating information about the reform to stakeholders, including service users. We find it difficult to provide an estimate for these costs. We nevertheless consider that the cost of providing both web-based and printed material is likely to be low, if not negligible. We would be grateful for any data from consultees.

Parliamentary/central Government time

- A.52 We understand that a standardised approach to the quantification of these costs is being developed in central Government. We will quantify costs in accordance with this approach once it is developed.