



**Law  
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## **Adult Social Care Scoping Report**

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**26 November 2008**

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**The Law Commission**

**ADULT SOCIAL CARE**

**A Scoping Report**



**THE LAW COMMISSION**  
**ADULT SOCIAL CARE: SCOPING REPORT**  
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# PART 1

## INTRODUCTION

- 1.1 In June 2008, the Law Commission published its Tenth Programme of Law Reform, which includes a project to review adult social care law in England and Wales. This scoping report is the first stage of this project and aims to delineate clearly the scope of the project and provide it with a detailed agenda for reform.

### SCOPE OF ADULT SOCIAL CARE LAW

- 1.2 Adult social care refers to the responsibilities of local social services authorities for adults and their carers. This includes the range of services that may be provided or arranged to be provided by social services departments, and in some cases by health authorities and other organisations or individuals. Examples of such services include care homes, day centres, equipment and adaptations, meals and home care.<sup>1</sup> The range of persons who may be provided with these services include older people, people with learning disabilities, physically disabled people, people with mental health problems and carers.<sup>2</sup> Adult social care also includes the mechanisms for delivering these services, such as assessments and direct payments, and all safeguarding adults procedures that are primarily the responsibility of social services departments.
- 1.3 The term “community care services” has a specific meaning in adult social care law and is defined in section 46(3) of the NHS and Community Care Act 1990 as services which a local authority may provide or arrange to be provided under any of the following provisions:
- (1) Part 3 of the National Assistance Act 1948;
  - (2) section 2 of the Chronically Sick and Disabled Persons Act 1970;<sup>3</sup>
  - (3) section 45 of the Health Services and Public Health Act 1968;
  - (4) section 254 and Schedule 20 of the NHS Act 2006;
  - (5) section 192 and Schedule 15 of the NHS (Wales) Act 2006; and

<sup>1</sup> In 2006-07 the numbers of adults receiving social care services in England were: 336,000 residential care; 586,000 home care; 503,000 professional support; 491,000 equipment and adaptations; 238,000 day care; 150,000 meals; and 119,000 short term residential and respite care. See Information Centre, *Community Care Statistics 2006-07: Referrals, Assessments and Packages of Care for Adults, England: National Summary* (2008).

<sup>2</sup> In 2006-07 the client groups as a percentage of gross expenditure by local authorities in England were: older people 43%; learning disabled adults 16%; physically disabled adults 7%; and mentally ill adults 5%. See Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2006-07* (2008).

<sup>3</sup> Although s 46(3) of the NHS and Community Care Act 1990 makes no explicit reference to s 2 of the Chronically Sick and Disabled Persons Act 1970, the courts have decided that s 2 of the 1970 Act is included by virtue of being an extension of s 29 of the National Assistance Act 1948, see *R v Kirklees MBC ex p Daykin* (1997-98) 1 Community Care Law Reports 512.

- (6) section 117 of the Mental Health Act 1983.

## **HOW THE LAW REGULATES ADULT SOCIAL CARE**

- 1.4 The law regulates adult social care through a wide range of mechanisms, including statute law, secondary legislation and guidance. The following discussion provides a brief overview of the key principles that are fundamental to an understanding of how the law regulates adult social care.
- 1.5 As a creature of statute, a local authority can only do, broadly speaking, what legislation expressly or impliedly authorises it to do.<sup>4</sup> Statute law sets out the functions of local authorities through a hierarchy of various duties and powers:
- (1) there are a number of specific statutory duties (specific duties), which are owed to, and can in principle be enforced by, individual people who satisfy the relevant criteria;<sup>5</sup>
  - (2) there are several general public law duties placed on local authorities (general duties), also known as target duties, which are not expressed as being owed to any specific individual but rather towards the local population.<sup>6</sup> General duties are therefore weaker in nature and less easily enforceable than specific duties;
  - (3) there are a number of general duties that can be converted into specific duties in certain circumstances. For example, the general duty to provide residential accommodation for adults in need of care and attention under section 21 of the National Assistance Act 1948 “becomes ‘crystallised’ and thus enforceable upon the happening of an event, namely a needs assessment”.<sup>7</sup> The need to avoid a breach of the requirements of the Human Rights Act 1998 may also transform a general duty into a specific duty;<sup>8</sup> and
  - (4) local authorities are also given a number of statutory powers, which may be acted upon but are not obligatory. For example, section 45 of the Health Services and Public Health Act 1968 provides that local authorities may make arrangements for promoting the welfare of older people.
- 1.6 Statute law can also empower the Secretary of State and the Welsh Ministers to issue the following:

<sup>4</sup> For example, the Local Authority Social Services Act 1970 continues to govern the operation of local social services authorities and includes a list of permitted functions.

<sup>5</sup> For example, s 2 of the Chronically Sick and Disabled Persons Act 1970.

<sup>6</sup> For example, s 29 of the National Assistance Act 1948.

<sup>7</sup> *R (A) v Lambeth LBC* [2001] EWCA Civ 1624, [2002] LGR 163 at [26], by Laws LJ.

<sup>8</sup> *R (T, D and P) v Haringey LBC* [2005] EWHC 2235, (2006) 9 Community Care Law Reports 58.

- (1) secondary legislation, such as regulations, rules and orders, which provide more detail about how legislation should be acted on, and which carry the full force of law;<sup>9</sup> and
- (2) directions, which have to be followed, and approvals, which give local authorities powers to do things. For example under section 29 of the National Assistance Act 1948, a local authority may provide welfare services but only with the approval of the Secretary of State and the Welsh Ministers and to such extent as they may direct.<sup>10</sup> In some cases directions and approvals are published separately, or, they can be attached to Local Authority Circulars (LAC) or National Assembly for Wales Circulars (NAFWC).<sup>11</sup>

1.7 Beyond primary and secondary legislation, and directions and approvals, the functions of local authorities are also regulated by central government guidance (also known as departmental guidance). The status of such guidance can, however, vary considerably.

- (1) Section 7(1) of the Local Authority and Social Services Act 1970 allows the Secretary of State and the Welsh Ministers to issue what is known as *statutory guidance* to local authorities. This guidance has a higher status and must be complied with unless there are good reasons for not doing so.<sup>12</sup> Whether or not guidance has been issued under section 7 of the 1970 Act will normally be indicated in the preface to the guidance.<sup>13</sup> When Lord Justice Sedley was a High Court judge, he explained the significance of statutory guidance in the following terms:

<sup>9</sup> For example, the National Assistance (Assessment of Resources) Regulations 1992, SI 1992 No 2977, issued under s 22(5) of the NAA 1948, sets out how charges for residential accommodation should be assessed.

<sup>10</sup> The current approvals and directions are included as an appendix to 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*. As a result of the transfer of functions following Welsh devolution, the Welsh Ministers are also empowered to issue such approvals and directions.

<sup>11</sup> These circulars normally contain guidance issued by central government.

<sup>12</sup> *R v Islington LBC ex p Rixon* [1997] 32 BMLR 136.

<sup>13</sup> Examples include: LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care* and Department of Health, *Fairer Charging Policies for Home Care and Other Non-Residential Social Services: Guidance for Councils with Social Services Responsibilities* (2003). However, not all statutory guidance contains an explicit statement. For example, Department of Health, *Caring for People: Community Care in the Next Decade and Beyond: Policy Guidance* (1990) has sometimes, but not always, been treated by the courts as statutory guidance even though it contains no such statement, see *R v Islington LBC ex p Rixon* [1997] 32 BMLR 136 at 140.

If this statutory guidance is to be departed from it must be with good reason, articulated in the course of some identifiable decision-making process even if not in the care plan itself. In the absence of any such considered decision, the deviation from statutory guidance is in my judgment a breach of law ...<sup>14</sup>

- (2) Most departmental guidance is not issued under section 7(1) of the Local Authority and Social Services Act 1970 and is known as *practice guidance*.<sup>15</sup> Although this is inherently weaker in status than statutory guidance, local authorities will still have to take account of it and give it due weight, in accordance with general public law principles.
- (3) Guidance may also be issued as a result of a specific statutory requirement. For example, both the Mental Health Act 1983 and the Mental Capacity Act 2005 require the preparation of a Code of Practice, which specific persons must *have regard to*.<sup>16</sup> However, the status of such guidance can vary. For example, the Mental Capacity Act Code of Practice states that “there are no specific sanctions for failure to comply with [this] Code”, but that, “a failure to comply with the Code can be used in evidence before a court or tribunal in any civil or criminal proceedings”.<sup>17</sup> In contrast, departures from the Mental Health Act Code of Practice “could give rise to legal challenge” and, in reviewing any departures, the court will “scrutinise the reasons for the departure to ensure there is sufficiently convincing justification in the circumstances”.<sup>18</sup>

<sup>14</sup> *R v Islington LBC ex p Rixon* [1997] 32 BMLR 136 at 140.

<sup>15</sup> An example of practice guidance is the combined guidance on carers’ assessments: Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005).

<sup>16</sup> Section 118 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) and section 42 of the Mental Capacity Act 2005.

<sup>17</sup> Department for Constitutional Affairs, *Mental Capacity Act: Code of Practice* (2007) p 8.

<sup>18</sup> Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para iv.

- 1.8 Devolution in Wales has also had a significant impact on the functions of local authorities. The Welsh Assembly Government's responsibilities for adult social care include funding, setting policy, reviewing, inspection and regulation. This has resulted in setting priorities which are often different to those of the UK Parliament and the consideration of different solutions to common problems. Recent examples include the appointment of a Commissioner for Older People in Wales<sup>19</sup> and the decision not to implement the delayed discharge legislation.<sup>20</sup> Increasingly, secondary legislation and guidance is also issued separately in England and in Wales, sometimes with material differences between them. One example is a distinction made in the two sets of regulations regarding what constitutes an exception to the obligation to register as a domiciliary care agency.<sup>21</sup>
- 1.9 Local authority functions are also affected by, and our review of adult social care law will need to ensure compatibility with, various other legal provisions, including:
- (1) the Human Rights Act 1998;
  - (2) the Disability Discrimination Act 1995;
  - (3) the Race Relations Act 1976;
  - (4) the Data Protection Act 1998;
  - (5) the Freedom of Information Act 2000; and
  - (6) European Union law.
- 1.10 The United Nations Convention on Disability Rights,<sup>22</sup> once ratified by the Government in respect of the United Kingdom of Great Britain and Northern Ireland,<sup>23</sup> will also affect the functions of local authorities. Although not part of domestic law, compliance with the Convention will be monitored through periodical reports from the Government and there is an optional protocol, which provides for individuals to submit complaints about violations to the Committee on the Rights of Persons with Disabilities.

<sup>19</sup> Commissioner for Older People (Wales) Act 2006.

<sup>20</sup> See LAC(2003)21, *Community Care (Delayed Discharge) Act 2003: Guidance for Implementation*.

<sup>21</sup> See Domiciliary Care Agencies Regulations 2002, SI 2002 No 3214, reg 3 and the Domiciliary Care Agencies (Wales) Regulations 2004, WSI 2004 No 219, reg 3.

<sup>22</sup> United Nations, *Convention on the Rights of Persons with Disabilities and Optional Protocol* (2006).

<sup>23</sup> In a written statement to Parliament on 6 May 2008, the Minister for Disabled People, Anne McGuire MP, indicated that ratification is expected to take place by the end of 2008, <http://www.officefordisability.gov.uk/docs/UN-Convention-on-Disability-Rights.pdf> (last visited 9 November 2008).

## THE WIDER POLICY CONTEXT

- 1.11 Adult social care law does not exist in a vacuum. Rather it co-exists alongside, and is inter-related with, other major policy debates concerning the care and support system. Some of these issues are long-term and largely unrelenting, while others are more transient in nature and reflect current social and political concerns. The following issues illustrate some of the main policy discourses that are pertinent to adult social care.

### Central versus local planning and decision making

- 1.12 An important principle in adult social care is that the priorities for local services should reflect the needs of the local population, especially since local authorities are responsible for raising money to pay for some of these services through council tax. This means that services and financial support can vary depending on where a person lives. For example, people with similar support needs living in an inner city London borough may get different care and support from people living in rural Cornwall.<sup>24</sup> This point is explicitly recognised in statutory guidance:

Councils should be aware that this guidance neither says that different councils should make identical decisions about eligibility, nor prescribes what services should be available to service users who have similar needs.<sup>25</sup>

- 1.13 There is, however, an inherent tension between local discretion and the view that care and support services should be the same or at least comparable across the country. For example, some commentators have pointed out that different decisions about priorities, as well as types and quality of services, have led to variation in resource allocation to social care and in the scale and quality of services in different areas.<sup>26</sup> On the other hand, the Government has argued that a more national system “would have huge implications on the degree to which services can respond to local needs”.<sup>27</sup>

<sup>24</sup> HM Government, *The Case for Change: Why England Needs a New Care and Support System* (2008) p 50.

<sup>25</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, para 1.

<sup>26</sup> This point is also discussed in Part 2 below.

<sup>27</sup> HM Government, *The Case for Change: Why England Needs a New Care and Support System* (2008) p 28.

## **Prevention services**

- 1.14 In recent years, there has been a retreat from the traditional model of social care provision whereby resources are concentrated on people with the highest levels of need. Research has indicated that, if relatively inexpensive services can be accessed at an early stage, they can defer or avoid the need for more intensive support at a later stage.<sup>28</sup> Shifting the adult social care system from high-level intensive needs to earlier preventative services has been identified as a Government priority in the Green Paper *Independence, Well-being and Choice*, the White Paper *Our Health, Our Care, Our Say* and the discussion paper on the future of the care and support system.<sup>29</sup> However, shifting the balance in this way may have implications not just for managing local budgets but also for the way in which local social services authorities determine who should be eligible for services.

## **Personalisation and self-directed support**

- 1.15 There has been an increased emphasis in recent years on allowing people to choose which services and support would best meet their needs. The Department of Health refers to this policy initiative as “personalisation”.<sup>30</sup> The clearest examples are the introduction of self-assessment, direct payments and individual budgets.<sup>31</sup> A Local Authority Circular has described personalisation in the following terms:

In the future, the social care system will allow individuals to make real choices, and take control, with appropriate support whatever their level of need. Everyone, with support if necessary, will be able to design services around their own needs, within a clear personal financial allocation.<sup>32</sup>

<sup>28</sup> See, for example, Audit Commission, *Independence and Well-Being* (2004).

<sup>29</sup> *Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England* (2005) Cm 6499; *Our Health, Our Care, Our say: A New Direction for Community Services* (2006) Cm 6737; and HM Government, *The Case for Change: Why England Needs a New Care and Support System* (2008).

<sup>30</sup> See, for example, HM Government and others, *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care* (2007).

<sup>31</sup> These are discussed in Part 4 below.

<sup>32</sup> LAC(DH)(2008)1, *Transforming Social Care*, para 27.

- 1.16 The term “self-directed support” is often associated and used interchangeably with personalisation.<sup>33</sup> However, it has been argued that whereas personalisation seeks to increase public service standards through consumer choice, self-directed support can be described as “disabled people exercising their rights to determine their own lives with the clear goal of achieving independent living”.<sup>34</sup> The concept of independent living has been defined as having three elements: an assertion that disabled people have the same opportunities for choice and control as non-disabled people; a challenge to the usual definition of independence; and the aspiration that any assistance required should be controlled by disabled people themselves.<sup>35</sup> It has also been suggested that this concept incorporates a strong presumption that an institutional care plan should only be preferred “where the social care authority concludes for professional (i.e. not solely financial) reasons that independent living is not viable”.<sup>36</sup>
- 1.17 Commentators have pointed to an increased acceptance at international and European levels that independent living is a human right.<sup>37</sup> For example, Article 19 of the United Nations Convention on the Rights of Persons with Disabilities provides that:

States Parties to the present Convention recognise the equal right of all persons with disabilities to live in the community, with choices equal to others and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community.<sup>38</sup>

<sup>33</sup> See, for example, LAC(DH)(2008)1, *Transforming Social Care*, para 17.

<sup>34</sup> C Hatton and others, *A Report on In Control's Second Phase: Evaluation and Learning 2005-2007* (2008) p 142.

<sup>35</sup> J Morris, “Independent Living and Community Care: A Disempowering Framework” (2004) 19 *Disability and Society* 427, 427.

<sup>36</sup> L Clements, *The Need for New Legislation* (2007) p 8, [http://www.lukeclements.co.uk/downloads/PDF\\_Sep08\\_04.pdf](http://www.lukeclements.co.uk/downloads/PDF_Sep08_04.pdf) (last visited 9 November 2008).

<sup>37</sup> See, for example, 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.

<sup>38</sup> United Nations, *Convention on the Rights of Persons with Disabilities and Optional Protocol* (2006).

## **Funding adult social care**

- 1.18 There has been rising concern about the future affordability of care and support. Care needs in people aged 65 and over are estimated to rise by 87% from 2002 to 2051.<sup>39</sup> Over the next 20 years, the number of people aged 85 and over in England is set to increase by two-thirds, compared with a 10 % growth in the total population.<sup>40</sup> Between 2002 and 2041, the number of disabled people is expected to double.<sup>41</sup> The Government expects that in 20 years' time over 1.7 million more people to have a need for care and support and there will be a funding gap of over £6 billion in adult social care.<sup>42</sup>
- 1.19 This has led to consideration of how adult social care will be paid for in the future. For example, a review led by Sir Derek Wanless recommended that the current means-tested funding system should be scrapped and replaced with a partnership model. Everyone in need would be entitled to an agreed level of free care, after which individuals' contributions would be matched by the state up to a defined limit. People on low incomes would be eligible for benefits to fund their contributions.<sup>43</sup>
- 1.20 A recent discussion paper published by the Government acknowledges that it needs to find a way to pay for care and support that will be sustainable in the future and there needs to be a debate about the balance of responsibility between the family, the individual and the Government.<sup>44</sup> A Green Paper on care and support is due to be published next year.

## **OUTLINE OF THE SCOPING REPORT**

- 1.21 Part 2 of this scoping report will examine why adult social care law needs to be reformed. This will involve consideration of the historical piecemeal development of adult social care law, the quantity and complexity of the law, outdated concepts, human rights concerns, costs and the tensions between central and local planning and decision making. Part 3 will briefly outline the main purposes of reforming adult social care law, namely simplification, consistency, transparency, modernisation and resource neutrality. Part 4 contains our proposed agenda for a detailed review of adult social care law. It sets out the major areas of the law and highlights the main issues for reform. Part 5 provides our early assessment of the likely impact of law reform and Part 6 sets out the scoping report's final recommendation.

<sup>39</sup> R Hancock and others, *Paying for Long-Term Care for Older People in the UK: Modelling and Distributional Effects of a Range of Options* (2007).

<sup>40</sup> Kings Fund, *Securing Good Care for Older People: Taking a Long-Term View* (2006).

<sup>41</sup> R Hancock and others, *Paying for Long-Term Care for Older People in the UK: Modelling and Distributional Effects of a Range of Options* (2007).

<sup>42</sup> HM Government, *The Case for Change: Why England Needs a New Care and Support System* (2008) p 24.

<sup>43</sup> Kings Fund, *Securing Good Care for Older People: Taking a Long-Term View* (2006).

<sup>44</sup> HM Government, *The Case for Change: Why England Needs a New Care and Support System* (2008) p 44.

## **STRUCTURE OF THE PROJECT**

- 1.22 The substantive project identified in this report is an ambitious one. It will require the Commission to devote considerable resources to it. Responding to our recommendations, and still more implementing them, will require a significant commitment from the Department of Health. Responding to the consultation paper that would be published as part of the substantive project will be asking much of the many organisations and individuals we hope will be involved.
- 1.23 This scoping report is part of the Commission's Tenth Programme of Law Reform, published on 10 June 2008 following approval by the Lord Chancellor. In the Tenth Programme, we made it clear that we considered that it was of the first importance that there should be continuing and positive commitment to the project from Ministers. So far, we believe that that commitment has been manifest. But if the resources devoted to the project by all parties are to be well spent, that must continue. The structure for the project announced in the Tenth Programme was therefore threefold. The end of each stage provides a break point, allowing both the Commission and the Government to reconsider the desirability of continuing to the next stage.
- 1.24 This scoping report constitutes the first stage. In approving this report, we have reaffirmed *our* commitment to the project. We hope that the Government will do likewise. On the assumption that the Government approves it, in the next stage we will publish a consultation paper, undertake a broad public consultation process and report on our conclusions as to how the law relating to adult social care should be structured. This will include a full impact assessment of the law reform options. We expect the second stage of the project to take about 26 months from its inception. The final report of this phase would not contain a draft bill. On the publication of that report, both the Commission and the Government will decide whether to proceed to the final phase.
- 1.25 The final phase would be the production of a draft bill to implement the conclusions in the second stage report. It would be pointless to draft a bill unless the Government had, at least broadly, accepted the conclusions of the second stage report. We would therefore expect the Government to indicate publicly their position on the report before embarking on the drafting of a bill. It is an important facet of the Law Commission's independence from Government that our drafting resources are applied to putting Law Commission recommendations into statutory form, not implementing Government policy. We would expect to enter into arrangements for drafting the bill that would reflect that principle.

## **LAW REFORM AND POLICY**

- 1.26 The Law Commission undertakes law reform. We would expect that the terms of reference for the substantive project would reflect the broader policy context. We will consider with Government the best way in which the terms of reference may be framed. However, the policy environment for adult social care law is in a state of development, and we must expect it to continue to change over the lifetime of a substantive social care project.

1.27 Moreover, the scope of the project covers legislation for England and Wales and we will therefore seek to develop appropriate mechanisms to ensure that we are aware of developing Government thinking, both in the Department of Health and the Welsh Assembly Government. However, it is considered that the differences are not currently significant enough to justify this being a joint project between the Department of Health and the Welsh Assembly Government. Instead the lead Government department will be the Department of Health. If circumstances change during the course of the project then the Welsh Assembly Government may review this decision.

## PART 2

### THE NEED FOR REFORM

- 2.1 Adult social care law remains a confusing patchwork of conflicting statutes enacted over a period of 60 years. Some of these statutes reflect the disparate and shifting philosophical, political and socio-economic concerns of various post-war governments. Other statutes were originally Private Members' Bills and represent an altogether different agenda of civil rights for disabled people and their carers. The law has also developed with an inconsistent regard for previous legislation: some statutes amend or repeal previous legislation; others repeat or seek to augment previous law; and others can be categorised as stand alone or parallel Acts of Parliament.
- 2.2 When Lord Justice Scott Baker was a High Court judge he described the complexity of adult social care law thus:

Community care legislation has grown piecemeal through numerous statutes over the last half century. There are many statutes aimed at different targets whose provisions are drawn in differing language. Each Act contains its own duties and powers. Specific duties have to be distinguished from target or general duties and duties from discretions. Sometimes a local authority has several ways in which it can meet an obligation. Some provisions overlap with others and the inter-relationship is not always easy.<sup>1</sup>

- 2.3 Added to this perplexing legislative structure is the vast array of case law, regulations, directions and soft law in the form of guidance and circulars that has accumulated over the years:

The statutory framework is confusing and fragmented. This is compounded by the fact that much of the relevant law is contained in a series of ministerial and departmental circulars and guidance, some of which is binding, some of which is not, and none of which is readily available except to those who are skilled in knowing where to look for it.<sup>2</sup>

<sup>1</sup> *A v Lambeth LBC* [2001] EWHC Admin 376, [2001] 2 FLR 1201 at [24].

<sup>2</sup> P Bowen, *Access To Social Care: A Critique of the Domestic Law Framework* (2006) p 3, <http://www.doughtystreet.co.uk/files/socialcare-bowen.pdf> (last visited 9 November 2008).

## THE PIECEMEAL DEVELOPMENT OF ADULT SOCIAL CARE LAW

- 2.4 The current legislative framework for adult social care can be traced back to the National Assistance Act 1948 (NAA 1948), one of the key pieces of welfare state legislation introduced by the post-war Labour Government. Part 3 enables local authorities to provide a broad swathe of welfare services to disabled people, including residential accommodation and domiciliary services. The courts have also interpreted the NAA 1948 as providing a last resort or safety net in certain circumstances when care and attention is not otherwise available to the person.<sup>3</sup>
- 2.5 The NAA 1948 has, however, been criticised for its heavy emphasis upon institutional care for disabled and older people, thus reflecting the prevailing view of the 1940s, and for establishing much less certain and limited powers to provide community and domiciliary services.<sup>4</sup>
- 2.6 The NAA 1948 remains the bedrock of adult social care law and is the only Beveridge statute still in force.<sup>5</sup> Despite being 60 years old, the courts have described it as:
- A prime example of an Act which is “always speaking”, and so should be construed “on a construction that continuously updates its wording to allow for changes since the Act was initially framed” ...<sup>6</sup>
- 2.7 Adult social care law remained largely unchanged over the next twenty years – until the Health Services and Public Health Act 1968 (HSPHA 1968) was enacted. This gave local authorities a discretionary power to provide services “promoting the welfare of older people”.<sup>7</sup> This was a response to concern that some older people did not fall within the relevant definition of disability in the NAA 1948 and were therefore ineligible for domiciliary services. The HSPHA 1968 did not, however, amend the NAA 1948 but instead established a separate statutory power to provide similar services. This marked the beginning of a trend that has characterised the development of adult social care law up until the present day.

<sup>3</sup> *R v Kensington and Chelsea RLBC ex p Kujtim* [1999] 4 All ER 161.

<sup>4</sup> See R Means and R Smith, *From Poor Law to Community Care* (2nd ed 1998) pp 143 to 148.

<sup>5</sup> The NAA 1948 was part of a package of measures that created the modern welfare state, the others being the Education Act 1944, the National Health Service Act 1946, and the Children Act 1948. Their purpose was to fight, what Sir William Beveridge had called, the “five giants on the road to reconstruction” – want, disease, ignorance, squalor and idleness. See *Social Insurance and Allied Services: Report by Sir William Beveridge* (November 1942) Cmd 6404.

<sup>6</sup> *R v Westminster CC ex p M* (1997) 1 Community Care Law Reports 85, 92D, by Lord Woolf MR.

<sup>7</sup> HSPHA 1968, s 45.

- 2.8 The Chronically Sick and Disabled Persons Act 1970 (CSDPA 1970) was the first major reform of adult social care law post-1948, and has been described as a “fundamental Bill of Rights for disabled people”.<sup>8</sup> Originally a Private Member’s Bill sponsored by Alf Morris MP, its civil rights agenda is in marked contrast to the vision of social services as a last resort or safety net articulated in the NAA 1948. The CSDPA 1970 aimed to bolster the weak duty in the NAA 1948 to provide community services with a strong and specific duty, amenable to enforcement by individual disabled people. It is the strength of this duty that has made the CSDPA 1970 the focus of judicial review cases. However, the CSDPA 1970 did not amend the NAA 1948 but instead is a parallel statute that augments the NAA 1948, and this has provoked some judicial confusion as to its status.<sup>9</sup>
- 2.9 The NHS Act 1977 extended the groups of people eligible for community care services by including a discretionary power for local authorities to provide certain services for “the purpose of 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”.<sup>10</sup> Like the HSPHA 1968, this was a response to concerns that potentially vulnerable groups of people had been excluded from the definition of disability under the NAA 1948. Like the HSPHA 1968, the NHS Act 1977 did not amend the NAA 1948 but instead created another parallel legal power to provide similar services.
- 2.10 To complicate matters further, the NHS Act 1977 also included a duty on local authorities to provide home help and a power to provide laundry services to households where such help is required owing to the presence of illness, handicap and age.<sup>11</sup> There is, therefore, considerable overlap between this provision and the power under the HSPHA 1968 to provide home help for older people and the duty under the CSDPA 1970 to provide home help and laundry services for persons who are “substantially and permanently handicapped” under section 29 of the NAA 1948.
- 2.11 The NHS Act 1977 has since been replaced by the NHS Act 2006 and the NHS (Wales) Act 2006 (the NHS Acts 2006). However, the text of the relevant parts of the NHS Act 1977 is in all material terms repeated in the NHS Acts 2006.

<sup>8</sup> *Hansard* (HL), 19 April 2000, vol 612, col 745 (Lord Hunt).

<sup>9</sup> See paras 4.170 to 4.171 below.

<sup>10</sup> NHS Act 1977, sch 8, para 2(1).

<sup>11</sup> NHS Act 1977, sch 8, para 3(1).

2.12 Section 117 of the Mental Health Act 1983 added a further nuance to adult social care law. It placed a duty on health and social services to provide after-care services to people who are detained in hospital for treatment under sections 3, 37, 45A, 47 or 48 of the Act, who then cease to be detained and leave hospital. The Government initially opposed this provision, arguing that it duplicated the general duty under the NHS Act 1977 to provide services for mentally disordered people.<sup>12</sup> However, section 117 goes much further by placing an enforceable joint duty on both local authorities and health bodies to consider the after-care needs of each individual to whom it relates.<sup>13</sup> The term “after-care” is not defined but in the opinion of the courts, covers a wide range of health and social care services.<sup>14</sup> Furthermore, it has been established that service users cannot be charged by local authorities for section 117 services.<sup>15</sup>

2.13 The Disabled Persons (Services, Consultation and Representation) Act 1986 (DP(SCR)A 1986), like the CSDPA 1970, originated as a Private Member’s Bill and is based on a disability rights agenda.<sup>16</sup> Amongst other matters, the DP(SCR)A 1986 aimed to close a lacuna in section 2 of the CSDPA 1970, which requires services to be provided to a disabled person when the local authority is satisfied that the services are necessary in order to fulfil this need but does not explicitly require them to assess the person’s need. However, in line with previous adult social care legislation, it did not seek to amend the CSDPA 1970 but instead created a parallel right to an assessment on top of the existing legislative provisions. The DP(SCR)A 1986 was passed despite opposition from the Government, and some of its provisions – such as a right to advocacy for disabled people and a statutory right to a care plan – have never been implemented.

<sup>12</sup> See R Jones, *Mental Health Act Manual* (10th ed 2006) para 1-1089.

<sup>13</sup> *R v Ealing Health Authority ex p Fox* [1993] 1 WLR 373.

<sup>14</sup> *Clunis v Camden and Islington Health Authority* [1998] QB 978.

<sup>15</sup> *R v Manchester City Council ex p Stennett* [2002] UKHL 34, [2002] 2 AC 1127.

<sup>16</sup> Sponsored by Tom Clarke MP.

- 2.14 The National Health Service and Community Care Act 1990 (NHSCCA 1990) was the first major government-initiated reform of adult social care law since 1948. Part 3 sets out a comprehensive right to an assessment for community care services and, under the care management process, gave social services the responsibility for assessing need and arranging a package of care to meet best those needs, to be provided by a range of public, private and voluntary organisations. This represented a significant recasting of the relationship between the public and private sectors. Local authorities moved away from the role of exclusive service provider and instead were instructed to “develop a ‘mixed economy of care’ making use of voluntary, not for profit and private providers whenever this was most cost-effective”.<sup>17</sup> The consumerist and managerial principles behind the NHSCCA 1990 are in marked contrast to the welfare state ideology that underpins the NAA 1948.<sup>18</sup>
- 2.15 Although attempting to give coherence to the legal framework for the provision of adult social care services, the NHSCCA 1990 is not a consolidating Act. It does not, for example, alter the access and entitlements to services contained in previous Acts nor does it seek to repeal the existing rights to an assessment contained in the CSDPA 1970 and DP(SCR)A 1986. However, the NHSCCA 1990 is widely recognised as the starting point for the provision of community care services. This has been acknowledged by Lord Justice Potter thus:

Section 47(1)(b) [of the NHSCCA 1990] created a separate statutory mechanism for assessing social need and was not, in my view, designed to modify the distinct powers and duties under the earlier legislation ... I consider that the wording of section 47(1)(b) is designed simply to reflect and accommodate the fact that local authorities enjoy a variety of powers and duties as a result of the provisions of the various statutes which together comprise the Community Care Services for which they are responsible.<sup>19</sup>

<sup>17</sup> *YL v Birmingham CC* [2007] UKHL 27, [2008] 1 AC 95 at [51], by Baroness Hale.

<sup>18</sup> For example, the policy guidance explains that the key objectives of the NHSCCA 1990 include local authorities becoming “enabling agencies” to “make maximum use of private and voluntary providers, and so increase the available range of options and widen consumer choice”. See Department Of Health, *Caring for People: Community Care in the Next Decade and Beyond: Policy Guidance* (1990) para 1.1.

<sup>19</sup> *R v Kensington and Chelsea RLBC ex p Kujtim* [1999] 4 All ER 161 at para 20.

- 2.16 The NHSCCA 1990 was silent on the issue of carers' rights and this was left to a Private Member's Bill sponsored by Malcolm Wicks MP. The Carers (Recognition and Services) Act 1995 (C(RS)A 1995) provides that, when a local authority carries out an assessment of an adult under the NHSCCA 1990 or a child under the CSDPA 1970 or the Children Act 1989, a carer can request an assessment of their own ability to provide care to that individual. Even though the C(RS)A 1995 interlocks with the NHSCCA 1990, the CSDPA 1970 and the Children Act 1989, it does not amend the previous legislation but instead adds a parallel legal entitlement to a carer's assessment. It also exists alongside the DP(SCR)A 1986, which had already placed a duty on local authorities to have regard to the ability of a carer to continue to provide care when deciding what services to provide for a disabled person.<sup>20</sup>
- 2.17 The Community Care (Direct Payments) Act 1996 empowered local authorities to make direct payments to people who have been assessed as needing community care services in order that they can make their own arrangements to meet their needs. This was largely a response to the rise of the disability rights movement in the 1990s which criticised the care management system as disabling and disempowering and sought greater control.<sup>21</sup> The provision of direct payments was later extended to include carers and parents of disabled children by virtue of the Carers and Disabled Children Act 2000. The legislation concerning direct payments has since been superseded by the Health and Social Care Act 2001, which, amongst other matters, places a duty on local authorities to provide direct payments in certain circumstances.
- 2.18 Following on from the C(RS)A 1995, the Carers and Disabled Children Act 2000 (CDCA 2000) is a further example of a statute which deals directly with the needs of carers. It gave carers a free standing right to an assessment, independent of the assessment of the cared-for person. This addressed a loophole in the C(RS)A 1995 that had prevented a carer's assessment taking place where the person cared for had refused a community care assessment. The CDCA 2000 also introduced a specific legal power to provide services for carers, which was not included in the C(RS)A 1995. Despite considerable overlap with the C(RS)A 1995, the CDCA 2000 does not amend or replace the previous legislation and needs to be read and understood in conjunction with the 1995 Act.

<sup>20</sup> Section 1(5) of the C(RS)A 1995 provides that s 8 of the DP(SCR)A 1986 does not apply where a carer's assessment is being carried out under the 1995 Act.

<sup>21</sup> See, for example, J Morris, *Independent Lives? Community Care and Disabled People* (1993) and C Barnes and G Mercer, *Independent Futures: Creating User-led Disability Services in a Disabling Society* (2006).

2.19 Carers' legislation was further added to by the Carers (Equal Opportunities) Act 2004 (C(EO)A 2004) which, like the C(RS)A 1995, originated as a Private Member's Bill.<sup>22</sup> Although this did not consolidate carers' legislation, it did amend both the C(RS)A 1995 and the CDCA 2000 by providing a number of new rights for carers, including a requirement that a carer's assessment must take into account whether the carer wishes to work or undertake education, training or any leisure activity. The 2004 Act therefore adopts a different approach to the legal rights of carers – focusing less on the caring role and support services for carers and instead emphasising the need to address social exclusion.

2.20 Since 1997 Government legislation has focused primarily on two main elements of adult social care. First, it has promoted the use of direct payments by establishing a qualified duty on local authorities to provide them<sup>23</sup> and by widening the groups of people who are eligible to receive them.<sup>24</sup> Secondly, there has been an increased focus on the structural reform of adult social care, for example:

- (1) the Care Standards Act 2000 created a separate legal framework for the regulation and registration of care homes and domiciliary services, and social care staff;
- (2) the Health and Social Care Act 2001 provided for the creation of Care Trusts to commission and/or provide integrated services covering health, social services and other health-related local authority functions;
- (3) the Community Care (Delayed Discharges etc.) Act 2003 (CC(DD)A 2003) established a new structure of time scales for community care assessments of NHS inpatients and fines or reimbursements if a delay in discharge is caused by social services;
- (4) the NHS Acts 2006 consolidated NHS legislation, which had been amended by the Health Act 1999 to allow NHS and local authorities to pool their resources, delegate certain specified functions and transfer resources to one another, thereby enabling a single provider to provide both health and local authority functions; and
- (5) the Health and Social Care Act 2008 will create a new Care Quality Commission by merging the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission.

<sup>22</sup> Sponsored by Dr Hywel Francis MP.

<sup>23</sup> Health and Social Care Act 2001.

<sup>24</sup> Health and Social Care Act 2008. See para 4.222 below.

## QUANTITY

- 2.21 One consequence of the piecemeal development of adult social care law is the sheer volume of legislation. It is estimated that there are currently over 30 Acts of Parliament dealing, to varying degrees, with adult social care.<sup>25</sup> There is much overlap and duplication between the various statutes: for example, there are at least three main, and arguably more, statutory provisions which place similar duties on local authorities to carry out a community care assessment,<sup>26</sup> and a further four statutes which cover carers' assessments.<sup>27</sup>
- 2.22 There is also a vast array of regulations, directions, circulars and guidance – often covering the same or similar issues. For example, in order to carry out a comprehensive community care assessment and carer's assessment, a social care professional would need to have regard to: four separate sets of general assessment guidance;<sup>28</sup> four separate sets of guidance on carers' assessments;<sup>29</sup> specific user group assessment guidance,<sup>30</sup> and directions.<sup>31</sup> Added to this are: the National Service Frameworks; targets; performance indicators; and auditing regimes.
- 2.23 The sheer volume of law makes it virtually impossible for service users, carers and even social workers to have a detailed knowledge of all of the various legal enactments and to keep up to date as the law changes. This was highlighted by Baroness O'Neil in her 2002 Reith Lecture:

<sup>25</sup> The main statutes are listed in Appendix A to this report.

<sup>26</sup> The three main duties to assess are contained in: s 2(1) of the CSDPA 1970; s 4 of the DP(SCR)A 1986; and s 47(1) of the NHSCCA 1990. Additional duties to assess may be contained in s 21 of the NAA 1948 and in the common law, see Part 4, fn 14 below.

<sup>27</sup> These are the: DP(SCR)A 1986; C(RS)A 1995; CDCA 2000; and C(EO)A 2004.

<sup>28</sup> Community Care in the Next Decade and Beyond (1989) Cm 849; Department of Health Social Services Inspectorate, *Care Management and Assessment: A Practitioners Guide* (1991); LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care* and in Wales NAFWC 09A/2002 *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care*; and Department of Health, *Fair Access to Care Services: Practice Guidance* (2003).

<sup>29</sup> Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) and Welsh Assembly Government, *Practitioners Guide to Carers' Assessment: Carers and Disabled Children Act 2000* (2001); Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Policy Guidance* (2001); Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005); and Social Care Institute for Excellence, *Practice Guide 5: Implementing the Carers (Equal Opportunities) Act 2004* (2007), <http://www.scie.org.uk/publications/practiceguides/carersguidance/index.asp> (last visited 9 November 2008).

<sup>30</sup> For example: for older people, see Department of Health, *National Service Framework for Older People* (2001) and *Single Assessment Process Policy Guidance* (2002); for mental health, see Department for Health, *National Service Framework for Mental Health* (1999) and *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* (2008); and for learning disability see *Valuing People: A New Strategy for Learning Disability for the 21<sup>st</sup> Century* (2001) Cm 5086.

<sup>31</sup> LAC(2004)24, *The Community Care Assessment Directions 2004*.

An unending stream of new legislation and regulation, memoranda and instructions, guidance and advice floods into public sector institutions. Many of you will have looked into the vast database of documents on the Department of Health website, with a mixture of despair and disbelief. Central planning may have failed in the former Soviet Union but it is alive and well in Britain today.<sup>32</sup>

## COMPLEXITY

2.24 A further consequence of the piecemeal development of adult social care law is its often baffling complexity, a point that has not been lost on the judiciary. The following quotations are from three separate judgements:

We cannot conclude this judgment without expressing our dismay at the complexity and labyrinthine nature of the relevant legislation and guidance, as well as (in some respects) its obscurity.<sup>33</sup>

Some of the worst, if indeed not the worst drafted and most confusing subordinate legislation it has ever been my misfortune to encounter.<sup>34</sup>

In the course of this judgment we have used the term “paper chase”, and have done so advisedly. This important area of law governs the scarce use of public resources in a difficult and sensitive field ... One part of the overall scheme has had to be litigated in the House of Lords. Now this part, closely related, has had to be litigated in this court. No doubt there are great pressures on the legislators. But the distribution of responsibility which is at the core of this case could surely have been provided much more clearly and simply.<sup>35</sup>

<sup>32</sup> O’Neil, *Reith Lectures 2002: A Question of Trust: Lecture 3, Called to Account* (2002), <http://www.bbc.co.uk/radio4/reith2002/lecture3.shtml> (last visited 9 November 2008).

<sup>33</sup> *Crofton v NHS Litigation Authority* [2007] EWCA Civ 71, [2007] 1 WLR 923 at [110], by Dyson LJ.

<sup>34</sup> *R v Liverpool Health Authority* [2002] Lloyd’s Rep Med 23, 5, by Munby J.

<sup>35</sup> *R (AW) v Croydon LBC and Hackney LBC* [2007] EWCA Civ 266, [2007] 1 WLR 3168 at [55], by Laws LJ.

- 2.25 There are numerous examples of the tortuous complexity of adult social care law. Merely establishing whether or not an individual is entitled to community care services requires a detailed knowledge of the inter-relationship between the various statutes, secondary legislation and relevant guidance. This inter-relationship, however, is not always clear. For example, statutory guidance states that, if an individual's "presenting needs"<sup>36</sup> fall into one or more of the bands that the local authority has included in its eligibility criteria, then the local authority must meet those needs.<sup>37</sup> However, this does not sit easily with some community care statutes which only contain a general duty or simply a power to provide services, such as the HSPHA 1968 and the NHS Acts 2006. In such cases, one commentator has suggested that "there is arguably no absolute duty [to provide a service], even if there is otherwise an apparently 'eligible need'" because "even central government guidance cannot turn powers into duties".<sup>38</sup>
- 2.26 Adding to this complexity is legislation that establishes different rights to similar services. For example, section 2 of the CSDPA 1970 creates specific duties in relation to certain domiciliary services, including meals and home care. The same services can also be provided to similar, but not identical, groups of people under the HSPHA 1968 and the NHS Acts 2006. However, local authorities are only given a power to provide these services under the HSPHA 1968 and the NHS Acts 2006 – except for home help, which authorities have a duty to provide under the NHS Acts 2006.
- 2.27 The complexity of adult social care law can be illustrated by considering the individual example of a person (in this case someone with mental health problems) seeking community services.
- (1) A person with mental health problems may be eligible for domiciliary services under section 29 of the NAA 1948 since "mental disorder" is included in the relevant client list.
  - (2) However, under section 29(6) of the NAA 1948 a service cannot be provided if it is "required" to be provided under the NHS Acts 2006. The NHS Acts 2006 apply to "ill people", which includes people with a mental disorder.

<sup>36</sup> The term "presenting needs" is defined in the guidance as those "issues and problems that are identified when individuals contact, or are referred to, councils seeking social care support". See LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, para 13.

<sup>37</sup> As above, para 52.

<sup>38</sup> M Mandelstam, *Community Care Practice and the Law* (3rd ed 2005) p 121.

- (3) Directions issued under the NHS Acts 2006 require local authorities to make arrangements for the prevention of mental disorder, or in relation to people who are or have been suffering from mental disorder “for the provision of centres (including training and day centres) or other facilities (including domiciliary facilities)” for training and occupation, and “to provide social work support and other domiciliary and care services”.<sup>39</sup> This suggests that the relevant legislation for a person with mental health problems seeking domiciliary services would, primarily, be the NHS Acts 2006 rather than the NAA 1948.
- (4) However, because mental disorder is also included in the client list in section 29 of the NAA 1948, a person with mental health problems may be eligible for services under section 2 of the CSDPA 1970.
- (5) There has been some confusion about whether section 2 of the CSDPA 1970 is a means of delivering services under section 29 of the NAA 1948 or whether it provides a free standing duty to provide services. Case law suggests that section 2 of the CSDPA 1970 is not free standing but merely an adjunct to section 29 of the NAA 1948.<sup>40</sup> However, Lord Justice McCowan in *R v Gloucestershire CC ex p Mahfood* described the consequences of this argument as “unattractive”, since it would follow that the duty to provide home help under the NHS Acts 2006 would prevent such services being provided under section 2 of the CSDPA 1970.<sup>41</sup>
- (6) In addition, the person may be eligible for community services under section 117 of the Mental Health Act 1983 if he or she has been detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the Act but has since ceased to be detained and left hospital. If this were the case, the person would have the additional advantage of not being charged for community services.<sup>42</sup>

## OUTDATED CONCEPTS

- 2.28 Adult social care law has been widely criticised for perpetuating outdated and discriminatory concepts of disability. As previously noted, the NAA 1948 was constructed around the widely held presumption, when the Act was passed, in favour of institutional care for disabled and older people, and it therefore establishes much less certain and limited powers to provide community and domiciliary services.

<sup>39</sup> 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*, Appendix 3, para 3(2).

<sup>40</sup> *R v Powys CC ex p Hambridge* [1989] 1 FLR 643.

<sup>41</sup> *R v Gloucestershire CC ex p Mahfood* (1997-98) 1 Community Care Law Reports 7 at 17C.

<sup>42</sup> *R v Manchester City Council ex p Stennett* [2002] UKHL 34, [2002] 2 AC 1127.

2.29 More specifically, section 29 of the NAA 1948, which is considered to contain the principal definition of a disabled person for the purposes of community care legislation, includes a cross heading describing the content of the section as: “welfare arrangements for blind, deaf, dumb and crippled persons, etc”. Section 29 goes on to describe those who are potentially eligible for domiciliary or community based services as persons aged 18 years or over who are:

Blind, deaf or dumb, or who suffer from mental disorder of any description and other persons aged 18 or over who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.

2.30 As the Prime Minister’s Strategy Unit points out:

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.<sup>43</sup>

2.31 The language used in section 29 of the NAA 1948 is widely recognised as stigmatising and out of kilter with modern medical terminology. However, some commentators go further and criticise the very use of medical terms to determine eligibility for community care services. It is argued that medical categories tend to focus attention on the impairment itself rather than the role played by attitudes, prejudice, discrimination and environmental barriers in excluding disabled people from equality of opportunity:

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?”<sup>44</sup>

2.32 The need to update adult social care law goes beyond removing offensive terminology, although this remains a central reason for reform. The outdated and discriminatory nature of adult social care law may also filter through into types of services and support that can be provided for disabled and older people. 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 providing disabled people with access to full citizenship.<sup>45</sup>

<sup>43</sup> Prime Minister’s Strategy Unit, *Improving the Life Chances of Disabled People* (2005) p 73.

<sup>44</sup> J Morris, “Independent Living and Community Care: A Disempowering Framework” (2004) 19 *Disability and Society* 427, 432.

<sup>45</sup> J Morris, *Citizenship and Disabled People: A Scoping Paper Prepared for the Disability Rights Commission* (2005), <http://www.leeds.ac.uk/disability-studies/archiveuk/morris/Citizenship%20and%20disabled%20people.pdf> (last visited 7 November 2008).

- 2.33 It has been argued that the model of ageing encouraged by the community care legal framework is also out of date. Older people have been portrayed as passive recipients of services and inevitable users of institutional care.<sup>46</sup> The Government has stated that a new model of ageing is required, which “support[s] independence rather than enforcing dependence, and develop[s] policies and services that respond to need rather than simply to chronological age”.<sup>47</sup>
- 2.34 More recent legislation has established that the starting point for the provision of services is the person’s individual needs rather than an inflexible medical category. For example, under the NHSCCA 1990 the provision of support depends on a person having a “need” for community care services rather than a specific disability. This is also recognised in Part 4 of the Education Act 1996 which uses the concept of “special educational needs”, rather than a list of disabilities, to describe children who require special educational provision.

### **HUMAN RIGHTS**

- 2.35 The enactment of the Human Rights Act 1998 has given rise to a number of questions as to whether aspects of adult social care law are compliant with the European Convention on Human Rights (ECHR). For example, the local authority’s seldom-used power to remove people to accommodation against their will, or at least the mechanism for challenging its use, has been singled out as potentially incompatible with Article 5(1)(e) and Article 6 of the ECHR.<sup>48</sup> A programme of reform provides an ideal opportunity to visit these questions.

### **COSTS**

- 2.36 The costs incurred because of the current legal framework of adult social care are difficult to quantify due to incomplete, or a lack of reliable information. The following is intended as an illustrative overview of some of the costs that arise in adult social care as a result of disputes.

### **Complaints**

- 2.37 All local authorities conduct their own complaint-handling systems, usually in three stages.<sup>49</sup> Each authority has a duty, pursuant to regulation 18 of the Local Authority Social Services Complaints (England) Regulations 2006 and regulation 30 of the Local Authority Social Services Complaints (Wales) Regulations 2005, to report on their activities in dealing with complaints after the conclusion of each financial year.<sup>50</sup> This information is not collated centrally but below are some examples obtained at random from local authorities:

<sup>46</sup> R Means and R Smith, *From Poor Law to Community Care* (2nd ed 1998) p 325.

<sup>47</sup> HM Government, *Opportunity Age: Meeting the Challenges of Ageing in the 21st Century* (2005) paras vii to ix.

<sup>48</sup> This is discussed in Part 4 below.

<sup>49</sup> Local authority complaints procedures are described in Part 4 below.

<sup>50</sup> SI 2006 No 1681 and WSI 2005 No 3366.

- (1) in Somerset, with a population of approximately 498,700,<sup>51</sup> 49 stage 1 complaints were made in 2006-07, six of which progressed to stage 2 and one to stage 3. These numbers represented an increase from 2005-06;<sup>52</sup>
- (2) in Waltham Forest, with a population of approximately 223,000,<sup>53</sup> adult social care complaints numbered 51 in 2006-07 and 76 in 2005-06.<sup>54</sup> One complaint in 2006-07 required a stage 2 investigation. The total cost of this investigation was £4181.70;<sup>55</sup> and
- (3) in Warwickshire, with a population of approximately 522,200,<sup>56</sup> 217 complaints were received in 2005-06, of which seven were taken to stage 2 and one to stage 3. In 2004-05, 159 complaints were made, plus five at stage 2 and two at stage 3. In 2003-04, 151 complaints were made, 21 of which progressed to stage 2 and three to stage 3.<sup>57</sup>

### Ombudsmen

- 2.38 Since 2000, complaints to the Local Government Ombudsmen for England on all subjects have been stable and have totalled some 18,500 per year.<sup>58</sup> Over the same period, complaints about social services departments have slowly increased in proportion from 6% to 8% of the total and most of the rise is attributable to complaints about services for adults, or community care.<sup>59</sup>
- 2.39 In 2004-05 there were 686 complaints about various aspects of community care and 389 of these were within the ombudsman's jurisdiction. Just over one third of the complaints within jurisdiction were upheld in whole or in part, and resulted in some form of remedy for the complainant. In particular, over a half involved compensation, and in the two years between 2003 and 2005, 133 complaints resulted in payments totalling just short of £350,000.<sup>60</sup>

<sup>51</sup> Somerset County Council, *Population Summary: Mid Year Population Estimates for Somerset County and Districts* (2001), <http://www.somerset.gov.uk/somerset/statistics/contents/population/population%20summary.pdf> (last visited 9 November 2008).

<sup>52</sup> Somerset County Council, *Adult Social Care Complaints 2006-07* (2007).

<sup>53</sup> Waltham Forest LBC, *Waltham Forest Economic Profile: Population* (2004) p 1.

<sup>54</sup> Waltham Forest LBC, *Adult Social Care Annual Complaints Report 2006-07* (2007) p 5.

<sup>55</sup> Waltham Forest LBC, *Adult Social Care Annual Complaints Report 2006-07* (2007) p11.

<sup>56</sup> Warwickshire County Council, *News Release: Latest Population Figures for Warwickshire* (23 August 2007), [http://www.warwickshire.gov.uk/corporate/pressr.nsf/\(DisplayLinks\)/44124AF744CF2B1680257340003AA227](http://www.warwickshire.gov.uk/corporate/pressr.nsf/(DisplayLinks)/44124AF744CF2B1680257340003AA227) (last visited 17 July 2008).

<sup>57</sup> Warwickshire County Council, *Annual Report on Social Care Complaints and Representations 2005-06* (2006).

<sup>58</sup> J White, "Community Care and the Local Government Ombudsmen for England" (2006) 9 *Community Care Law Reports* 8, 8.

<sup>59</sup> As above, 8. For example, in 2006-07 there were 18,320 complaints and in 2005-06 there were 18,626 complaints.

<sup>60</sup> As above, 11.

- 2.40 In 2006-07, the Local Government Ombudsmen received 795 complaints regarding adult care,<sup>61</sup> and completed ten investigation reports.<sup>62</sup> In 2007-08, this number dropped to 679 complaints about adult care services, of which seven were subject to a report.<sup>63</sup>
- 2.41 The Public Services Ombudsman for Wales reported a total of 1,888 complaints of maladministration or service failure by public bodies in 2007-08, of which 8% were about social services.<sup>64</sup>

### **Legal Aid**

- 2.42 The majority of social care law cases are brought by claimants with the assistance of public funding. Although the Legal Services Commission provides a separate category for community care cases, legal advice and assistance relating to adult social care may also be provided under alternative categories such as mental health, immigration, public law, welfare benefits and housing.
- 2.43 In March 2008, there were 70 solicitor supplier contacts and 23 in the not-for-profit sector offering advice and representation in the field of community care.<sup>65</sup> In 2007-08, the overall number of community care supplier contracts increased from 73 to 93.<sup>66</sup> Cases where legal advice and assistance was publicly funded in 2007-08 saw a 6% increase from 4,559 to 4,853.<sup>67</sup> There were 816 applications for licensed work and 697 funding certificates granted.<sup>68</sup>
- 2.44 In 2007-08, 512 bills were paid on community care cases (excluding welfare cases) where the cost was met by public funds, resulting in a total expenditure of £2 million, and an average cost of £3,951 per case.<sup>69</sup> There were a further 43 bills paid where the costs were met by opponents, to a total value of £885,505 and an average cost of £20,593 per case.<sup>70</sup>

<sup>61</sup> Local Government Ombudsmen, *Annual Report 2006-2007: Supplement to the Annual Review (2007)* p 6.

<sup>62</sup> As above, p 8.

<sup>63</sup> Local Government Ombudsmen, *Analysis of Complaints Statistics for 2007/08* (2008).

<sup>64</sup> Public Services Ombudsman for Wales, *Annual Report 2007-08* (2008) p 16.

<sup>65</sup> Legal Services Commission, *Statistical Information 2007/08* (2008) p 3.

<sup>66</sup> As above, p 3.

<sup>67</sup> As above, p 4. This refers to controlled work under the civil contract which covers legal advice and assistance (Legal Help), Help at Court and Legal Representation in front of Mental Health Review Tribunals and the Asylum and Immigration Tribunal.

<sup>68</sup> As above, p 6. "Licensed work" refers to work under the civil contract which covers all legal representation (representation by solicitors and barristers which could go to court) except work covered by Controlled Work or Very High Cost Cases.

<sup>69</sup> As above, p 11.

<sup>70</sup> As above, p 11.

2.45 The total number of bills paid for civil non-family proceedings where the cost was met by public funds in that period was 21,734, on which £88.8 million was paid in total, with an average bill cost of £4,090.<sup>71</sup> In those cases where the cost was met by opponents, there were 5,089 bills paid for civil non-family proceedings to a total value of £122.6 million, and an average cost of £24,089 per case.<sup>72</sup>

2.46 In 2007-08, the Legal Services Commission introduced new reporting codes, which provide information on the types of services that legal aid providers report when they close a case. Analysis of claims recorded on the Legal Services Commission's Supplier Management System indicates that in community care, the overall numbers (as a percentage) of the different types of cases reported were as follows:

- (1) obtaining an assessment 26%;
- (2) provision of services 24.8%;
- (3) challenging an assessment 7.8%;
- (4) protection of vulnerable adults 3.3%;
- (5) charges for services 2.9%;
- (6) provision of direct payments or equivalent 1.4%;
- (7) issues arising from the health/social care divide 1.1%;
- (8) other 17.7%; and
- (9) not recorded 15%.<sup>73</sup>

### **CENTRAL VERSUS LOCAL PLANNING AND DECISION MAKING**

2.47 In Part 1, we highlighted a tension between local discretion and the view that care and support services should be the same or at least comparable across the country. Some commentators have pointed out that different decisions about priorities, as well as types and quality of services, have led to variation in resource allocation to social care and in the scale and quality of services in different places.

2.48 To some extent, this is a matter of policy and the inevitable result of a locally rather than nationally driven social care system. However, there remain a number of concerns about how the law negotiates the tension between local and central planning and decision making. These concerns are discussed below.

<sup>71</sup> As above, p 11.

<sup>72</sup> As above, p 11.

<sup>73</sup> Unpublished analysis provided by the Legal Services Commission (August 2008).

## Eligibility criteria

2.49 When carrying out assessments of need and making service provision decisions, statutory guidance requires local authorities to place the person's presenting needs into one of four bands or levels of need.<sup>74</sup> These levels are (in decreasing order of severity): *critical*; *substantial*; *moderate*; and *low*. Although all local authorities must adopt this framework, it is up to each local authority to decide which of the bands will attract the provision of services (the eligibility criteria). In deciding which of the four bands it will include in its eligibility criteria, the local authority may take account of its resources, local expectations and local costs.<sup>75</sup>

2.50 This has led to two main criticisms of this framework:

- (1) it produces wide local variations in eligibility for services: for example in 2006-07, a report by the Commission for Social Care Inspection found that 62% of councils in England operated at the highest two levels of substantial and critical; 32% included moderate needs; and 6% included all four bands;<sup>76</sup> and
- (2) it has led to local authorities increasingly restricting services to those with the highest levels of need. According to the same report: 4% of councils confined their help to the critical band only; councils raising their eligibility thresholds to substantial increased from 53% to 62% in 2006-07; and the trend is expected to continue as 73% of councils anticipate that they will be operating at substantial or critical levels in 2007-08.<sup>77</sup>

## Service provision

2.51 Although local authorities are under a duty to meet an eligible need, it may be that the need can be met by alternative care packages. In such cases the relevant guidance and case law are explicit that a local authority may take resources into account when deciding which care package will be provided (although decisions cannot be taken on the basis of resources alone).<sup>78</sup>

2.52 This may lead to some disparity in the provision of services. For example, a disabled person with an eligible need for structured daytime activities may in one local authority attend a resource centre that provides a range of services aimed at promoting independence and well-being. In another authority, such a person may be provided with a less expensive informal social group.

<sup>74</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care* and NAFWC 09A/2002, *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care*.

<sup>75</sup> As above, para 18 (England) and para 5.19 (Wales).

<sup>76</sup> Commission for Social Care Inspection, *The State of Social Care in England 2006-07* (2008) para 7.23.

<sup>77</sup> As above, para 7.23.

<sup>78</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, para 52 and NAFWC 09A/2002 *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care*, para 5.30. Also, see *R v Kirklees MBC ex p Daykin* (1997-98) 1 Community Care Law Reports 512.

## Charging policies

2.53 Local authorities are given discretion over whether to charge adult recipients of non-residential services, and how to design their charging policies within certain “minimum standards” or “minimum requirements” set out in statutory guidance.<sup>79</sup> An inevitable result of this discretion is regional variation in the way that different local authorities calculate their charges for non-residential services. For example, research in 2004 by Age Concern found:

- (1) seventy one per cent of local authorities set a maximum weekly charge, above which no-one will be charged (which ranged from £23.50 to £400). Some charged the full cost of the service, while others used a banding system;
- (2) hourly charges for home care ranged from £3.50 to £15.50. Thirty-five of authorities did not subsidise this rate, while the other authorities each had its own system of charging based on an assessment of the service user’s means and/or the level of service provided; and
- (3) there were variations in the extent to which disability welfare benefits, capital and a partner’s resources were taken into account.<sup>80</sup>

2.54 In Wales, a proposal for a Legislative Competence Order relating to charging for domiciliary care has been made in the context of concerns expressed by service users, carers and their representatives that:

Charges are often set too high and that differing amounts can be charged by different local authorities for similar services resulting in inequities and uncertainties for these groups of people. There is also disparity in the way that benefits and/or disability related expenditure are treated in an individual’s assessment.<sup>81</sup>

<sup>79</sup> Department of Health, *Fairer Charging Policies for Home Care and Other Non-Residential Social Services: Guidance for Councils with Social Services Responsibilities* (2003) para 5 and Welsh Assembly Government, *Fairer Charging Policies for Home Care and Other Non-Residential Social Services: Guidance for Local Authorities* (2002) para 8.

<sup>80</sup> P Thompson and D Mathew, *Fair enough? Research on the Implementation of the Department of Health Guidance Fairer Charging Policies for Home Care and Other Non-residential Social Services* (2004).

<sup>81</sup> Memorandum From the Deputy Minister for Health and Social Services, *Constitutional Law: Devolution Wales, The National Assembly for Wales (Legislative Competence) (No. 4) Order 2008, Proposal for a Legislative Competence Order Relating to Charging for Non-residential Social Care (Domiciliary Care)* (2008).

### **Portability of services**

- 2.55 It has been suggested that the overall impact of a legal framework based on local discretion has been to dissuade service users and carers from moving to another local authority, since they do not know whether they will still be eligible for services, what services will be available and how much they will be charged for them in the new area.<sup>82</sup> This, according to Baroness Campbell, leads to the “intolerable injustice” of disabled people becoming “a prisoner of one’s local authority, unable to enjoy the same social and economic mobility and freedom of movement as our non-disabled counterparts”.<sup>83</sup>
- 2.56 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 people face when moving from one local authority area to another because they are unable to find out in advance what package of community care services will be made available to them in the new area.<sup>84</sup>

### **CONCLUSION**

- 2.57 Adult social care law is in urgent need of reform. It remains a complex and confusing patchwork of conflicting statutes enacted over a period of 60 years. The law is also based on outdated and often discriminatory concepts and gives rise to human rights concerns. A number of significant costs are incurred as a direct result of the complexity of this area of law. Finally, there are concerns about how the law negotiates the tension between local and central planning and decision making. In short, it is in need of reform.
- 2.58 The scoping report will now consider the purpose of law reform.

<sup>82</sup> Note, however, that according to case law it would be unlawful for a local authority to refuse to assess someone purely on the basis that they are not yet ordinarily resident in the authority’s area. See *R v Berkshire CC ex p P* (1997-98) 1 Community Care Law Reports 141.

<sup>83</sup> *Hansard* (HL), 1 July 2008, vol 703, col 153.

<sup>84</sup> This was also announced in the House of Lords during debates on the Health and Social Care Bill 2007 concerning ordinary residence: *Hansard* (HL), 1 July 2008, vol 703, col 160 to 161 (Baroness Thornton).

## **PART 3**

# **THE PURPOSE OF ADULT SOCIAL CARE LAW REFORM**

### **SIMPLIFICATION**

- 3.1 The overall purpose of reform would be to provide a clearer and more cohesive legal framework for adult social care. This would help to ensure that service users, carers, social care workers, health professionals and lawyers are clear about entitlements to services and which services are available. According to Professor Luke Clements, this is the principal reason behind the need for new legislation:

The need for reform ... springs from the extraordinary complexity of the current legislative regime: time and time again it reduces senior lawyers and judges to a state of consternation ... If the law is obscure to our cleverest legal minds – then how does it fare with the poorly informed, the unassertive, the fearful, the exhausted, the distracted and those with intellectual impairments?<sup>1</sup>

- 3.2 A simplified legal framework would, in turn, promote a more efficient legal system. The current state of adult social care law leads to inefficiency, since negotiating complex and outdated law takes longer and requires more resources. A clearer and more cohesive legal framework would lead to less time being spent on law and litigation.
- 3.3 Simplification of the law also reinforces the constitutional notion that citizenship entails a clear understanding of rights and responsibilities. Lord Bingham has stated that the first sub-rule of the Rule of Law is that the law must be accessible and so far as possible intelligible, clear and predictable.<sup>2</sup> It is therefore crucial that a citizen should not be denied the constitutional right to a body of law which is accessible, intelligible and in accordance with modern needs.

### **CONSISTENCY**

- 3.4 Another goal of reform would be to establish a greater degree of consistency in adult social care law. A consolidated adult social care statute would provide, for example, that adult social care is no longer based on a series of piecemeal and inconsistent Acts of Parliament, which the courts and professionals alike are left to interpret in light of present day circumstances. Reform would also present an opportunity to consider whether clear statutory principles could be established to inform and underpin decisions about service provision.

<sup>1</sup> L Clements, *The Need for New Legislation* (2007) p 2, [http://www.lukeclements.co.uk/downloads/PDF\\_Sep08\\_04.pdf](http://www.lukeclements.co.uk/downloads/PDF_Sep08_04.pdf) (last visited 9 December 2008).

<sup>2</sup> Lord Bingham, *The Sixth Sir David Williams Lecture: The Rule of Law* (2006), <http://www.cpl.law.cam.ac.uk/Media/THE%20RULE%20OF%20LAW%202006.pdf> (last visited 9 November 2008).

- 3.5 As noted in Part 3 of this report, a social care system based largely on local discretion will still face external demands for greater consistency in decision making across different local authorities. Legal clarity would help to promote a greater degree of consistency within this framework, since local authorities would be clear about when and how decisions need to be taken.

### **TRANSPARENCY**

- 3.6 Reform of adult social care law will seek to promote legal transparency. Law that is easy to understand will help to ensure that people who approach their local authority for assistance are clear about how decisions to ration services are made by the authority. Law that is transparent will also be easier to enforce, since service users will be aware of their rights and local authorities will understand their responsibilities.
- 3.7 It will also be important to establish greater transparency concerning the overall purpose and principles underlying adult social care law. As detailed above, existing statute law reflects a range of different and often conflicting philosophical and political approaches. Furthermore, the present complexities and uncertainties inherent in the system often conspire to obscure the purpose of adult social care.

### **MODERNISATION**

- 3.8 Law reform would aim to bring adult social care law in line with modern understandings of disability. It would for example be an opportunity to eradicate the discriminatory and stigmatising concepts that persist in the law and develop legislation that is more consistent with the Disability Discrimination Act 1995 and the Human Rights Act 1998.
- 3.9 Reform would also look towards utilising modern legislative innovations, such as the inclusion of explicit principles and checklists for decision making, as developed in other areas of social welfare law such as the Children Act 1989 and the Mental Capacity Act 2005.<sup>3</sup>

### **RESOURCE NEUTRALITY**

- 3.10 Reform of adult social care law would be expected to work on a broadly expenditure-neutral basis. Consideration of the long term funding of adult social care would be outside of the scope of the review.<sup>4</sup> The ultimate aim would be to produce an overarching legal structure that would work at any given level of resources.<sup>5</sup>

<sup>3</sup> This issue is covered in Part 4 below.

<sup>4</sup> However, we recommend that our substantive project should consider the legal framework that governs charging for services, see discussion in Part 4 below.

<sup>5</sup> One exception to this general expectation would be the possibility of a proposal for the establishment of a tribunal to adjudicate disputes between social services departments and users and carers.

## **LAW REFORM**

- 3.11 Our main task in this project is to review adult social care law and, as in all our projects, make recommendations for change. We will seek to ensure that the law is as simple, accessible, fair, modern and cost effective as possible. The specific types of law reform specified in the Law Commission Act 1965 are the removal of anomalies, repeal of obsolete and unnecessary enactments, consolidation and the simplification and modernisation of the law.

## **PART 4**

### **AREAS FOR REVIEW**

- 4.1 This part of the scoping report contains our comprehensive analysis of adult social care law. The following areas are covered in detail: statutory principles; community care assessments; carers' assessments; hospital discharge; eligibility for services; ordinary residence; the provision of services; eligibility and client groups; direct payments; charging for services; the health/social care divide; safeguarding adults from abuse; strategic planning and information to the public; care standards and regulation; and complaints and redress. The discussion will highlight the key issues for law reform and present our proposed agenda for the substantive project.

#### **STATUTORY PRINCIPLES**

- 4.2 One of the main criticisms of adult social care law is that the lack of a consolidated statute means that there is no coherent set of overarching principles to direct and assist local authorities, courts and others in carrying out their functions in this area.
- 4.3 Recently, the concept of including a set of principles at the outset of a piece of legislation has found an increasing level of support in England and Wales. The use of principles is particularly prevalent in the field of social welfare law and the main examples are listed below:
- (1) section 1(1) of the Children Act 1989 sets out the central principle that a child's welfare shall be the court's paramount consideration when determining any question regarding a child's upbringing or the administration of a child's property or the application of any income arising from it. This is supported by the general principle that any delay in court proceedings is likely to prejudice the child's welfare, which applies to any proceedings where the question of the upbringing of the child arises,<sup>1</sup> as well as by the principle that a court should not make any order unless it is better for the child than making no order at all, which applies to all orders made under the Children Act 1989.<sup>2</sup> Section 1 also contains a checklist of factors, known as the welfare checklist, which a court must have regard to when considering certain orders;
  - (2) section 1 of the Adoption and Children Act 2002 sets out considerations applying to the exercise of powers by a court or adoption agency. This is similar in substance to section 1 of the Children Act 1989, with a few additions to tailor the provision to the specific circumstances of adoption; and

<sup>1</sup> Children Act 1989, s 1(2).

<sup>2</sup> Children Act 1989, s 1(5).

- (3) section 1 of the Mental Capacity Act 2005 sets out principles which apply for the purposes of the Act, including: the presumption that a person has capacity unless it is established that he or she lacks capacity; and a requirement that all decisions and acts made on behalf of a person who lacks capacity must be in that person's best interests. Section 4 of the Act also sets out a checklist of factors that must be considered when determining a person's best interests.

4.4 There are numerous examples of principles in similar statutes in other jurisdictions, especially Scotland, Canada and Australia.<sup>3</sup> The fact that principles provisions are so often included in existing social welfare statutes, not only in the UK but in other jurisdictions, suggests that the use of principles is becoming international common practice in this sector.

#### **Purpose of statutory principles**

4.5 The main purpose of principles is to articulate the underlying aims of the legislation. This can be achieved by expressly codifying important principles of the common law to create synthesis between different sets of rules, and more broadly by outlining the policy rationale behind the legislation. For example, in the Mental Capacity Act 2005:

- (1) the inclusion of the principle that all decisions and actions must be in the best interests of a person who lacks capacity was designed to reflect and build on a well-established common law principle;<sup>4</sup> and
- (2) the overall effect of the statutory principles is to make the founding basis of the legislation explicit. This is acknowledged in the Code of Practice:

[The principles are] the values that underpin the legal requirements in the Act. The Act is intended to be enabling and supportive of people who lack capacity, not restricting or controlling of their lives. It aims to protect people who lack capacity to make particular decisions, but also to maximise their ability to make decisions, or to participate in decision-making, as far as they are able to do so.<sup>5</sup>

4.6 Statutory principles can also be used to affirm the supremacy of one particular principle. The inclusion of the welfare principle in the Children Act 1989 is arguably the strongest example of an attempt to fulfil this purpose. This was recognised by the Lord Chancellor during the debates on the Children Bill in the House of Lords:

<sup>3</sup> For example: Adult Support and Protection (Scotland) Act 2007; Mental Health (Care and Treatment) (Scotland) Act 2003; Adults with Incapacity (Scotland) Act 2000; Long-Term Care Homes Act 2007 (Canada); Long-Term Care Act 2000 (Canada); Aged Care Act 1997 (Australia); and Family Law Act 1975 (Australia).

<sup>4</sup> Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) para 2.12.

<sup>5</sup> As above, p 19.

What we have done – and I think everyone has agreed with this – is to put in the forefront of the Bill, in Clause 1(1), the fundamental principle that where a court determines questions of the sort that are in issue the child's welfare shall be the court's paramount consideration ... What we have done next, as I said in relation to the last amendment, is to put in the forefront of the particular circumstances to be applied or to be considered in applying that principle ... [T]his is a matter that must be looked at very seriously and principally. As I have said, we have given it the first importance ... We have put the real principle right in the forefront.<sup>6</sup>

- 4.7 The incorporation of principles into statute also creates a clear framework to guide practitioners in the activities they undertake pursuant to the legislation. As principles tend to stipulate ends rather than means, the framework can be flexible enough to cope with a variety of factual scenarios, including novel or complex situations. This was recognised by the Joint Parliamentary Committee on the draft Mental Incapacity Bill:

We believe that such a statement inserted as an initial point of reference could give valuable guidance to the Courts, as well as helping non-lawyers to weigh up difficult decisions. Evidence given to us indicates this would be welcome to a wide range of those who have to deal with the problems of substitute decision making in practice.<sup>7</sup>

- 4.8 The inclusion of principles can also perform an important educational role by promoting positive images of vulnerable groups of people, and highlighting the need for greater dignity and respect. For example, the third principle of the Mental Capacity Act 2005, that a person is not to be treated as unable to make a decision unless all practical steps to help them to do so have been taken without success, aims to stop people being automatically labelled as lacking capacity as a result of an illness or disability.<sup>8</sup> Earl Howe summed up the importance of statutory principles, during an unsuccessful attempt in the House of Lords to amend the Mental Health Bill 2006 to include principles on the face of the Mental Health Act 1983,<sup>9</sup> saying:

<sup>6</sup> *Hansard* (HL), 19 December 1988, vol 502, col 1152 (Lord Mackay).

<sup>7</sup> House of Lords House of Commons Joint Committee on the Draft Mental Incapacity Bill, Draft Mental Incapacity Bill, Session 2002-03, Vol 1 (2003) HL 189-1, HC1083-1, para 43.

<sup>8</sup> Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) para 2.6.

<sup>9</sup> Although unsuccessful, the Bill was eventually amended to insert a new section into the 1983 Act which states that principles will be included in the Code of Practice and that in setting these principles, the Secretary of State must ensure that a number of matters are addressed, including respect for the patient's wishes and minimising restrictions on liberty.

The inclusion of principles in the legislation is a visible recognition by Parliament that stigma, discrimination and racial stereotyping need to be banished. I believe that the amendment will help promote, in their place, a culture of respect and confidence ...<sup>10</sup>

#### **Status and application of principles**

- 4.9 The status of statutory principles will depend on the way they are drafted. Some statutory principles are constructed in such a way that gives them a clear mandatory and overarching effect. For example, section 1(1) of the Children Act 1989 states that “the child’s welfare shall be the court’s paramount consideration”. Other principles are drafted to create a strong presumption or place emphasise on the need to take or avoid certain actions. For example, section 1(2) of the Children Act 1989 states that “the court shall have regard to the general principle that any delay in determining the question is likely to prejudice the welfare of the child”.
- 4.10 Principles can be drafted as applying to specific individuals or bodies, in particular circumstances. For example, the principles in section 1 of the Adoption and Children Act 2002 apply whenever a court or adoption agency is coming to a decision relating to the adoption of a child. Alternatively a principle can be drafted to apply to a broader group of people and in more general circumstances. Thus, the principles of the Mental Capacity Act 2005 have a broad application and apply to any person undertaking an assessment of capacity or who makes a decision or takes an action on behalf of a person who lacks capacity, including courts, health and social care professionals, lawyers, informal carers and family members.
- 4.11 Principles need not apply to the whole of the legislation and can be excluded from applying to specific parts or sections. For example, the welfare principle in section 1(1) of the Children Act 1989 does not apply to local authority duties and powers under Part 3 of the Act; and in particular, does not apply to the decision of a local authority to place a child in secure accommodation under section 25 of the Act, nor to any review of that decision by a court.<sup>11</sup>
- 4.12 Principles are also often reinforced by additional provisions within the statute, as well as appropriate guidance and codes of practice. For instance, the Mental Capacity Act 2005 reiterates, at several points, that a person or body must apply the principles in section 1 and the best interests test in section 4 when carrying out their duties under the Act.

<sup>10</sup> *Hansard* (HL), 8 January 2007, vol 688, col 14 (Earl Howe).

<sup>11</sup> *Re M (A Minor) (Secure Accommodation Order)* [1995] 1 FLR 418.

- 4.13 It is also important to recognise that even where principles are not directly binding on a person or a body they can have a broader normative effect on practice and behaviour. For example, local authorities may still consider the welfare of the child as an important consideration, rather than their paramount consideration, when carrying out their powers and duties under Part 3 of the Children Act 1989.<sup>12</sup>
- 4.14 The extent to which principles are enforceable is unclear and may depend on how they are drafted. In relation to the Mental Capacity Act 2005, for example, one commentator has suggested that:

The status of [section 1] is that decisions and actions carried out under the Act should be tested against the principles which act as benchmarks for decision makers. Although there is no duty placed on persons or bodies to apply the principles, a failure to do so could be cited in legal proceedings as evidence of unlawful conduct.<sup>13</sup>

### **Issues for reform**

- 4.15 We believe that the substantive review should consider the desirability of introducing statutory principles into a consolidated adult social care statute, and develop proposals for the content of any such principles, as well as their status and application. Clearly this will be an area where consultation with a wide range of stakeholders will be crucial.

## **COMMUNITY CARE ASSESSMENTS**

### **The duty to assess**

- 4.16 The duty to assess has a history reflective of the incremental and piecemeal development of adult social care law itself. The primary duty to carry out assessment for community care services is provided in section 47 of the NHSCCA 1990; however, this was preceded by several earlier versions, none of which have been repealed. This means that there are at least three main duties to assess in adult social care legislation, and arguably more.<sup>14</sup>
- 4.17 A duty to assess is part of the duty to “make arrangements” to provide services for certain persons under section 29(1) of the NAA 1948 and section 2(1) of the CSDPA 1970. The latter section provides that a local authority with functions under section 29 of the NAA 1948 has a duty to make arrangements for the provision of services to persons if “satisfied” they are necessary in order to meet the needs of that person. In order to be “satisfied”, it would appear necessary for some form of assessment to be undertaken.

<sup>12</sup> *Re M (A Minor) (Secure Accommodation Order)* [1995] 1 FLR 373 at 379.

<sup>13</sup> R Jones, *Mental Capacity Act Manual* (2nd ed 2007) para 1-011.

<sup>14</sup> For example, it has been argued that the nature of the duty to provide residential accommodation under s 21 of the NAA 1948 means that it should be assessed differently from access to other services and the NHSCCA 1990 has effectively been rendered otiose for these purposes: P Bartlett and R Sandland, *Mental Health Law: Policy and Practice* (3rd ed 2007) pp 458 to 460. It is also argued that social services have always been under a public law obligation to assess potential community care service users: L Clements and P Thompson, *Community Care and the Law* (4th ed 2007) p 47.

- 4.18 It was acknowledged in the course of debates on the Disabled Persons (Services, Consultation and Representation) Bill 1986 that section 2(1) of the CSDPA 1970 “did not make it explicitly clear whether a local authority has a duty to determine what the needs of a disabled person are”.<sup>15</sup> The effect of this was that the duty to make arrangements “could be interpreted as applying only after the local authority are satisfied that such arrangements are necessary in order to meet particular needs and that a local authority may refuse to come to a view as to what the needs are”.<sup>16</sup>
- 4.19 Although it was clear the majority of local authorities were not interpreting the section in this way, it was agreed that the matter should be put beyond doubt.<sup>17</sup> This led to section 4 of the DP(SCR)A 1986, a Private Member’s Bill, which places a specific duty on local authorities to undertake an assessment when requested by a disabled person or their carer. This section was intended to clarify that local authorities have a duty to decide whether the needs of a disabled person call for the provision of services under section 2 of the CSDPA 1970 when requested by the disabled person.<sup>18</sup>
- 4.20 It has been suggested, however, that the right to request an assessment has proved to be an “unsatisfactory mechanism” to access services under the CSDPA 1970, as it requires the disabled person to “know of the existence of their right to services before they could access those services”.<sup>19</sup> There may also be limitations with a request mechanism where the person being assessed lacks capacity to request an assessment, or where an individual refuses an assessment in circumstances where they clearly require one. For these reasons, it was thought that a general duty to assess, not conditional on a request, was required.
- 4.21 This duty was contemplated in the 1989 White Paper, *Caring for People*, which accepted the view that the provision of care at public expense should be preceded by a proper assessment of the individual’s needs.<sup>20</sup> It was envisaged that social service authorities would have a gatekeeper role, in which they would be responsible for carrying out an appropriate assessment of an individual’s need for social care, in collaboration with medical, nursing and other agencies, before deciding what services should be provided.<sup>21</sup>

<sup>15</sup> *Hansard* (HL), 18 June 1986, vol 476, col 978 (Baroness Trumpington).

<sup>16</sup> As above. See also LAC(87)6, *Disabled Persons Act (Services, Consultation and Representation) Act 1986: Implementation of Sections 4, 8(1), 9 & 10*, para 3.

<sup>17</sup> As above, para 3.

<sup>18</sup> LAC(87)6, *Disabled Persons Act (Services, Consultation and Representation) Act 1986: Implementation of Sections 4, 8(1), 9 & 10*, para 4.

<sup>19</sup> L Clements and P Thompson, *Community Care and the Law* (4th ed 2007) p 48.

<sup>20</sup> *Caring for People: Community Care in the Next Decade and Beyond* (1989) Cm 849, para 3.1.3.

<sup>21</sup> As above, para 3.1.3.

### **The section 47 duty**

- 4.22 This idea from the White Paper is reflected in the general duty to assess in section 47 of the NHSCCA 1990, which operates in addition to the assessment duties under the CSDPA 1970 and DP(SCR)A 1986. Section 47(1)(a) imposes a duty on a local authority to carry out an assessment of a person's needs for the provision of community care services in circumstances where:
- (1) the local authority is empowered to provide or arrange for the provision of community care services for that person;
  - (2) the person's circumstances have come to the knowledge of the authority; and
  - (3) it appears to the local authority that the person may be in need of community care services.<sup>22</sup>
- 4.23 Once the local authority has undertaken the assessment, it must, having regard to the results of the assessment, decide whether the person's needs call for the provision by the local authority of any community care services.<sup>23</sup> This obligation is set out in section 47(1)(b) and is commonly referred to as the service provision decision.
- 4.24 If during the assessment it appears that the person is disabled, section 47(2) requires the local authority to decide whether services referred to in section 4 of the DP(SCR)A 1986 are required, without the person requesting them to do so under that section. The services referred to in the 1986 Act are those listed in section 2 of the CSDPA 1970. The local authority must also inform the person that they are doing this and of their rights under the 1986 Act.
- 4.25 Section 47(5) allows a local authority to provide temporary community care services without having undertaken an assessment where it is the opinion of the local authority that the condition of that person is such that they require those services as a matter of urgency. However, if services are provided, under subsection (5), then as soon as practicable thereafter an assessment of the person's needs must be made under section 47(1).

<sup>22</sup> NHSCCA 1990, s 47(1)(a).

<sup>23</sup> NHSCCA 1990, s 47(1)(b). Note "community care services" are defined in s 46(3) to mean services which a local authority may provide or arrange to be provided under: Part 3 of the NAA 1948; s 45 of the HSPHA 1968; s 254/192 and Sch 20/15 of the NHS Acts 2006; and s 117 of the Mental Health Act 1983.

### ***When the duty to assess arises***

- 4.26 The duty to assess will arise in certain circumstances. These circumstances have been clarified by the courts and through a range of both statutory and practice guidance issued by the Department of Health and the Welsh Assembly – in particular *Fair Access to Care Services* (FACS) in England and the *Unified and Fair System for Assessing and Managing Care* (UFSAMC) in Wales, both of which are statutory guidance.<sup>24</sup>
- 4.27 First, section 47(1)(a) requires an assessment to be carried out by the local authority whether or not the individual requests it. That is, the “obligation to make an assessment for community care services does not depend on a request, but on the ‘appearance of need’”.<sup>25</sup>
- 4.28 Secondly, the degree of need required before the duty to assess is triggered is only “apparent” or “possible” need; it does not have to be “urgent or pressing or actual need”.<sup>26</sup> The FACS guidance explicitly provides that local authorities should set a low threshold in deciding whether an individual appears to be in need of community care services and “avoid screening individuals out of the assessment process before sufficient information is known about them”.<sup>27</sup>
- 4.29 Thirdly, the duty to assess arises irrespective of whether there is little prospect of the individual actually qualifying for the services, either because of resource limitations on the part of the local authority<sup>28</sup> or because of the financial circumstances of the service user.<sup>29</sup> Similarly, the duty to assess arises even when services are discretionary: the duty “is not dependent upon a collateral statutory duty to provide or upon the person being ordinarily resident in the local authority’s area”.<sup>30</sup>

<sup>24</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care* and NAFWC 09A/2002 *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care*.

<sup>25</sup> *R v Gloucestershire CC ex p RADAR* (1997-98) 1 Community Care Law Reports 476, 483D, by Carnwath J.

<sup>26</sup> R Gordon, *Community Care Assessments: A Practical Legal Framework* (1993) p 9. This level of need is also reflected in the definition of “qualifying individual” in s 50 of the NHSCCA 1990.

<sup>27</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, para 30.

<sup>28</sup> *R v Bristol CC ex parte Penfold* (1997-98) 1 Community Care Law Reports 315.

<sup>29</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, para 70.

<sup>30</sup> L Clements and P Thompson, *Community Care and the Law* (4th ed 2007) p 68. See also *R v Berkshire CC ex parte P* (1997-98) 1 Community Care Law Reports 141.

### ***The assessment process***

4.30 In contrast to the DP(SCR)A 1986, the actual assessment process is not set out in the NHSCCA 1990.<sup>31</sup> However, section 47(4) requires assessments to be conducted in accordance with directions issued by the Secretary of State and the Welsh Ministers. The Community Care Assessment Directions 2004 require local authorities in England to comply with the following requirements when undertaking an assessment:

- (1) consult the person and, where appropriate, consult the person's carer(s);
- (2) take all reasonable steps to reach agreement with the person and, where appropriate, any carers of that person, on the community care services which they are considering providing to the person to meet their needs; and
- (3) provide information to the person and, where appropriate, any carers of that person, about the amount of the payment (if any) which the person will be liable to make in respect of the community care services which they are considering providing to him.<sup>32</sup>

4.31 In addition to these directions, the Department of Health and Welsh Assembly Government have issued a range of statutory and practice guidance concerning the assessment process. These include FACS and UFSAMC and also a number of user group specific practice guidance relating to the assessment of older people, mental health service users, people with learning disabilities, disabled children and carers.<sup>33</sup>

4.32 The advantage of having separate guidance for different client groups is that the guidance can address issues specific to the particular group. The disadvantage is that it may obscure the core need to carry out a community care assessment. In *R (HP) v Islington LBC*, where a man had been assessed and rejected for support from specialist mental health services using the Care Programme Approach guidance, and was also found to be ineligible for community care services on the basis of this assessment, the court held that a proper community care assessment had not been carried out.<sup>34</sup>

<sup>31</sup> Note s 3 of DP(SCR)A 1986 describes the procedure to be followed in an assessment under s 2 of the same Act. However, s 3 has never been brought into force because of resource and administrative implications.

<sup>32</sup> There are no equivalent directions in Wales. In the absence of directions, s 47(4) of the NHSCCA 1990 provides that assessments are to be carried out in such manner and take such form as the local authority considers appropriate.

<sup>33</sup> For example: for older people, see Department of Health, *National Service Framework for Older People* (2001) and *Single Assessment Process Policy Guidance* (2002); for mental health, see Department of Health, *National Service Framework for Mental Health* (1999) and *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* (2008); and for learning disability, see *Valuing People: A New Strategy for Learning Disability for the 21<sup>st</sup> Century* (2001) Cm 5086.

<sup>34</sup> [2004] EWHC 7 (Admin), (2005) 82 BMLR 113.

- 4.33 The FACS/UFSAMC guidance provides that the central purpose of the assessment process is “to identify and evaluate an individual’s presenting needs and how they constrain or support his/her capacity to live a full and independent life”.<sup>35</sup> Presenting needs are defined in the FACS guidance as those issues and problems that are identified when individuals contact or are referred to local authorities seeking social care support.<sup>36</sup> The assessor is required to collect sufficient data about the person’s presenting needs under section 47(1)(a) in order to determine which of the applicant’s presenting needs call for the provision of community care services under section 47(1)(b).

### **Self-assessment**

- 4.34 In recent times there has been a move towards what is called *self-assessment*, which enables a person to complete an assessment form as part of the assessment process. The work to develop a Common Assessment Framework includes a commitment “to allow people to self-assess wherever possible”.<sup>37</sup> The Department of Health is funding a 12 month research project to “test the scope and feasibility of people with health and social care needs to self-assess for support from a range of services, including equipment/aids, home care, housing adaptations and low level preventative services”.<sup>38</sup> According to the Government, self-assessment has been “enthusiastically endorsed” and “will help put people in control, letting them identify where they need support from care services”.<sup>39</sup>
- 4.35 There has been some debate about the legality of self-assessment. Some commentators have argued that a local authority cannot rely entirely on self-assessment since under section 47 of the NHSCCA 1990 it is the local authority who must take the final decision on the provision of services.<sup>40</sup> Partly in response to this concern, some local authorities have developed “co-produced self-assessments”, whereby whoever produces a care plan, it remains the role of the local authority to check and approve it.<sup>41</sup>

<sup>35</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, para 28. See also NAFWC 09A/2002 *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care: Guidance*, para 2.2.

<sup>36</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, para 13. Practice guidance issued in 1991 describes “needs” as shorthand for “the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life”: Department of Health Social Services Inspectorate, *Care Management and Assessment: A Practitioners Guide* (1991) p 12. The Welsh community care assessment guidance does not use the term “presenting needs”: NAFWC 09A/2002 *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care*.

<sup>37</sup> Department of Health, *Care Services Improvement Partnership, Self Assessment Project* (2006), <http://www.socialcare.csip.org.uk/index.cfm?pid=81> (last visited 28 June 2008).

<sup>38</sup> As above.

<sup>39</sup> I Lewis MP, Parliamentary Under Secretary of State for Care Services, Speech at Community Care Live Event (17 May 2006), [http://www.dh.gov.uk/en/News/Speeches/Speecheslist/DH\\_4135291](http://www.dh.gov.uk/en/News/Speeches/Speecheslist/DH_4135291) (last visited 11 November 2008).

<sup>40</sup> M Mandelstam, *Community Care Practice and the Law* (3rd ed 2005) pp 134 to 135.

<sup>41</sup> S Duffy, “Care Management and Self-Directed Support” (2007) 15 *Journal of Integrated Care* 3, 9.

### Issues for reform

- 4.36 We recommend that the review consider whether the various duties to assess should be consolidated into a single duty; the main advantages being greater clarity, consistency and less confusion for service users. One option would be to establish section 47 of the NHSCCA 1990, or a similarly worded provision, as the single duty to assess. One of the strengths of the section 47 duty is that it does not refer to categories of disability, but rather focuses on and refers only to *need*. A potential disadvantage of consolidating all the existing duties to assess (implied or express) is that it might remove some of the strong rights to services which are provided in other community care statutes. This issue is discussed in more detail below.
- 4.37 Another issue for the review is whether any consolidated duty to assess should also incorporate a right to request an assessment. Thus an assessment could be triggered by the appearance of need and also by a request from a service user or some other person(s).<sup>42</sup> A model for this is provided by the Mental Health (Care and Treatment) (Scotland) Act 1984, which allows specified people, such as the service user and his or her carer, to request a community care assessment and if this is refused, the local authority must give reasons in writing.<sup>43</sup> The question would be whether the ability to request an assessment offers any further benefits which are not contained in a general duty to assess based on the appearance of need.
- 4.38 A third issue to consider is whether it is necessary to retain the provision contained in section 47(2) of the NHSCCA 1990, which in effect creates a different assessment process for a disabled person (see paragraph 4.24 above). It is not obvious that this provision adds anything of substance to the normal community care assessment and indeed appears to add to the fragmented and confusing legal framework that regulates these assessments.

<sup>42</sup> For a discussion of this point, see Mental Health Alliance, *A Duty To Assess Needs: House of Commons Committee Stage Amendment Briefing* (2007), [http://www.mentalhealthalliance.org.uk/policy/documents/Commons\\_Cttee\\_Stage\\_Duty\\_Assess\\_Needs.pdf](http://www.mentalhealthalliance.org.uk/policy/documents/Commons_Cttee_Stage_Duty_Assess_Needs.pdf) (last visited 9 November 2008).

<sup>43</sup> See Mental Health (Care and Treatment) (Scotland) Act 1984, s 227.

- 4.39 There has been considerable commentary on the amount of guidance issued concerning the assessment process and the multiple assessment regimes for different service users.<sup>44</sup> In the White Paper, *Our Health, Our Care, Our Say*, the Government acknowledged the desire for greater integration between different services.<sup>45</sup> The Care Services Improvements Partnership also recognises that “difficulties arise from having three separate approaches for adults, particularly for individuals with multiple needs who have to negotiate the different systems”.<sup>46</sup> A further issue for the review will be to consider the appropriate boundary between primary legislation and soft law, such as departmental guidance, and whether the proliferation of guidance undermines the goals of consistency and clarity in the legislative framework.
- 4.40 An associated issue is the number of community care assessments a service user may have to endure and the duplication of information that arises. For example, a service user who moves area, or is being transferred to a different team, or is referred to a specialist service, may experience multiple assessments. We believe that the review should, therefore, also consider the portability of community care assessments.
- 4.41 We also recommend that the review should consider self-assessment and how this should fit into the legal framework.

## **CARERS’ ASSESSMENTS**

### **The statutory framework**

- 4.42 There are several statutes that deal directly with carers’ assessments. As with the duty to carry out a community care assessment, each subsequent Act builds on the earlier Act and does not repeal it.
- 4.43 The first statute to consider is the C(RS)A 1995. This provides that where a local authority is carrying out an assessment under section 47(1)(a) of the NHSCCA 1990 of a person, and an individual (the carer) provides or intends to provide a substantial amount of care on a regular basis for that person, the carer may request an assessment. This applies to all carers regardless of their age.
- 4.44 The assessment is of the carer’s ability to provide and to continue to provide care for the cared-for person. If the carer makes such a request, the local authority must carry out the assessment before it makes its decision as to whether the needs of the cared-for person call for the provision of any services and it must take the results of the assessment into account when making that decision.<sup>47</sup>

<sup>44</sup> See, for example, *Our Health, Our Care, Our Say: A New Direction for Community Service* (2006) Cm 6367, para 5.26. Also see <http://www.socialcare.csip.org.uk/index.cfm?pid=7> (last visited 9 November 2008).

<sup>45</sup> *Our Health, Our Care, Our Say: A New Direction for Community Service* (2006) Cm 6367, para 5.26.

<sup>46</sup> See <http://www.socialcare.csip.org.uk/index.cfm?pid=7> (last visited 9 November 2008).

<sup>47</sup> C(RS)A 1995, s 1(1).

- 4.45 One critical limitation of the C(SR)A 1995 is that a carer is only entitled to request an assessment at the time the person they care for is being assessed for community care services under section 47(1)(a) of the NHSCCA 1990. Thus, a carer's assessment could not take place in circumstances where, for example, the cared-for person had refused a community care assessment. A further limitation is that the C(RS)A 1995 includes no explicit power to provide services to carers.<sup>48</sup> The Department of Health acknowledged that this prevented carers "receiving help in their own right",<sup>49</sup> and promised to legislate to "ensure that authorities are able to address carer's wishes and needs more directly".<sup>50</sup>
- 4.46 The manifestation of this promise was the CDCA 2000. This Act widened the availability of a carer's assessment by giving carers a free standing right to an assessment independent of the assessment of the cared-for person. All that is required to qualify for the right to an assessment is that:
- (1) the carer is aged 16 years or over and provides or intends to provide a substantial amount of care on a regular basis for another individual aged 18 years or over;
  - (2) the carer requests the local authority to carry out an assessment of his or her ability to provide and to continue to provide care for the cared-for person; and
  - (3) the local authority is satisfied that the cared-for person is someone for whom it may provide or arrange for the provision of community care services.<sup>51</sup>
- 4.47 While this Act enables a carer to request an assessment in circumstances where the cared-for person has refused an assessment for, or the provision of, community care services, it still requires the assessment process to be triggered by the carer's request.<sup>52</sup> In order to request the assessment, the carer needs to know that they have this right.<sup>53</sup>
- 4.48 This limitation was addressed by a Private Member's Bill, the C(EO)A 2004, which placed a duty on local authorities 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 the C(SR)A 1995 or the CDCA 2000.<sup>54</sup>

<sup>48</sup> *R v Kirklees MBC ex p Good* (1997-98) 1 Community Care Law Reports 506.

<sup>49</sup> Department of Health, *Caring about Carers: A National Strategy for Carers* (1999) p 57.

<sup>50</sup> Department of Health, *Caring about Carers: A National Strategy for Carers* (1999) p 58.

<sup>51</sup> CDCA 2000, s 1(1). Section 2 of this Act also enables the provision of services directly to the carer.

<sup>52</sup> Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 4.

<sup>53</sup> Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 19.

<sup>54</sup> C(EO)A 2004, ss 1(1) and 1(2). Section 2 sets out the exceptions to this duty.

- 4.49 The C(EO)A 2004 also made an important addition to the nature of a carer's assessment by requiring that any assessment conducted under the C(SR)A 1995 or the CDCA 2000 must include consideration of whether the carer:
- (1) works or wishes to work; and
  - (2) is undertaking, or wishes to undertake, education, training or any leisure activity.<sup>55</sup>
- 4.50 This reflected the principle that "carers are entitled to the same life chances as others and should not be socially excluded as a result of their caring role".<sup>56</sup>
- 4.51 In addition to these statutes, section 8 of the DP(SCR)A 1986 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. Although this obligation is less substantial than a right to an assessment, this section is still important because it "exists in all cases and does not have to be triggered by a request from the carer".<sup>57</sup> Therefore, the obligation will exist even if the carer declines an assessment under the C(RS)A 1995 or the CDCA 2000. In such cases, guidance attached to the Community Care Assessment Directions 2004 provides that a carer's refusal to be assessed should not be "used as a reason to exclude the carer from assisting with care planning".<sup>58</sup>

#### **Definition of a carer**

- 4.52 The effect of the above statutes is that a carer is entitled to request – and to be informed of their right to request – an assessment of:
- (1) the sustainability of the caring relationship with the cared-for person; and
  - (2) the work, education and leisure needs of the carer.
- 4.53 In order to avail themselves of these rights, the person must come within the definition of a carer. The Acts generally define a carer in community care legislation in terms of their qualification for a carer's assessment.<sup>59</sup> That is, an individual must "provide or intends to provide a substantial amount of care on a regular basis for the relevant person".<sup>60</sup>

<sup>55</sup> C(EO)A 2004, s 2.

<sup>56</sup> Social Care Institute for Excellence, *Practice Guide 5: Implementing the Carers (Equal Opportunities) Act 2004* (2007), <http://www.scie.org.uk/publications/practiceguides/carersguidance/index.asp> (last visited 9 November 2008).

<sup>57</sup> L Clements and P Thompson, *Community Care and the Law* (4th ed 2007) p 527.

<sup>58</sup> LAC(2004)24, *The Community Care Assessment Directions 2004*, para 2.2.

<sup>59</sup> Note, however, that s 46(3) of the NHSCCA 1990 defines a private carer to mean "a person who is not employed to provide the care in question by any body in the exercise of its functions under any enactment". See also the definition of carer in Social Care Institute for Excellence, *Practice Guide 5: Implementing the Carers (Equal Opportunities) Act 2004* (2007), <http://www.scie.org.uk/publications/practiceguides/carersguidance/index.asp> (last visited 9 November 2008).

4.54 The two key requirements here are that the care be *substantial* and *regular*. The Department of Health practice guidance provides that:

The process of assessing the impact of the caring role on the carer, and thus whether the care provided is regular and substantial, is based on a consideration of two dimensions:

- Key factors relevant to sustaining the chosen caring role,
- Extent of the risk to the sustainability of that role.<sup>61</sup>

4.55 The requirements of *substantial* and *regular* appear to pertain to the impact of the caring role on the carer, rather than the nature of the care being provided to the person cared for. Practice guidance recognises that any judgment as to whether care is substantial and regular should recognise that it is not only the time spent caring that has an impact on carers. There are many different types of caring roles with many different impacts on the carers. As such, “any assessment of the carer’s need for support has to look at the impact of the whole caring situation”.<sup>62</sup> This is also consistent with the assessment process itself, which should “focus on outcomes the carer would want to see help them in their caring roles and maintain their health and well-being”.<sup>63</sup>

4.56 The C(SR)A 1995 and CDCA 2000 exclude from the definition of a carer, paid care workers and volunteers from a voluntary organisation. However the DP(SCR)A 1986 only excludes paid carers but not volunteers.<sup>64</sup> There is some uncertainty over whether these provisions would exclude a carer who had previously performed this role on an informal basis but is now being employed by the service user through a direct payment.<sup>65</sup>

### Young carers

4.57 Any carer below the age of 18 years is a “young carer”.<sup>66</sup> In particular, young carers are “children or young people under 18 who provide, or intend to provide, care, assistance or support to another family member”.<sup>67</sup>

<sup>60</sup> C(RS)A 1995, s 1(1).

<sup>61</sup> Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 48.

<sup>62</sup> As above, para 49.

<sup>63</sup> As above, para 29; Welsh Assembly, *Practitioners Guide to Carer’s Assessment* (2001) para 3.6.

<sup>64</sup> The definition of a carer provided in s 8(1)(a) of the DP(SCR)A 1986 excludes “persons employed to provide such care by any body in the exercise of its functions under any enactment”.

<sup>65</sup> It is likely that any care to which a direct payment relates should be disregarded when considering whether or not the carer is providing substantial and regular care.

<sup>66</sup> Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 35.

- 4.58 There is a widespread agreement that children should not be undertaking regular and substantial caring responsibilities or inappropriate personal care tasks.<sup>68</sup> Nevertheless, there is evidence of large numbers of young carers. The 2001 Census recorded a total of almost 150,000 young carers, of whom the most numerous group were 12-14 year olds who provided one to 19 hours of care each week.<sup>69</sup>
- 4.59 There is no specific legislation for young carers. However, the C(RS)A 1995 and C(EO)A 2004 apply equally to all carers regardless of their age. Thus a young carer may have a right to an assessment under C(RS)A 1995 to establish their ability to provide and continue to provide care, and a local authority is required to take that assessment into account in deciding what community care services to provide for the cared-for person.<sup>70</sup> In contrast, the CDCA 2000 only applies to carers aged 16 years or over, which creates the odd situation that while all young carers must be informed of their right to request an assessment, only young carers aged between 16 and 18 have a free standing right to a carer's assessment. In any event, any assessment of young carers – whether aged 15 or 17 – must take into account their wish to undertake extra-curricular pursuits.
- 4.60 Notwithstanding the availability of an assessment under the C(RS)A 1995, practice guidance advises that young carers should be “routinely assessed under the Children Act 1989”,<sup>71</sup> as they may be entitled to services in their own right under that Act. The Children Act 1989 – and the assessment framework which accompanies it<sup>72</sup> – is said to provide for a “more holistic” assessment.<sup>73</sup> Regardless, however, of the Act the young carer is assessed under, the obligation to consider a young carer's wish to work or undertake education, training or leisure set out in C(EO)A 2004 would still apply.<sup>74</sup>
- 4.61 To benefit from services under the Children Act 1989, a young carer must come within the definition of a *child in need*. This is defined in section 17(1) as a child:

<sup>67</sup> Social Care Institute for Excellence, *Practice Guide 5: Implementing the Carers (Equal Opportunities) Act 2004* (2007), <http://www.scie.org.uk/publications/practiceguides/carersguidance/index.asp> (last visited 9 November 2008).

<sup>68</sup> As above.

<sup>69</sup> Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) Foreword.

<sup>70</sup> Department of Health, *Framework for the Assessment of Children in Need and their Families* (2004) para 3.63.

<sup>71</sup> Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 10.

<sup>72</sup> Department of Health, *Framework for the Assessment of Children in Need and their Families* (2004).

<sup>73</sup> Social Care Institute for Excellence, *Practice Guide 5: Implementing the Carers (Equal Opportunities) Act 2004* (2007), <http://www.scie.org.uk/publications/practiceguides/carersguidance/index.asp> (last visited 9 November 2008).

<sup>74</sup> Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 10.

- (1) who is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him of services by a local authority; or
  - (2) whose health or development is likely to be significantly impaired, or further impaired without provision for him of such services; or
  - (3) who is disabled.
- 4.62 Practice guidance issued by the Social Care Institute for Excellence recognises that many young people carry out a level of caring responsibility which prevents them from enjoying normal social opportunities and from achieving full school attendance. Some of the detrimental effects on young people of being a carer include problems at school, health problems, emotional difficulties, isolation, and lack of leisure time.<sup>75</sup>
- 4.63 Given this, “many young carers with significant caring responsibilities should therefore be seen as children in need”.<sup>76</sup> As such, statutory guidance states that “an assessment of family circumstances is essential” because “young carers should not be expected to carry inappropriate levels of caring which have an adverse impact on their development and life chances”.<sup>77</sup>

#### **Parent carers**

- 4.64 A person with parental responsibility for a disabled child who provides or intends to provide a substantial amount of care on a regular basis for the disabled child is referred to as a *parent carer*. Pursuant to section 1(2) of the C(RS)A 1995 and section 6 of the CDCA 2000, parent carers are entitled to request an assessment of their ability to provide and to continue to provide care to a disabled child.
- 4.65 As with carers generally, in order to qualify for an assessment under the C(RS)A 1995, the local authority must be in the process of assessing the needs of the disabled child under the Children Act 1989 or the CSDPA 1970. The local authority must undertake the carer’s assessment before making its decision as to whether the needs of the disabled child call for the provision of services, and must take the results of the assessment into account in making that decision.
- 4.66 In relation to the CDCA 2000, the local authority must carry out an assessment if it is satisfied that the disabled child and their family are persons for whom it may provide or arrange for the provision of services under section 17 of the Children Act 1989.

<sup>75</sup> Social Care Institute for Excellence, *Practice Guide 5: Implementing the Carers (Equal Opportunities) Act 2004* (2007), <http://www.scie.org.uk/publications/practiceguides/carersguidance/index.asp> (last visited 9 November 2008).

<sup>76</sup> LAC(96)7, *Carers (Recognition and Services) Act 1995: Policy Guidance*.

<sup>77</sup> Department of Health, *Framework for the Assessment of Children in Need and their Families* (2004) para 3.62.

- 4.67 Pursuant to the C(EO)A 2004, a parent carer must be informed of their right to an assessment under the C(RS)A 1995 or CDCA 2000. In addition, any assessment conducted under the C(RS)A 1995 or CDCA 2000 must consider whether the parent carer works or wishes to work and whether the carer is undertaking, or wishes to undertake, any education, training or leisure activity.<sup>78</sup> This means “local authorities have a duty to ask carers about these activities and take their wishes into account when planning the care package”.<sup>79</sup>
- 4.68 In addition to these rights to an assessment, parent carers may have their needs addressed as part of their child’s assessment under the Children Act 1989. Statutory guidance provides specifically that “the needs of parent carers are an integral part of an assessment”.<sup>80</sup> In particular, “providing services which meet the needs of parents is often the most effective means of promoting the welfare of children, in particular disabled children”.<sup>81</sup> The local authority must take into account the results of any assessment carried out under the CDCA 2000 when deciding what services, if any, to provide under section 17 of the Children Act 1989.
- 4.69 There is some suggestion that there is a stigma attached to a parent having a child considered in need under the Children Act 1989. For some parents there is “an association with ‘child protection’, with children being at risk of harm, and with social workers’ roles of assessing parenting capability”.<sup>82</sup> This may particularly be the case for disabled parents.

#### **Issues for reform**

- 4.70 We recommend that the review considers whether the various duties regarding carers’ assessments – as set out in the DP(SCR)A 1986, C(RS)A 1995, CDCA 2000 and C(EO)A 2004 – should be consolidated into one central duty. The dual purpose of this duty would be to assess the carer’s ability to provide and to continue to provide care for the cared-for person, and to consider their desire to work or undertake education, training or any leisure activity.<sup>83</sup> Such a consolidation may have benefits in terms of both clarity and convenience for carers and local authorities.

<sup>78</sup> Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 71.

<sup>79</sup> As above, para 71.

<sup>80</sup> Department of Health, *Framework for the Assessment of Children in Need and their Families* (2004) para 1.29.

<sup>81</sup> As above, para 1.29.

<sup>82</sup> J Morris, “Independent Living and Community Care: A Disempowering Framework” (2004) 19 *Disability and Society* 427, 434.

<sup>83</sup> C(EO)A 2004, s 2.

- 4.71 A related issue to consolidating the duties is to consider whether the duty to undertake a carer's assessment should continue to be triggered by a request from the carer. The alternative (or additional option) would be to give local authorities a duty to undertake an assessment on the appearance of need for carers' services, which in effect would be a slightly modified version of the duty to assess contained in section 47 of the NHSCCA 1990.<sup>84</sup> If the latter approach was adopted, consideration could be given to whether the right to a carer's assessment should be rolled into a general duty to assess persons who appear to be in need of services – either because they are potentially the primary recipient of care, or they are a carer.
- 4.72 We believe that the review should also consider whether the legal threshold for qualifying as a carer for the purposes of a carer's assessment should be simplified. For example, it has been suggested that the requirement in the C(RS)A 1995 and the CDCA 2000 that any care provided must be *substantial* and *regular* is unclear and overly-reliant on the discretion of local authorities.<sup>85</sup> Moreover, a survey of carers in Wales found that only 38% of respondents had received an assessment and of those who had been turned down, the vast majority appeared to be providing regular and substantial care.<sup>86</sup>
- 4.73 The review should also consider the current exemption that applies to employed carers and how this affects the position of carers who in the past had performed this role on an informal basis but are now being employed by the service user through a direct payment.
- 4.74 A further issue is whether the overlap between adult social care legislation and the Children Act 1989, in relation to carers' assessments, could be simplified. One option would be for the law relating to carers to apply regardless of the age of the carer, so long as the age of the cared-for person is 18 years or over. Thus if the cared-for person is 18 years or over, the carer would have the right to an assessment regardless of whether they were under or over the age of 18. An alternative would be to restrict carer's assessments to people aged 18 and over, regardless of the age of the cared-for person. Carers under the age of 18 would instead be assessed under the Children Act 1989.

<sup>84</sup> It can be argued that a similar right to a carer's assessment on the appearance of need (albeit a limited one) already exists. Since the needs of a carer are inextricably linked to the needs of the cared for person, then the appearance of need for carers services would trigger a community care assessment and, even if a carer's assessment has not been requested or even refused, then under the DP(SCR)A 1986 the local authority must still have regard to the ability of the carer to continue to provide a substantial amount of care on a regular basis.

<sup>85</sup> See, for example, J Leece, "Extending Direct Payments to Informal Carers: Some Issues for Local Authorities" (2002) 14 *Practice* 31.

<sup>86</sup> Wales Carers Alliance, *Carer Assessment Survey* (2004).

## HOSPITAL DISCHARGE

- 4.75 The CC(DD)A 2003 added an additional layer to the community care assessment process by creating separate procedures for NHS patients who are being discharged from acute medical care. This Act was a response to the problem of delayed discharges in NHS hospitals and it establishes statutory time scales for the completion of community care assessments and fines or reimbursements if a delay in discharge is caused by social services.
- 4.76 These provisions do not at present cover discharge from mental health hospitals, maternity care, palliative care, intermediate or rehabilitative or recuperation care.<sup>87</sup> However, there is a power in the CC(DD)A 2003 to extend the provisions to other categories of patients.<sup>88</sup>
- 4.77 In 2007 the Department of Health launched a project “to consider the practical steps, support materials and policy levers (including reimbursement) to secure effective discharge practice in non-acute and mental health services”.<sup>89</sup>
- 4.78 The CC(DD)A 2003 has only been implemented in England. The National Assembly for Wales has the option of implementing the provisions in Wales, but “it has no intention of doing so for the foreseeable future”.<sup>90</sup>

### The notification and assessment process

- 4.79 Where the NHS authority considers that it is unlikely to be safe to discharge a patient from hospital unless community care services are made available, then they are under a duty to give notice in writing to the appropriate social services authority. This is known as the *assessment notification*. Before issuing this notice the NHS authority must consult both the patient and where appropriate their carer(s). Directions have also been issued which require the NHS to satisfy itself that a patient is not entitled to NHS Continuing Healthcare before it issues a notification.<sup>91</sup>

<sup>87</sup> Delayed Discharge (England) Regulations 2003, SI 2003 No 2277, reg 3.

<sup>88</sup> CC(DD)A 2003, s 1. Any extension to cover mental health care would, however, be subject to the affirmative resolution procedure in Parliament: s 11(4).

<sup>89</sup> See [http://www.dh.gov.uk/en/Healthcare/IntegratedCare/Delayeddischarges/DH\\_4126246](http://www.dh.gov.uk/en/Healthcare/IntegratedCare/Delayeddischarges/DH_4126246) (last visited 29 June 2008).

<sup>90</sup> LAC(2003)21, *Community Care (Delayed Discharge) Act 2003: Guidance for Implementation*, para 30.

<sup>91</sup> The NHS Continuing Healthcare (Responsibilities) Directions 2007, dir 2.

- 4.80 Once the assessment 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 which, if any, of those services will be provided. The CC(DD)A 2003 refers to a *minimum interval* after the assessment notification has been issued, which is the minimum period provided for social services to carry out these assessments and is set at 2 days.<sup>92</sup> A social services authority cannot be charged for a delay before the minimum interval has elapsed.<sup>93</sup>
- 4.81 The NHS authority is also required to issue a *discharge notification* to the social services authority at least one day before the proposed discharge date.

### **Delayed discharge payments**

- 4.82 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 carers that it had decided to make available, the culpable local authority will have to 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.<sup>94</sup>

### **Disputes**

- 4.83 A person can challenge a discharge decision through the appropriate complaints procedure but in the meantime they do not have the right to stay in hospital and the NHS and social services should consider providing suitable non-acute care.<sup>95</sup> If the dispute relates to NHS Continuing Healthcare decisions then the person can apply to a review panel set up by the Strategic Health Authority.<sup>96</sup>
- 4.84 In cases of disputes between public authorities, the bodies may apply to the Strategic Health Authority for the appointment of a panel.<sup>97</sup>

<sup>92</sup> Delayed Discharge (England) Regulations 2003, SI 2003 No 2277, reg 6.

<sup>93</sup> The guidance makes it clear, however, that there are few patients for whom a payment would be liable immediately after the minimum interval, since the majority of patients likely to need services on discharge are older people and will remain in hospital longer than three days. See LAC(2003)21, *Community Care (Delayed Discharge) Act 2003: Guidance for Implementation*, para 77.

<sup>94</sup> Delayed Discharge (England) Regulations 2003, SI 2003 No 2277, reg 7 and sch. The Higher Rate Authorities are mainly located in and around London.

<sup>95</sup> LAC(2003)21, *Community Care (Delayed Discharge) Act 2003: Guidance for Implementation*, para 96.

<sup>96</sup> Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* (2007).

<sup>97</sup> Delayed Discharge (England) Regulations 2003, SI 2003 No 2277, reg 15.

### **Impact of the delayed discharge procedures**

- 4.85 Supporters of the delayed discharge provisions point out that hospital beds are a scarce resource and prolonged stays can lead to poor recovery rates through loss of physical functioning, hospital infection or increased dependency. Statistics also indicate that since 2003 there has been a decline in the number of “bed days” lost through delayed discharge from acute hospitals in England: for example from 776,101 in 2005-06 to 733,000 in 2006-07 (a fall of 5.6%).<sup>98</sup>
- 4.86 However, concern has been raised that the new procedures may have led to people being discharged prematurely or placed in unsuitable residential accommodation in order that local authorities can avoid paying the reimbursement charges. It has been pointed out that while delayed discharges are being reduced, emergency readmissions to hospital in England are on the increase, rising from 203,095 in 2004-05 to 221,847 in 2005-06.<sup>99</sup> In 2007, the Joint Committee on Human Rights reported that the premature or inappropriate discharge of older people could lead to their readmission shortly afterwards and recommended that the delayed discharge regulations should be amended “to allow for flexibility in applying the time period so as to ensure that the Article 8 ECHR rights of older people are respected”.<sup>100</sup>

### **Issues for reform**

- 4.87 We recommend that the review consider the legal framework for discharging NHS patients from acute medical care, and in particular, whether or not the procedures could be refined or simplified.

## **ELIGIBILITY FOR SERVICES**

### **Eligibility criteria**

- 4.88 Once a local authority has carried out an assessment under section 47(1)(a) of the NHSCCA 1990 of an individual’s presenting needs, it must then decide which, if any, of those needs call for the provision of services. The relevant statutory guidance is FACS in England, and UFSAMC in Wales, both of which have been issued to help local authorities make this decision.<sup>101</sup> Although they differ in detail and emphasis, both the FACS and UFSAMC essentially establish the same overall standardised framework for setting eligibility criteria for social care services.

<sup>98</sup> Announcement by I Lewis MP, reported in the Guardian 9 November 2007, <http://www.guardian.co.uk/society/2007/nov/09/nhs.longtermcare> (last visited 9 November 2008).

<sup>99</sup> Information Centre, *Compendium of Clinical and Health Indicators* (2007). Also, see The Human Rights of Older People in Healthcare, Report of the Joint Committee on Human Rights (2006-07) HL 156-1, HC 378-1, para 35.

<sup>100</sup> The Human Rights of Older People in Healthcare, Report of the Joint Committee on Human Rights (2006-07) HL 156-1, HC 378-1, para 40.

<sup>101</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care* and NAFWC 09A/2002 *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care*.

- 4.89 The eligibility framework is graded into four bands: *critical*; *substantial*; *moderate*; and *low*. Each band includes a number of descriptors or risk factors. Local authorities may add additional risk factors within a band but they cannot delete or amend the wording of the eligibility framework.<sup>102</sup> Although all social services must use this framework, each authority has discretion to decide which of the four bands it will include in its eligibility criteria. If the individual's presenting needs fall into one or more bands that the local authority has decided it will provide services to meet, such needs are termed "eligible needs" and the local authority must meet those needs.<sup>103</sup>
- 4.90 When deciding into which band a presenting need should be placed, the local authority must evaluate the person's presenting need "against the risks to his/her autonomy, health and safety, ability to manage daily routines, and involvement in family and wider community life" both in the immediate and longer-term.<sup>104</sup>
- 4.91 Crucially in deciding which of the four bands it will include in its eligibility criteria, the local authority can take account of its resources, local expectations and local costs.<sup>105</sup> This in part reflects the ruling in *R v Gloucestershire CC ex p Barry*, where the majority held that a local authority was entitled to have regard to costs and available resources when deciding which services to provide to a client under section 2 of the CSDPA 1970.<sup>106</sup>
- 4.92 However, resources cannot be the sole factor in deciding which of the bands to include in its eligibility criteria. Lord Nicholls of Birkenhead in *R v Gloucestershire CC ex p Barry* explained this principle in the following terms:

In the course of the argument some emphasis was placed upon a submission that if a local authority may properly take its resources into account in the way I have described, the section 2(1) [of the CSDPA 1970] duty would in effect be limited to making arrangements to the extent only that the authority should decide to allocate money for this purpose. The duty, it was said, would collapse into a power. I do not agree. A local authority must carry out its functions under section 2(1) [of the CSDPA 1970] in a responsible fashion. In the event of a local authority acting with Wednesbury unreasonableness ... a disabled person would have a remedy.<sup>107</sup>

<sup>102</sup> Department of Health, *Fair Access to Care Services: Practice Guidance: Implementation Questions and Answers* (2003) Q 3.1.

<sup>103</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, para 52. Although the Welsh guidance does not include this exact statement, the point is implicit throughout, see NAFWC 09A/2002 *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care*, paras 5.4, 5.5, 5.13 and 5.32.

<sup>104</sup> As above, para 42 (England) and para 5.10 (Wales). The Welsh guidance refers to evaluating the assessment domains against four key factors of independence.

<sup>105</sup> As above, para 18 (England) and para 5.19 (Wales).

<sup>106</sup> [1997] 2 All ER 1.

<sup>107</sup> As above, at 12.

- 4.93 A local authority must comply with general duties to combat discrimination when setting its eligibility criteria. In *R (Chavada) v Harrow LBC* the court struck down a decision of the authority to restrict community care services to those with critical needs alone on the basis that there was no evidence that the authority had taken into account its duty under section 45A of the Disability Discrimination Act 1995 to have due regard, in carrying out their functions, to the need to eliminate unlawful discrimination and promote equality of opportunity for disabled people.<sup>108</sup>

#### **Concerns about eligibility criteria**

- 4.94 To some degree, the criticisms of FACS and UFSAMC may reflect concerns about an inadequately funded social care system, rather than any inherent fault with the eligibility framework itself. Nevertheless, many of these criticisms can also be linked to the structure of the legal framework.
- 4.95 As noted in Part 2 of this report, concerns have been raised that FACS and UFSAMC have led to regional variations in eligibility for services. The introduction of a national framework was intended to promote “a more consistent approach to eligibility and fairer access to care services across the country”, however, the guidance does not require councils to make identical decisions about eligibility “nor prescribes what services should be available to service users who have similar needs”.<sup>109</sup> This can mean that disabled people are unable to move to another local authority for fear that their care package may be discontinued.
- 4.96 Concerns about the ever-tightening eligibility criteria for adult social care and the rising number of people excluded from services are well documented. For example, two reports published in 2008 by the Commission for Social Care Inspection, found that a growing number of councils in England are restricting services to people with the highest level of need and that individuals and families increasingly have to find and pay for their own social care.<sup>110</sup>
- 4.97 The FACS guidance in England is explicit that a local authority can decide to provide services to meet critical needs only:

Starting with the critical band, if the estimated costs of providing services to individuals with needs in this band equals the resources locally available to adult social care, then the council’s eligibility framework would simply comprise the critical band.<sup>111</sup>

- 4.98 This statement has been the subject of some criticism – especially due to a number of concerns, which are listed below, that the critical band described in FACS is too severe and overly restrictive:

<sup>108</sup> [2007] EWHC 3064 (Admin), [2007] 100 BMLR 27.

<sup>109</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, para 1.

<sup>110</sup> Commission for Social Care Inspection, *The State of Social Care in England 2006-07* (2008). For example, para 7.23 reports that three councils have restricted their eligibility to critical needs only. See also M Henwood and B Hudson, *Lost to the System: the Impact of Fair Access to Care* (2008).

<sup>111</sup> Department of Health, *Fair Access to Care Services: Practice Guidance: Implementation Questions and Answers* (2003) Q 3.9.

- (1) the FACS guidance on the critical band states that “life is, or will be threatened”, whereas the Welsh description of the critical band is that “life is, or could be, threatened”;<sup>112</sup>
- (2) the critical band, as described in FACS, refers to “serious abuse or neglect” and therefore suggests that in some circumstances it would be acceptable to deny support based on “abuse or neglect”; whereas the Welsh guidance requires all abuse to be recorded as “critical”;<sup>113</sup> and
- (3) the FACS guidance does not include “an inability to carry out the majority of personal care or domestic routines” in the critical band. This is only included under the substantial band in the guidance.<sup>114</sup>

4.99 The severity of the critical band has also provoked judicial criticism:

An ordinary interpretation of Mrs Bernard’s needs suggests that they are more likely to fall into the “substantial” band rather than the “critical”. If correct this means either that the critical band descriptors are too severe, or that the FACS guidance on this issue is mistaken.<sup>115</sup>

4.100 In addition to the concerns outlined above, the Commission for Social Care Inspection noted a number of other criticisms of FACS in its recent review of eligibility criteria.<sup>116</sup> These included: a lack of clarity and transparency; a lack of fairness; service-led rather than needs-led approaches; limitations of a risk/needs-based model; insularity and fragmentation; neglect of the prevention and inclusion agendas; inadequate diversion and signposting; dominance of budgetary considerations; and tensions with the personalisation agenda.<sup>117</sup> It recommended a new system which replaces the FACS criteria with three “priorities for intervention” as a means of allocating public resources: immediate, early and longer-term intervention.<sup>118</sup>

<sup>112</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care*, para 16 and NAFWC 09A/2002 *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care*, para 5.16.

<sup>113</sup> L Clements and P Thompson, *Community Care and the Law* (4th ed 2007) para 3.200.

<sup>114</sup> As above, para 3.200.

<sup>115</sup> *R (Bernard) v Enfield LBC* [2002] EWHC 2282 (Admin), (2002) 5 Community Care Law Reports 577 at [88], by Sullivan J.

<sup>116</sup> Commission for Social Care Inspection, *Cutting the Cake Fairly: CSCI Review of Eligibility Criteria for Social Care* (2008).

<sup>117</sup> As above, pp 32 to 44.

<sup>118</sup> As above, pp 9 to 10.

### **Issues for reform**

- 4.101 In its response to the Commission for Social Care Inspection's review of FACS, the Department of Health announced plans to issue revised FACS guidance to put to consultation in spring 2009.<sup>119</sup> We propose that our review should cover the issues raised above to the extent that it can helpfully add to the Government's review in this area.
- 4.102 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 people face when moving from one local authority area to another because they are unable to find out in advance what package of community care services will be made available to them in the new area. The substantive review will, therefore, consider the extent to which the legal framework governing eligibility criteria and the ordinary residence rules (see below) contributes to these difficulties.
- 4.103 We also recommend that the review should consider whether the legal framework could be clarified or refined, to address some of the concerns that have been raised about restrictive eligibility criteria and the portability of services. The options might include one or more of the following:
- (1) the use of statutory principles to inform the setting of eligibility criteria;
  - (2) the inclusion of a purpose clause which would require that eligibility criteria must be set to achieve a number of aims, such as eliminating discrimination and to respect and promote human rights; and
  - (3) a requirement for local authorities to consider or consult the views of local service users, carers and other interested parties, before setting the eligibility criteria.

### **Carers**

- 4.104 The C(RS)A 1995 provides that when a local authority carries out an assessment of an adult under section 47 of the NHSCCA 1990 or a child under section 2 of the CSDPA 1970 or Part 3 of the Children Act 1989, a carer can request an assessment of their own ability to provide care to that individual. The assessment of the carer must then be taken into account when deciding what the needs of the individual being assessed under the NHSCCA 1990, the CSDPA 1970 or the Children Act 1989 are. However, the C(RS)A 1995 includes no explicit legal power to provide services to carers other than an assessment.<sup>120</sup>
- 4.105 In contrast the CDCA 2000 requires local authorities to carry out a carer's assessment and decide:

<sup>119</sup> Department of Health, *Cutting the Cake Fairly: CSCI Review of Eligibility Criteria for Social Care: Government Response* (2008).

<sup>120</sup> *R v Kirklees MBC ex p Good* (1997-98) 1 Community Care Law Reports 506.

- (1) whether the carer has any needs in relation to the care which they provide or intend to provide;
- (2) if so, whether they could be satisfied (wholly or partly) by services which the local authority may provide; and
- (3) if they could be so satisfied, whether or not to provide services to the carer.<sup>121</sup>

4.106 However, the provision of services to carers under the CDCA 2000 is discretionary. According to practice guidance issued by the Department of Health, a carer's assessment should use the same grading system as the FACS guidance (critical, substantial, moderate and low) to assess risk to the sustainability of the caring role.<sup>122</sup> However, 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. Additional guidance issued by the Social Care Institute for Excellence does, however, suggest that in the case of a critical risk being identified in the carer's assessment, then this would trigger an obligation on the local authority to make an appropriate response to address this risk.<sup>123</sup>

#### ***Issues for reform***

4.107 We recommend 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.

#### **ORDINARY RESIDENCE**

4.108 The ordinary residence rules are intended to establish which local authority is primarily responsible for a person in need of services, based on his or her residency in the area. For service users, establishing which local authority has responsibility for providing care services may be crucial, particularly if one local authority has a more generous eligibility criteria than the other.

<sup>121</sup> CDCA 2000, s 2(1).

<sup>122</sup> Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) para 70. This point is not covered in the equivalent practice guidance issued in Wales: Welsh Assembly, *Practitioners Guide to Carers' Assessment: Carers and Disabled Children Act 2000* (2001).

<sup>123</sup> Social Care Institute for Excellence, *Practice Guide 5: Implementing the Carers (Equal Opportunities) Act 2004* (2007), under "essential steps/clear published eligibility criteria", <http://www.scie.org.uk/publications/practiceguides/carersguidance/index.asp> (last visited 9 November 2008).

4.109 Some local authority duties to provide services depend on whether the person in need of services is ordinarily resident in their area. For example, the provision of residential accommodation and community services to disabled people under Part 3 of the NAA 1948 becomes a *duty* if the person is ordinarily resident in the local authority's area (or is in urgent need and of no settled residence); and a *power* if the person is not ordinarily resident in the authority's area.<sup>124</sup> Furthermore, the duty to provide domiciliary services under section 2 of the CSDPA 1970 applies only to those ordinarily resident in the authority's area and no power is established to provide those services to non-residents.

4.110 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" and involves questions of fact and degree.<sup>125</sup> Factors such as times, intention and continuity, each of which may be given different weight according to the context, have to be taken into account.<sup>126</sup>

4.111 In *R v Barnet LBC ex p Shah*, Lord Scarman held that:

Unless ... it can be shown that the statutory framework or the legal context in which the words are used requires a different meaning, I unhesitatingly subscribe to the view that "ordinarily resident" refers to a man's abode in a particular place or country which he has adopted voluntarily and for settled purposes as part of the regular order of his life for the time being, whether of short or of long duration.<sup>127</sup>

4.112 Cases where the relevant person lacks capacity to decide where to live or where the place of residence has not been voluntarily adopted can cause particular difficulties. For example:

- (1) in *R v Waltham Forest LBC ex p Vale*<sup>128</sup> the 28 year old applicant, who had severe learning disabilities and was totally dependent on her parents, was found to be ordinarily resident with her parents which was where she was temporarily living at the time. It was held that voluntarily adopted residence and settled purpose did not arise, and her parents' home was her base in the same way as it was for a small child; and
- (2) in *R (Mani) v Lambeth LBC*<sup>129</sup> it was held that accommodation arranged for an asylum seeker by the National Asylum Seekers Support Service for six months had been voluntarily adopted.

<sup>124</sup> 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*, Appendix 1 para 2(1)(b) and Appendix 2 para 2(1).

<sup>125</sup> LAC(93)7, *Ordinary Residence*, para 2 and WOC 41/93, *Ordinary Residence – Personal Social Services*, para 4.

<sup>126</sup> As above, para 4.

<sup>127</sup> *R v Barnet LBC ex p Shah* [1983] 2 AC 309 at 343.

<sup>128</sup> *R v Waltham Forest LBC ex p Vale*, *The Times* 25 February 1985.

<sup>129</sup> *R (Mani) v Lambeth LBC* [2003] EWCA Civ 836, [2004] LGR 35.

- 4.113 The importance of ordinary residence varies between different statutes. It does not, for example, apply to services for older people under the HSPHA 1968 and services under the NHS Acts 2006. For a carer's assessment under the C(RS)A 1995 or the CDCA 2000 the ordinary residence rules do not apply in the same way. Where the carer lives some distance away from the cared-for person it will be the cared-for person's local authority that will be responsible for the assessment and provision of any services.<sup>130</sup>

#### **Concerns about ordinary residence**

- 4.114 General concerns have been raised that the ordinary residence rules undermine the freedom of movement of many disabled people by failing to guarantee the portability or continuity of support services when they move from one area to another.<sup>131</sup> This was summed up by Lord Low during the Parliamentary debates on the Health and Social Care Bill 2007 as follows:

It is a fundamental principle that the ability to change one's place of ordinary residence should not be dependent on purely administrative considerations or the convenience of health and social care systems and that a framework should be put in place for the transfer of funds between authorities so that the issue of ordinary residence can no longer be used as a basis for refusing to provide care and support.<sup>132</sup>

- 4.115 A further concern has been expressed about the impact of the ordinary residence rules on people in care homes. Section 24(5) of the NAA 1948 states that where a person is provided with residential accommodation under Part 3, they shall be deemed ordinarily resident in the area in which they were ordinarily resident immediately before residential accommodation was provided. The guidance specifies that if the person has been placed in a care home in another authority's area then the placing authority will normally retain the same responsibility that it has for someone living in its own area.<sup>133</sup> If subsequently, the person moves out of the care home to live independently in the area in which they have been living, then the local authority in which the person was placed becomes financially responsible. This has led to a number of criticisms. For example, it has been suggested that:

<sup>130</sup> 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. This point is not explicitly made in the equivalent Welsh guidance but is strongly implied, see The National Assembly for Wales, *Practitioners Guide to Carers' Assessment: Carers and Disabled Children Act 2000* (2001) para 4.3.1.

<sup>131</sup> For example, Baroness Campbell of Surbiton moved an amendment to the Health and Social Care Bill 2007 which would have provided that service users moving from one authority to another, were entitled, for a transitional period, to equivalent services or direct payments to cover their support needs before they undergo an assessment in the new authority: *Hansard* (HL), 22 May 2008, vol 701 col GC640.

<sup>132</sup> *Hansard* (HL), 22 May 2008, vol 701, col GC643 (Lord Low).

<sup>133</sup> LAC(97)3, *Ordinary Residency*, para 72 and WOC 41/93, *Ordinary Residence – Personal Social Services*, para 7.

- (1) the rules create a perverse financial incentive for placing authorities to encourage disabled people living in registered care homes out of area to move into the local community under tenancies too soon, or to encourage out of area homes to de-register so that the original placing authority no longer retains financial responsibility for their clients' personal support costs;<sup>134</sup>
- (2) the rules create a perverse incentive for the authority in which the person is placed, to oppose any decision by the resident to move into independent accommodation in the authority's area because the authority would then become responsible for funding that person's home care;<sup>135</sup> and
- (3) the rules reward local authorities who encourage, but do not make any arrangements for, "self-funders"<sup>136</sup> to move into a care home in another authority. This is because when the person's capital falls below the relevant amount for residential accommodation under the NAA 1948, they will become ordinarily resident in the new local authority. The courts have upheld this approach, unless the first local authority should have made the necessary arrangements and failed to do so.<sup>137</sup> The local authority can provide self-funders with advice and information about the care home and even go on to help them to move in and settle, but will not be seen as having arranged the accommodation, unless the local authority has entered into a contract with the care home.<sup>138</sup>

<sup>134</sup> *Hansard* (HL), 23 July 2007, vol 694, cols 608 to 610 (Lord Low).

<sup>135</sup> Voluntary Organisations Disability Group, *No Place Like Home* (2007).

<sup>136</sup> Self-funders are people who fund their own social care services without any financial assistance from a local authority.

<sup>137</sup> *R (Greenwich LBC) v Secretary of State for Health and Bexley LBC* [2006] EWHC 2576 (Admin), (2007) 10 *Community Care Law Reports* 60.

<sup>138</sup> The Hounslow and Surrey determination (1996), discussed in: S Bull, "Ordinary Residence – Choice or Chance?" (2008) 11 *Community Care Law Reports* 215, 221.

- 4.116 Concern has also been raised about the complex inter-relationship between local authority rules on ordinary residence and NHS rules on establishing the responsible commissioner for NHS services. In England, where the patient is registered with a General Practitioner (GP), the responsible commissioner will be the primary care trust (PCT) that holds the contract with that GP practice.<sup>139</sup> If a patient is not registered with a GP, the responsible commissioner will be the PCT in whose geographic area the patient is “usually resident”, which is based on the patient’s perception of where they live.<sup>140</sup> In Wales, the system is based on where the person is usually resident rather than which GP they are registered with.<sup>141</sup> The complex inter-relationship between the local authority and NHS rules means that a person could be living in one area but be provided with health care services from a PCT or health board in a different area and social care services from a local authority in another different area.

### **Ordinary residence disputes**

- 4.117 In most cases, ordinary residence is clear-cut but disputes can arise. Under section 32(3) of the NAA 1948, the Secretary of State or Welsh Ministers are responsible for determining any questions as to the ordinary residence of a person arising under Part 3 of the NAA 1948. As a result of the Health and Social Care Act 2008, ordinary residence disputes for the purposes of services provided under the CSDPA 1970 are also determined by the Secretary of State or Welsh Ministers.<sup>142</sup>
- 4.118 Where a person has been assessed as needing services under the NAA 1948 or the CSDPA 1970, then the guidance states that one of the authorities involved in the dispute should have provisionally accepted liability to provide the services before the Secretary of State or Welsh Ministers are approached for a determination.<sup>143</sup> This is subject to reimbursement under section 32 of the NAA 1948, if the local authority is subsequently found not to be responsible, and also does not mean that the local authority is conceding liability in the future.

<sup>139</sup> NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administrations Arrangements) (England) Regulations 2002, SI 2002 No 2469, as amended.

<sup>140</sup> Department of Health, *Who Pays? Establishing the Responsible Commissioner* (2007) Annex A.

<sup>141</sup> Local Health Board (Functions) (Wales) Regulations 2003, WSI 2003 No 150, as amended.

<sup>142</sup> Before the implementation of this Act, ordinary residence disputes under the NAA 1948 were determined by the Secretary of State or the Welsh Ministers, whereas ordinary residence disputes under the CSDPA 1970 were determined by the court. See *R v Kent CC ex p S*, *R v Kent CC ex p Pierre* [2000] 1 FLR 155.

<sup>143</sup> LAC(93)7, *Ordinary Residence*, para 26 and WOC 41/93, *Ordinary Residence – Personal Social Services*, para 32.

- 4.119 The duty to assess under section 47 of the NHSCCA 1990 does not depend on the person being ordinarily resident in the local authority's area or whether the local authority is prepared to exercise its discretion to provide services to such a person.<sup>144</sup> This will, therefore, include people whose ordinary residence is in dispute and the expectation of the Department of Health is that "the local authority where the person currently is" will carry out the assessment.<sup>145</sup>
- 4.120 In the case of cross-border disputes, where one or more of the local authorities is in England and one or more in Wales, either the Secretary of State or the Welsh Ministers will determine the case, depending on where the person whose ordinary residence is disputed currently lives.<sup>146</sup> This arrangement has been criticised because full legal responsibility may not remain with whichever body makes the determination. The Health and Social Care Act 2008 gives the Secretary of State and Welsh Ministers power to make and publish arrangements in relation to cross-border disputes, which are likely to ensure that responsibility remains with the body making the determination.
- 4.121 During the Parliamentary debates on the Health and Social Care Bill 2007, the Government announced that guidance will be updated by early 2009 to help local authorities decide who should pay for an individual's care and that directions will be issued in 2008 setting out the steps that local authorities should take to resolve the dispute initially and the documents that must be provided in cases where the dispute is referred to the Secretary of State.<sup>147</sup>

#### ***Criticisms of the dispute process***

- 4.122 The procedures for determining ordinary residence disputes have been criticised as costly and time consuming. For example, Lord Low on behalf of the Local Government Association has suggested that disputes can "drag on for months and even years".<sup>148</sup> A report in 2007 by the Voluntary Organisations Disability Group estimated that at least 500 people are caught up in ordinary residence disputes at any one time, costing an estimated £3 million a year in legal fees and administrative costs for local authorities.<sup>149</sup>

<sup>144</sup> *R v Berkshire CC ex p P* (1997-98) 1 Community Care Law Reports 141.

<sup>145</sup> M Pedler, "Ordinary Residence under the National Assistance Act 1948: a Department of Health Perspective" (2008) 11 *Community Care Law Reports* 207, 213.

<sup>146</sup> Arrangement under section 41 of the Government of Wales Act 1998 between the National Assembly for Wales and the Secretary of State for Health: attached to a letter from David Behan, Department of Health, *Determining Ordinary Residence Disputes Between English and Welsh Authorities* (7 December 2007), [http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH\\_081151?IdcService=GET\\_FILE&dID=155802&Rendition=Web](http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_081151?IdcService=GET_FILE&dID=155802&Rendition=Web) (last visited 9 November 2008).

<sup>147</sup> *Hansard* (HL), 22 May 2008, vol 701, cols GC646 to GC647 (Baroness Thornton).

<sup>148</sup> As above, col GC643 (Lord Low).

<sup>149</sup> Voluntary Organisations Disability Group, *No Place Like Home* (July 2007) pp 35 to 36.

- 4.123 Part of the reason for this delay may be ongoing negotiations between local authorities to resolve the dispute informally, which can turn into “an unseemly squabble”.<sup>150</sup> In addition, the Department of Health has been criticised for the length of time taken to make ordinary residence determinations. The Department has stated that it aims to have a determination sent to the parties within three months of receipt of a full set of papers and where cases take longer it is often because further documentation has been requested.<sup>151</sup>

#### **Issues for reform**

- 4.124 As noted in paragraph 4.102 above, the review will consider the extent to which the legal framework governing eligibility criteria and the ordinary residence rules contribute to the problems that people face when moving to another area because their care package may be discontinued.
- 4.125 We believe that the review should also consider the definition of ordinary residence and whether this needs to be clarified or simplified. A further issue is whether the ordinary residence rules should apply consistently to all adult social care services, including those which currently come under the HSPHA 1968 and the NHS Acts 2006.
- 4.126 We also recommend that the review consider the legal mechanism for resolving disputes and whether a referral to the Secretary of State or the Welsh Ministers is the most effective means of dealing with disputes. One option would be to consider whether a community care tribunal would be a more appropriate body for resolving ordinary residence disputes.

#### **THE PROVISION OF SERVICES**

- 4.127 The various powers and duties which enable social services authorities to provide adult social care services are scattered across a range of statutes and secondary legislation. As noted in Part 2, the various legal provisions sometimes reflect incompatible principles, and are often convoluted and frequently overlap.
- 4.128 The formula adopted by most of the main statutes is to entitle similar but not identical groups of clients, to similar but not identical services. In order to understand the legal entitlement to services it is therefore not only necessary to understand which services can be provided but also which client groups are entitled to these services.
- 4.129 This section of the scoping report will consider the types of services that can be provided and is divided into: care homes and residential accommodation; community and domiciliary services; carers’ services; after-care services; services for disabled children; and transition services. The next section will consider which client groups are eligible for services.

<sup>150</sup> S Bull, “Ordinary Residence – Choice or Chance?” (2008) 11 *Community Care Law Reports* 215, 216.

<sup>151</sup> M Pedler, “Ordinary Residence under the National Assistance Act 1948: a Department of Health Perspective” (2008) 11 *Community Care Law Reports* 207, 213.

### Care homes and residential accommodation

4.130 The powers and duties given to local authorities to arrange residential accommodation are primarily contained in section 21 of the NAA 1948. This enables a local authority to provide residential accommodation “with the approval of the Secretary of State and to such extent as he may direct”.<sup>152</sup> The relevant directions issued under this section establish a duty to provide residential accommodation in the following circumstances:

- (1) the person is aged 18 or over;
- (2) due to age, illness, disability or any other circumstance he or she is in need of care and attention not otherwise available to them; and
- (3) the person is ordinarily resident in the social services authority’s area or in urgent need of residential accommodation, or (in relation to persons who are or have been suffering from mental disorder, or for the purpose of the prevention of mental disorder) has no settled residence but is in the authority’s area.<sup>153</sup>

4.131 The relevant approvals issued under section 21 of the NAA 1948 also give local social services authorities the power to provide residential accommodation for:

- (1) persons aged 18 or over who by reason of age, illness, disability or any other circumstance are in need of care and attention not otherwise available to them, who are ordinarily resident in the area of another local authority, with the consent of that authority; and
- (2) expectant and nursing mothers (of any age)<sup>154</sup> in need of care and attention not otherwise available to them.<sup>155</sup>

4.132 Residential accommodation can be provided in premises managed by the local authority or by another local authority.<sup>156</sup> Section 26(1) of the NAA 1948<sup>157</sup> allows local authorities to discharge their duty to provide residential accommodation by arrangements with the private and voluntary sector.

<sup>152</sup> NAA 1948, s 21(1). As a result of the transfer of functions following Welsh devolution, the Welsh Ministers are also empowered to issue such approvals.

<sup>153</sup> 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*, Appendix 1, para 2.

<sup>154</sup> In practice, however, expectant and nursing mothers under the age of 18 are more likely to be assessed for residential accommodation under Part 3 of the Children Act 1989.

<sup>155</sup> 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*, Appendix 1, paras 2(1)(a) and 3.

<sup>156</sup> NAA 1948, s 21(4).

<sup>157</sup> As amended by the HSPHA 1968, s 44.

***In need of care and attention***

4.133 Residential accommodation is only available under section 21 of the NAA 1948 to those persons “in need of care and attention”. This term is not defined in legislation, and the courts have adopted a broad approach such that:

- (1) it could include a combination of circumstances, such as sleeping rough, going without food, an inability to speak English, ignorance of Britain and the stress of moving to this country, which would result in the person needing care and attention;<sup>158</sup>
- (2) “care and attention” must mean something more than accommodation and the words 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 do for himself”;<sup>159</sup>
- (3) it is not confined to people with an accommodation related need,<sup>160</sup> and
- (4) it might include a person who is not in immediate need of care and attention but is likely to be so soon.<sup>161</sup> However, the primary focus must be on present rather than future needs.<sup>162</sup>

***Not otherwise available to them***

4.134 Residential accommodation is also only available under section 21 of the NAA 1948 when the care and attention that a person needs is not otherwise available to them.

4.135 Despite some grammatical confusion, it is accepted that the words “not otherwise available to them” govern the words “care and attention” and not the words “residential accommodation” in s 21 of the NAA 1948. Thus:

A person may have a roof over her head but still be in need of care and attention which is not available to her in that home and therefore qualify for residential accommodation [under the NAA 1948].<sup>163</sup>

<sup>158</sup> *R v Hammersmith and Fulham ex p M* (1998) 30 HLR 10.

<sup>159</sup> *R (M) v Slough Borough Council* [2008] UKHL 52, [2008] 1 WLR 1808 at [33], by Baroness Hale.

<sup>160</sup> *R (Mani) v Lambeth LBC* [2003] EWCA Civ 836, [2004] LGR 35.

<sup>161</sup> *R v Newham LBC ex p Gorenkin* [1997] 30 HLR 278.

<sup>162</sup> *R (M) v Slough Borough Council* [2008] UKHL 52, [2008] 1 WLR 1808.

<sup>163</sup> As above, at [15], by Baroness Hale.

- 4.136 When determining whether care and attention is not otherwise available, section 21(2A) of the NAA 1948 provides that the local authority must disregard so much of the person's capital that falls below the capital limit for the purposes of charging. However, statutory guidance stipulates that having capital in excess of the upper limit does not in itself constitute adequate access to alternative care and attention and that local authorities "must satisfy themselves that the individual is able to make their own arrangements, or has others who are willing and able to make arrangements for them, for appropriate care".<sup>164</sup> In such cases, the local authority may need to make the necessary arrangements and then look to charge the client.

***The nature of the duty under section 21 of the NAA 1948***

- 4.137 Lord Woolf MR in *R v Sefton MBC ex p Help the Aged*<sup>165</sup> considered the nature of section 21 of the NAA 1948 by contrasting it with the duty to provide community services under section 2 of the CSDPA 1970. While he acknowledged that the words "necessary in order to meet the needs of that person" in section 2 of the CSDPA 1970 are similar to "in need of care of attention" in section 21 of the NAA 1948, there were crucial differences:

The presence of the word "necessary" in [section 2 of the CSDPA 1970] does however provide an emphasis which is absent from section 21 of the 1948 Act. It will also be noted that many of the matters dealt with by [section 2 of the CSDPA 1970], while very important to the recipient, are not of the same significance as accommodation itself which is dealt with in section 21.<sup>166</sup>

- 4.138 This led to the conclusion that while it was possible to perform a costs benefit analysis in relation to providing services under section 2 of the CSDPA, "it [is] much more difficult to perform the same exercise when deciding if a person is in need of care and attention [under section 21 of the NAA 1948]".<sup>167</sup>
- 4.139 Thus the CSDPA 1970 duty arises if the authority is not only satisfied that the services would meet the needs of the person but also that it was necessary for the services to be provided to meet those needs – taking into account the resources of the authority. In contrast, under section 21 of the NAA 1948, once the authority has come to the conclusion that the person is in need of care and attention, which is not otherwise available to them, then the residential accommodation must be provided – irrespective of resources.
- 4.140 The duty to provide accommodation under section 21 of the NAA 1948 has also been seen by the courts as a duty of last resort since it applies when the care and attention that a person needs is "not otherwise available to them":

<sup>164</sup> LAC(98)19, *Community Care (Residential Accommodation) Act 1998*, para 10 and WOC 27/98, para 9.

<sup>165</sup> *R v Sefton MBC ex p Help the Aged* [1997] 4 All ER 532.

<sup>166</sup> As above, at 540.

<sup>167</sup> As above, at 543.

The provisions of section 21 of the 1948 Act as amended are “safety net” provisions designed to assist the poorest and most needy members of society, at rock bottom as it were. For a variety of reasons of personal and social disadvantage, they may well be persons who find difficulty complying with the norms of social behaviour or self control, while falling outside the specific areas of need catered for by other provision within the Community Care Services or under housing legislation.<sup>168</sup>

- 4.141 However, this does not mean that section 21 of the NAA 1948 is a safety net for anyone who happens to be short of accommodation and money and there must be a need demonstrated in individual cases.<sup>169</sup>

#### **Other legislation**

- 4.142 In addition to section 21 of the NAA 1948, residential accommodation can also be provided under the following legislation:

- (1) section 29(4) of the NAA 1948 and the relevant directions issued under this section,<sup>170</sup> which establish a power to provide hostel accommodation for disabled people engaged in workshops provided for under this section;
- (2) section 117 of the Mental Health Act 1983 which establishes a separate duty to provide accommodation and other community care services to people who are 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; and
- (3) in exceptional cases, under section 2 of the Local Government Act 2000, which is a general power for local authorities to do anything to promote or improve the social well-being of their area, if the use of this power is the only way in which a local authority could avoid a breach of a person’s rights under the ECHR.<sup>171</sup>

#### **Issues for reform**

- 4.143 We recommend that the review consider the extent to which the powers and duties to provide residential accommodation contained in section 21 of the NAA 1948 and other legislation could be simplified and rolled into a single legal provision. We do not, however, envisage section 117 of the Mental Health Act 1983 being brought into community care legislation.<sup>172</sup>

<sup>168</sup> *R v Kensington and Chelsea RLBC ex p Kujtim* [1999] 4 All ER 161 at 33.

<sup>169</sup> *R v Westminster CC ex p A* [1997] 1 Community Care Law Reports 69.

<sup>170</sup> 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*, Appendix 2.

<sup>171</sup> *R (J) v Enfield LBC and Secretary of State for Health* [2002] EWHC 432 (Admin), [2002] 2 LGR 390.

<sup>172</sup> See paras 4.190 to 4.194 below.

- 4.144 We believe that the review should consider whether a distinct legal provision setting out the powers and duties of local authorities to provide residential accommodation is necessary. It might, for example, be argued that stipulating a specific type of service that must be provided is out-of-kilter with the idea that local authorities should be given wide scope to provide a range of services tailored to individual needs. An alternative model would be to move away from having separate powers and duties placed on local authorities to provide residential accommodation in addition to the community care assessment process. Thus, a person would be assessed to see if they have an eligible need, which calls for the provision of residential accommodation, and if so, there would be a duty to provide this service.
- 4.145 However, the review would also need to consider the robust nature of the section 21 duty and ensure that it is not diminished, and make certain that there will continue to be a strong obligation on local authorities to provide residential accommodation or other services in certain circumstances and as a duty of last resort.

#### **Ordinary accommodation**

- 4.146 Section 21(8) of the NAA 1948 provides that nothing in this section authorises or requires a local authority to make any provision authorised or required to be made in any other statute. Case law, however, has established that in certain circumstances ordinary housing can be provided under section 21 of the NAA 1948 “when it is the answer to a need which would otherwise have to be met by other community care services”.<sup>173</sup>
- 4.147 This creates some overlap with the Housing Act 1996 and the courts have been mindful of the danger of people attempting to get housing more swiftly through social services rather than the housing register.<sup>174</sup> However, if a person is assessed as having an eligible need that can only be met through the provision of ordinary housing, then there will be a duty to arrange this. This may apply, for example, if a person is judged to be intentionally homeless and not eligible for housing under the Housing Act 1996,<sup>175</sup> or if a person is not able to be assured of provision of such housing within a reasonable time.<sup>176</sup>

#### ISSUES FOR REFORM

- 4.148 We recommend that the review should consider the dividing line between adult social care law and the Housing Act 1996 and whether this needs to be clarified and simplified. This will include consideration of whether the wording of section 21(8) of the NAA 1948 is sufficiently clear or whether additional provisions are necessary.

<sup>173</sup> *R v Bristol City Council ex p Penfold* (1997-98) 1 Community Care Law Reports 315.

<sup>174</sup> *R (Wahid) v Tower Hamlets LBC* [2002] EWCA Civ 287, [2003] LGR 545.

<sup>175</sup> *R (Bernard) v Enfield LBC* [2002] EWHC 2282 (Admin), [2003] 5 Community Care Law Reports 577.

<sup>176</sup> *R (Batantu) v Islington LBC* (2001) 4 Community Care Law Reports 445.

### **Choice of accommodation**

4.149 The NAA 1948 (Choice of Accommodation) Directions 1992 provide that when a person is eligible for residential accommodation, they can choose which care home is provided as long as certain conditions apply. The relevant conditions are that:

- (1) the accommodation is suitable in relation to the individual's assessed needs;
- (2) to do so would not cost the council more than what it would usually expect to pay for accommodation for someone with the individual's assessed needs;
- (3) the accommodation is available;
- (4) the person in charge of the accommodation is willing to provide accommodation subject to the council's usual terms and conditions for such accommodation; and
- (5) the accommodation is in England or Wales.

4.150 Where a resident chooses a care home which is more expensive than the local authority would usually expect to pay, the regulations allow for the resident to be placed in the more expensive accommodation, provided that a third party is able and willing to top-up the difference. This might, for example, involve a relative or friend providing the top-up. Residents who are subject to the 12 week property disregard<sup>177</sup> or have entered into a deferred payments agreement<sup>178</sup> may make top-ups from specified resources on their own behalf.<sup>179</sup>

### ISSUES FOR REFORM

4.151 We believe that the review should consider the legal framework for allowing people to choose which care home is provided. In particular, this would look at whether some aspects of the directions would be strengthened or otherwise benefit from being placed in statute law.

<sup>177</sup> The value of a resident's home is disregarded for the first 12 weeks of a permanent admission to a care home.

<sup>178</sup> An agreement whereby the value of the resident's property is disregarded when providing residential accommodation but the local authority recovers the fees from the sale of the property, normally after the resident's death.

<sup>179</sup> National Assistance Act (Choice of Accommodation) Directions 1992 and LAC(2004)20, *Guidance on National Assistance Act (Choice of Accommodation) Directions 1992*, paras 3.1 to 3.2.

### **Asylum seekers**

- 4.152 The provision of welfare support (including community care) for asylum seekers, and others subject to immigration control,<sup>180</sup> has been described as a “cat and mouse situation”, whereby Parliament has passed a great deal of legislation, the courts have scrutinised the legislation for loopholes and local authorities have made sustained attempts to avoid responsibilities they feel to be unfair.<sup>181</sup> The main battleground in adult social care law has been section 21 of the NAA 1948 and specifically the question of:

Where to draw the line between those for whom the social services were responsible and those for whom they were not, for those of whom the asylum support service might be responsible and for some of whom there might be no-one responsible at all.<sup>182</sup>

- 4.153 Amendments to section 21 of the NAA 1948 provide that asylum seekers, and others subject to immigration control, may not be provided with residential accommodation if their need for care and attention arises solely because the person is destitute or because of the physical or anticipated physical effects of being destitute.<sup>183</sup>

- 4.154 In *Westminster CC v National Asylum Support Service* it was held that this excluded social services from providing support for “able bodied destitute” asylum seekers, but did not exclude authorities from providing support for “infirm destitute” asylum seekers whose need for care and attention has not arisen solely as a result of destitution but also infirmity.<sup>184</sup> Lord Justice Simon Brown in *R v Wandsworth LBC ex p O* noted that:

The word “solely” in the new section is a strong one and its purpose there seems to me evident. Assistance under the Act of 1948 is, it need hardly be emphasised, the last refuge for the destitute. If there are to be immigrant beggars on our streets, let them at least not be old, ill or disabled.<sup>185</sup>

<sup>180</sup> Under s 115 of the Immigration and Asylum Act 1999, a person is subject to immigration control if he or she is not a national of a European Economic Area state and: (a) requires leave to enter or remain in the UK but does not have that leave; (b) has leave to enter or remain on condition of not having recourse to public funds; (c) has leave to enter or remain as a result of a maintenance undertaking by another person; (d) during an appeal concerning leave.

<sup>181</sup> M Mandelstam, *Community Care Practice and the Law* (3rd ed 2005) p 283.

<sup>182</sup> *R (M) v Slough Borough Council* [2008] UKHL 52, [2008] 1 WLR 1808 at [24], by Baroness Hale.

<sup>183</sup> NAA 1948, s 21(1A). Destitution is defined in s 95(3) of the Immigration and Asylum Act 1999 as not having adequate accommodation or any means of obtaining it (whether or not other essential living needs are being met) or having adequate accommodation or the means of obtaining it, but unable to meet other essential living needs.

<sup>184</sup> [2002] UKHL 38, [2002], 1 WLR 2956 at [32].

<sup>185</sup> [2000] 1 WLR 2539 at 2548.

- 4.155 Subsequent case law has confirmed that local authorities have a duty to provide residential accommodation for infirm destitute asylum seekers who have a need for care and attention but not of a kind that requires the provision of residential accommodation.<sup>186</sup> It has been recognised that this gives asylum seekers a lower threshold for residential accommodation than would normally be the case under section 21 of the NAA 1948, although there must still be a need for care and attention which is not otherwise available.<sup>187</sup>
- 4.156 Adults who are subject to immigration control, other than asylum seekers, are excluded from residential accommodation under section 21 and nearly all other community care legislation by virtue of Schedule 3 of the Nationality, Immigration and Asylum Act 2002.<sup>188</sup>
- 4.157 Failed asylum seekers who are destitute and unable to leave the UK due to circumstances beyond their control may be eligible for support under section 21 of the NAA 1948 on a similar basis as infirm destitute asylum seekers. The exceptions to this are failed asylum seekers who fail to comply with removal directions<sup>189</sup> and those who did not claim asylum as soon as they arrived in the UK, unless support is necessary to avoid a breach of their rights under the ECHR.<sup>190</sup>

#### ISSUES FOR REFORM

- 4.158 We recommend that the review considers the interface between adult social care law and immigration and asylum law and how this could be expressed in any future consolidated adult social care statute. In doing so, the review would take into account Government plans to simplify immigration laws, rules and guidance by introducing a new consolidated statute and clearer secondary legislation.<sup>191</sup>
- 4.159 In reviewing this area we would not, however, enter into policy considerations, nor would we consider the merits of the various arguments concerning the provision of social care for asylum seekers. Rather, our focus would be on ensuring that any consolidated adult social care statute reflects the division of responsibilities for asylum seekers between social service authorities and the Home Office.

<sup>186</sup> *R (Mani) v Lambeth LBC* [2003] EWCA Civ 836, [2004] LGR 35.

<sup>187</sup> *R (P) v Camden LBC* [2004] EWHC 55 (Admin), [2004] ALL ER (D) 69 (Jan).

<sup>188</sup> This bars social services from providing support under the NAA 1948, HSPHA 1968, CSDPA 1970 and NHS Acts 2006. It also covers services for adults provided under the Children Act 1989. It does not include services provided under s 117 of the Mental Health Act 1983.

<sup>189</sup> Nationality, Immigration and Asylum Act 2002, sch 3.

<sup>190</sup> *R (AW) v Croydon LBC* [2007] EWCA Civ 266, [2007] 1 WLR 3168.

<sup>191</sup> A draft (partial) Immigration and Citizenship Bill was published in July 2008, see <http://www.ukba.homeoffice.gov.uk/sitecontent/documents/policyandlaw/immigrationandcitizenshipbill/> (last visited 9 November 2008). Although access to services is not included in the draft Bill, the Government has stated that this area of law will be added to the full Bill before it is introduced. See Home Office UK Border Agency, *Making Change Stick: An Introduction to the Immigration and Citizenship Bill* (2008) p 8.

## **Community and domiciliary services**

### **Section 29 of the NAA 1948**

4.160 The statutory regime governing domiciliary and community services is founded on section 29(1) of the NAA 1948, which provides that:

A local authority may, with the approval of the Secretary of State, and to such an extent as he may direct in relation to persons ordinarily resident in the local authority shall, make arrangements for promoting the welfare of persons to whom this section applies.<sup>192</sup>

4.161 Under section 29(1), eligibility for such services is restricted to people who are:

Blind, deaf or dumb or who suffer from mental disorder of any description, and other persons aged 18 or over who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.

4.162 Section 29(4) goes on to list, in general terms, the range of services that local authorities are empowered to provide. The services referred to are:

- (a) informing persons, to whom section 29(1) applies, of the services available for them thereunder;
- (b) giving such persons instruction in their own homes or elsewhere in methods of overcoming the effects of their disabilities;
- (c) providing workshops where such persons may be engaged (whether under a contract of service or otherwise) in suitable work, and hostels where persons engaged in the workshops, and other persons to whom section 29(1) applies and for whom work or training is being provided in pursuance of the Disabled Persons (Employment) Act 1944, or the Employment and Training Act 1973 may live;
- (d) providing persons, to whom section 29(1) applies, with suitable work (whether under a contract of service or otherwise) in their own homes or elsewhere;
- (e) helping such persons in disposing of the produce of their work;
- (f) providing such persons with recreational facilities in their own homes or elsewhere; and
- (g) compiling and maintaining classified registers of the persons to whom section 29(1) applies.

<sup>192</sup> As a result of the transfer of functions following Welsh devolution, the Welsh Ministers are also empowered to issue such approvals and directions.

4.163 It is left to the Secretary of State and the Welsh Ministers to decide which services must be provided under this section and the relevant directions<sup>193</sup> establish a duty to provide the following:

- (1) a social work service, support and advice as may be needed for people in their own homes or elsewhere;
- (2) whether at centres or elsewhere, facilities for social rehabilitation and adjustment to disability, including assistance in overcoming limitations of mobility or communication;
- (3) whether at centres or elsewhere, facilities for occupational, social, cultural and recreational activities and where appropriate the making of payments to persons for work undertaken by them; and
- (4) a register of people to whom section 29(1) of the NAA 1948 applies.

4.164 The directions also give social services authorities the discretion to provide:

- (1) holiday homes;
- (2) free or subsidised travel;
- (3) assistance in finding accommodation;
- (4) contributions to the cost of wardens in assisted housing schemes; and
- (5) warden services for occupiers of private housing.

4.165 The extent of the duties established by section 29 and the subsequent directions have been the subject of judicial deliberation. Mr Justice Sedley described them as establishing a “parallel set of target duties”, which requires the local authority “to aim to make the prescribed provision but does not regard failure to achieve it, without more, as a breach”.<sup>194</sup> However, this argument has been criticised by Lord Justice Potter as “not altogether easy to follow”.<sup>195</sup> In another case, Mr Justice Mitting argued that there should be “no difference in principle or practice” between section 29 of the NAA 1948 and section 21 of the NAA 1948, which is a specific legal duty:

<sup>193</sup> 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*, Appendix 2.

<sup>194</sup> *R v Islington LBC ex p Rixon* [1997] 32 BMLR 136 at 139.

<sup>195</sup> *R v Kensington and Chelsea RLBC ex p Kujtim* [1999] 4 All ER 161 at 29.

Section 29 imposes a duty to make arrangements for promoting the welfare of relevant persons to such an extent as the Secretary of State may direct. He has so directed in Local Authority Circular 93/10, Appendix 2 to provide “such support as may be needed for people in their own home”. Section 7 of the Local Authority Social Services Act provides that the Secretary of State may give guidance to local authorities in the exercise of their functions under s 29. Liverpool accept that they are obliged to follow the guidance of the Secretary of State in making those arrangements. The Secretary of State’s guidance provides that they should identify eligible needs and meet them (see paras 3 and 43 of the guidance).<sup>196</sup>

### **Section 45 of the HSPHA 1968**

4.166 Section 45 of the HSPHA establishes that a local authority may, with the approval of the Secretary of State and the Welsh Ministers, provide services which are aimed at promoting the welfare of older people. The relevant directions issued under this section give local authorities the power to provide the following services:

- (1) meals and recreation in the home and elsewhere;
- (2) inform old people of services available to them and to identify old people in need of services;
- (3) travel assistance for participating in local authority services;
- (4) assistance in finding boarding accommodation;
- (5) visiting and advisory services and social work support;
- (6) assistance in the home including additional facilities to secure greater safety, comfort and convenience; and
- (7) warden services and contributions to the costs of employing a warden.<sup>197</sup>

### **Section 2 of the CSDPA 1970**

4.167 As noted in Part 2 of this report, section 2 of the CSDPA 1970 aimed to bolster the weak duty contained in section 29 of the NAA 1948 by converting it into a specific public law duty, amenable to enforcement by individual disabled people. It provides that a local authority has a duty to make arrangements for a number of welfare services where it is satisfied that:

- (1) the person is disabled under the definition contained in section 29 of the NAA 1948;
- (2) he or she is ordinarily resident in their area; and

<sup>196</sup> *R (Hughes) v Liverpool City Council* [2005] EWHC 428 (Admin), [2005] LGR 531 at [26].

<sup>197</sup> DHSS 19/71, *Welfare of the Elderly: Implementation of Section 45 of the Health Services and Public Health Act 1986*, para 4.

- (3) it is necessary in order to meet the needs of that person for that authority to make arrangements for the provision of all or any of those services.

4.168 The services set out in section 2 are as follows:

- (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.

4.169 The strength of this duty has been confirmed on a number of occasions by the courts, including in *R v Gloucestershire CC ex p Barry* where the House of Lords considered the legality of eligibility criteria:

The right given to the person by section 2(1) of the Act of 1970 was a right to have the arrangements made which the local authority was satisfied were necessary to meet his needs. The duty only arises if or when the local authority is so satisfied. But when it does arise then it is clear that a shortage of resources will not excuse a failure in the performance of the duty.<sup>198</sup>

4.170 However, there has been some confusion about the relationship between section 2 of the CSDPA 1970 and section 29 of the NAA 1948. Case law suggests that services provided under section 2 of the CSDPA 1970 should not be regarded as free standing but instead are an adjunct to section 29 of the NAA 1948. This view was expressed by Mr Justice Popplewell in the following terms:

When providing welfare services under section 2 the local authority are exercising their functions under section 29. They are not providing services under section 2; they are making arrangements under the 1948 Act for the provision of their services.<sup>199</sup>

<sup>198</sup> [1997] 2 All ER 1, 16, by Lord Clyde.

<sup>199</sup> *R v Powys CC ex p Hambridge* [1998] 1 FLR 643 at 650.

4.171 In considering this question, it is notable that the definition of community care services provided in section 46(3) of the NHSCCA 1990 does not include specific reference to services provided under section 2 of the CSDPA 1970. The reason for this, in the opinion of the courts, is that section 2 of the CSDPA 1970 has been included by the reference to services provided under Part 3 of the NAA 1948.<sup>200</sup> However, this view has been criticised for the following reasons:

- (1) it does not fully explain 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);<sup>201</sup> and
- (2) as noted in *R v Gloucestershire CC ex p Mahfood*, it would lead to the “unattractive” conclusion that home help could not be provided under section 2(1)(a) of the CSDPA 1970, even though this Act explicitly authorises this service.<sup>202</sup> 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.<sup>203</sup>

#### ***The National Health Service Acts 2006***

4.172 The directions issued under Schedule 20 to the NHS Act 2006 and Schedule 15 to the NHS (Wales) Act 2006 provide that local authorities are under a duty to provide the following services for the prevention of mental disorder or in relation to persons who have been suffering from mental disorder:

- (1) centres (including training centres and day centres) or other facilities (including domestic facilities) whether in premises managed by the local authority or otherwise, for training and occupation;
- (2) sufficient social workers to act as Approved Social Workers under the Mental Health Act 1983 and to exercise the functions of the authority under the guardianship provisions of this Act,<sup>204</sup> and
- (3) social work and related services to help in the identification, diagnosis, assessment and social treatment of mental disorder and to provide social work support and other domiciliary and care services to people living in their home and elsewhere.<sup>205</sup>

<sup>200</sup> *R v Kirklees MBC ex p Daykin* (1997-98) 1 Community Care Law Reports 512.

<sup>201</sup> L Clements and P Thompson, *Community Care and the Law* (4th ed 2007) paras 9.128 to 9.129.

<sup>202</sup> (1997-98) 1 Community Care Law Reports 7 at 17C.

<sup>203</sup> NHS Act 2006, sch 20 para 3. This covers Welsh and English authorities.

<sup>204</sup> The role of the Approved Social Worker has been replaced by the Approved Mental Health Professional as a result of the Mental Health Act 2007.

<sup>205</sup> 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*, Appendix 3.

4.173 The directions also state that local authorities have the power to provide for the care of expectant and nursing mothers (of any age) other than the provision of accommodation. It also empowers authorities to provide the following services “for the prevention of illness, and the care of people suffering from illness and for the after-care of persons who have been suffering”:

- (1) centres or other facilities for training them or keeping them suitably occupied and the equipment and maintenance of such centres;
- (2) ancillary or supplemental services;
- (3) meals at the centres and meals-on-wheels for housebound people which is not provided for under section 45 of the HSPHA 1968 and Health and Social Services and Social Security Adjudication Act 1983;
- (4) remuneration for persons engaged in suitable work at the centres;
- (5) social services (including advice and support) for the purpose of preventing the impairment of physical or mental health of adults in families where such impairment is likely, and for the purpose of preventing the break-up of such families, or for assisting their rehabilitation;
- (6) night sitter services;
- (7) recuperative holidays;
- (8) facilities for social or recreational activities; and
- (9) services specifically for persons who are alcoholic or drug dependent.

4.174 The NHS Acts 2006 also place a duty on local authorities to provide home help for households where such help is required due to the presence of a person who is: suffering from illness; pregnant or has recently given birth; aged; or handicapped as a result of having suffered from illness or by congenital deformity. There is a power to provide a laundry service for households where home help is being or can be provided.<sup>206</sup> The use of the term *households*, which could include informal carers in that household, means that there is some overlap with carers’ legislation.

<sup>206</sup> The provisions for home help and laundry services are contained in sch 20, para 3 to the NHS Act 2006. They do not appear in the NHS (Wales) Act 2006, however the definition of a local authority in s 275 of the NHS Act 2006 (which applies to sch 8 to this Act) includes Welsh and English authorities.

### **Issues for reform**

- 4.175 We recommend that the review consider whether all of these legislative provisions could be rolled into a single provision, which sets out local authorities' powers and duties to provide non-residential services. This could be achieved by setting out in legislation a specific duty and a power to provide services, followed by a list of the different types of services that must or may be provided. This is, for example, similar to the method adopted in section 2 of the CSDPA 1970. Alternatively the legislation could empower the Secretary of State and the Welsh Ministers to issue directions or approvals as to the types of services which must and can be provided. This would have the advantage of being easier to amend if some of the listed services become less relevant or if other services need to be added in the future.
- 4.176 It might, however, be argued that there is an inherent contradiction between providing a list of services, either in statute or in approvals and directions, and the need to give local authorities wide scope to provide a range of services tailored to individual needs. As detailed below, carers' legislation does not explicitly define the services that can be provided and arguably this gives local authorities greater flexibility. This also applies to after-care services, which are left undefined by section 117 of the Mental Health Act 1983, and the courts have maintained that this section therefore gives local authorities and health bodies considerable discretion.<sup>207</sup>
- 4.177 An alternative approach would be to move away from having separate powers and duties placed on local authorities to provide non-residential services in addition to the community care assessment process. Thus a person would be assessed to see if they had an eligible need which calls for the provision of community services and, if he or she did, there would be a duty to provide those services. An important consideration, however, will be whether section 2 of the CSDPA 1970 provides a stronger obligation on local authorities to provide services in certain circumstances.

### **Carers' services**

- 4.178 The CDCA 2000 is the main statute that enables services to be provided to carers.<sup>208</sup> In contrast to the approach taken in many adult social care statutes, the CDCA 2000 does not set out a list of services, which either can or must be provided, but rather gives local authorities considerable discretion. The services referred to in the CDCA 2000 are any services which:
- (1) the local authority sees fit to provide; and
  - (2) will in the local authority's view help the carer care for the person cared for,

<sup>207</sup> See *Clunis v Camden and Islington Health Authority* [1998] 3 All ER 180 at 225.

<sup>208</sup> In addition young carers can be provided with services under section 17 of the Children Act 1989. Services to carers can also be provided under sch 20 to the NHS Act 2006, see para 4.174 above.

and may take the form of physical help or other forms of support.<sup>209</sup>

4.179 The CDCA 2000 also specifies that vouchers can be issued for short-term breaks.<sup>210</sup>

4.180 The importance of flexibility in service provision for carers is highlighted in the relevant guidance:

Services to carers are not defined as such in the 2000 Act. The local authority may provide any services they see fit to provide and which in their view will help the person care. These services may take any form, for example, a gardening service or assistance around the house for a carer who devotes most of his or her time to providing intimate care to the person cared for. Practitioners carrying out carer assessments are encouraged to consider flexible and innovative use of services which would help minimise the impact of the caring role on the carer's own life.<sup>211</sup>

4.181 It should be noted, however, that as a result of the amendments to the CDCA 2000, by the C(EO)A 2004, there is a strong emphasis on services that would assist a carer in remaining in or pursuing employment, education, training or leisure activities.<sup>212</sup>

4.182 In general terms, if as a result of a carer's assessment under the C(RS)A 1995 or the CDCA 2000, services are provided to the cared-for person then they are limited to community care services.<sup>213</sup> Services that are provided to the carer, under the CDCA 2000 or the Children Act 1989, are not so limited. In some circumstances local authorities may provide a carer's service that takes the form of a service delivered to the person cared for, for example, because the cared-for person has refused an assessment.<sup>214</sup> This is limited to "services that can be provided to the cared-for person through community care legislation and they may not, except in prescribed circumstances, include anything of an intimate nature".<sup>215</sup>

<sup>209</sup> CDCA 2000, s 2(2).

<sup>210</sup> See CDCA 2000, s 3 and the Carers and Disabled Children (Vouchers)(England) Regulations 2001, SI 2001 No 441 and the Carers (Services) and Direct Payments (Amendment) (Wales) Regulations 2001, WSI 2001 No 2186.

<sup>211</sup> Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 52.

<sup>212</sup> See previous discussion on carers' assessments.

<sup>213</sup> As defined under s 46(3) of the NHSCCA 1990.

<sup>214</sup> CDCA 2000, s 2(3).

<sup>215</sup> Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 54. The definition of services that are intimate in nature can be found in the Carers (Services) and Direct Payments (Amendment) (England) Regulations 2001, SI 2001 No 441, reg 2(1) and the Carers (Services) and Direct Payments (Amendment) (Wales) Regulations 2001, WSI 2001 No 2186, reg 2(1).

### **Issues for reform**

- 4.183 We believe the review should consider whether the legislative provisions contained in the DP(SCR)A 1986, the C(RS)A 1995, the CDCA 2000 and the C(EO)A 2004 could be rolled into a single section governing the provision of services to carers.
- 4.184 At present the types of services are not listed and are generally left undefined, and the review will consider whether this approach should be maintained. An important consideration here would be consistency with our law reform proposals for the provision of services to cared-for people.
- 4.185 An additional point for the review to consider would be whether there needs to be any distinction in legal terms between services provided for carers and community care services provided for those they look after. The current legal division can be complex and confusing. Consideration would therefore be given to providing carers' services under the general banner of community care services.

### **After-care services**

- 4.186 Section 117 of the Mental Health Act 1983 imposes a joint duty on health and social services to provide, in co-operation with voluntary agencies, after-care services to people who are detained in hospital for treatment under sections 3, 37, 45A, 47 or 48 of the Act, who then cease to be detained and leave hospital.
- 4.187 The courts have interpreted section 117 as imposing a specific duty on health and local authorities to arrange after-care services, which is owed to individual patients.<sup>216</sup> However, in some cases where Mental Health Review Tribunals have directed the deferred conditional discharge of psychiatric patients, the courts have described section 117 as imposing a mere duty to "use its best endeavours to procure" the services that the health and social service authorities deem necessary.<sup>217</sup>
- 4.188 It is now clearly established that section 117 imposes a free standing duty to provide after-care services and it is not a gateway provision that leads to services being provided under other statutes. It follows that, since section 117 does not include a charging provision, it is not permissible to charge for section 117 services.<sup>218</sup>
- 4.189 The term "after-care services" is not defined in the 1983 Act but case law has established a wide definition that includes "social work, support in helping the ex-patient with problems of employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities".<sup>219</sup>

<sup>216</sup> *R v Ealing District Health Authority ex p Fox* [1993] 1 WLR 373.

<sup>217</sup> *R (IH) v Secretary of State for the Home Department and others* [2003] UKHL 59, [2003] 3 WLR 1278 at [29].

<sup>218</sup> *R v Manchester CC ex p Stennett* [2002] UKHL 34, [2002] 2 AC 1127.

<sup>219</sup> *Clunis v Camden and Islington Health Authority* [1998] 3 All ER 180 at 225.

### ***Issues for reform***

- 4.190 The review would not consider whether the duty to provide after-care services under section 117 should continue to exist. The specific and strong nature of this duty and the prohibition on charging for section 117 services would also remain outside the scope of the review.
- 4.191 It has been suggested that section 117 reflects the legal principle of reciprocity, namely that:
- When society imposes the exercise of compulsory powers on a person, there is a reciprocal right for that person to have services provided to help them get better.<sup>220</sup>
- 4.192 This principle is, in general terms, applicable to legislation that provides for compulsory powers, such as the Mental Health Act 1983, which gives section 117 a different context to the vast majority of adult social care law. We therefore envisage that section 117 would remain as a stand alone community care provision in the Mental Health Act 1983 and not be brought into a consolidated community care statute.
- 4.193 However, we believe the review should consider whether section 117 could or should be more fully integrated within the legal framework for the provision of adult social care services. Specifically, the ordinary residency rules do not apply to people subject to section 117<sup>221</sup> and the NAA 1948 (Choice of Accommodation) Directions 1992 do not apply to accommodation provided under this section, which leads to uncertainty about whether people can pay top-up fees.<sup>222</sup>
- 4.194 The review would also consider whether the lack of a statutory definition of services under section 117 has been a successful innovation, and whether this approach could serve as a model for services under adult social care legislation.

<sup>220</sup> The Draft Mental Health Bill, Report of the House of Lords and House of Commons Joint Committee, Volume 1 (2004-05) HL 79-1, HC 95-1, para 346.

<sup>221</sup> Section 117(3) of the Mental Health Act 1983 refers to the responsible health and social services bodies as being those “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”. The relevant guidance is HSC 2000/003 and LAC(2000)3, *After-Care Under the Mental Health Act 1983*.

<sup>222</sup> For example, see Local Government Ombudsman, Complaint No 05/C/13158 against North Yorkshire County Council, 24 July 2007. It has been argued that “as long as the authority commits itself to providing a level of funding that would adequately meet the assessed needs of the patient for accommodation, there is nothing to prevent top-up payments being made by the patient or another person to fund accommodation that provides a higher level of either service or accommodation”: R Jones, *Mental Health Act Manual* (11th ed 2008) para 1-1078.

### **Services for disabled children**

- 4.195 Most community care legislation applies to adults over 18 years of age. The main exception is section 2 of the CSDPA 1970, which applies to children as well as adults.<sup>223</sup> This is reinforced by a duty under section 4 of the DP(SCR)A 1986, on request by a disabled child or a parent, to decide whether a disabled child's needs call for the provision of services under section 2 of the CSDPA 1970.
- 4.196 The courts have pointed out that, in contrast to the general target duty in section 17 of the Children Act 1989, the CSDPA 1970 establishes a specific public law duty, amenable to enforcement by individuals. Therefore, any choice between providing services under the Children Act 1989 and the CSDPA 1970 should be settled in favour of the latter.<sup>224</sup>
- 4.197 It was determined in *R (Spink) v Wandsworth LBC* that references to Part 3 of the Children Act 1989 are substituted for references to section 29 of the NAA 1948 throughout section 2 of the CSDPA 1970.<sup>225</sup> It therefore follows that when providing welfare services to children under the CSDPA 1970, local authorities are exercising their functions under Part 3 of the Children Act 1989.
- 4.198 The other exception to the general rule that community care legislation applies only to adults, is the provision of home help and laundry services under Schedule 20 paragraph 3 to the NHS Act 2006, which also has no age restriction.

### **Issues for reform**

- 4.199 We recommend that the review consider whether the legal framework could be simplified by drawing a clear line in law between the provision of community care services to adults and services for children. Thus, a future consolidated adult social care statute might apply only to persons aged 18 and over, while those under 18 would be assessed under the Children Act 1989.
- 4.200 We recognise that one possible consequence of delineating the provision of services in this way would be that children would in effect lose legally enforceable rights to services. An alternative would be to recommend specifically enforceable rights under the Children Act 1989, in similar circumstances to those that exist under adult social care law.

### **Transition services**

- 4.201 As a general rule, services for disabled children are provided under the Children Act 1989 and cease to be available when they reach the age of 18. There are, however, a number of exceptions to this, including:

<sup>223</sup> CSDPA 1970, s 28A.

<sup>224</sup> *R v Bexley LBC ex p B* (2000) 3 Community Care Law Reports 15.

<sup>225</sup> [2005] EWCA Civ 302, [2005] 1 WLR 2884.

- (1) the Children (Leaving Care) Act 2000, which amended the Children Act 1989 and placed duties on local authorities to prepare young people (aged 16 and 17) for leaving care and where they have left care (up until the age of 21 and in some cases beyond) to advise, assist and befriend them with a view to promoting their welfare; and
- (2) any eligibility for services under the CSDPA 1970, section 117 of the Mental Health Act 1983, the C(RS)A 1995, and Schedule 20, paragraph 3 of the NHS Acts 2006, which would apply regardless of age.

4.202 There are also a number of legal provisions to promote joint planning for the transition from children's services to adult services. These include:

- (1) the DP(SCR)A 1986, which requires the local education authority to consult social services authorities to establish whether a child over the age of 14 who has been statemented under Part 4 of the Education Act 1996 is likely to require support from the social services department when they leave school,<sup>226</sup> and
- (2) the Education (Special Educational Needs) (England) (Consolidation) Regulations 2001, which requires the contribution of the social services authority and others to a transitional plan which the education department is required to prepare on the annual review of a statement made when the child reaches 14 to ensure smooth transition into adult life.<sup>227</sup>

### ***Issues for reform***

4.203 We believe the review should consider whether a clear dividing line should be drawn between the provision of services for children and adult social care services, or whether the current legal position should continue, which allows some transition services to be made available.

4.204 The review would also consider whether any additional legislative provision is needed to encourage joint working during the transition phase. This might include, for example, additional duties on adult social services and children departments to consult and co-operate when a relevant young person approaches the age of 18. Alternatively, this may be seen as an issue that is best dealt with in guidance.

<sup>226</sup> DP(SCR)A 1986, ss 5 and 6.

<sup>227</sup> SI 2001 No 3455, reg 21. The equivalent provision for Wales can be found in the Education (Special Educational Needs) (Wales) Regulations 2002, WSI 2002 No 152, reg 21.

## **SERVICE PROVISION AND CLIENT GROUPS**

- 4.205 Most of the main adult social care statutes, which authorise the provision of services, adopt the same approach of making eligibility for services dependent on whether the individual fits into one or more categories or client groups. However, the client groups that are used vary between different statutes and there is considerable overlap between some of the groupings. This means that eligibility for different services, and sometimes the same service, can vary according to which statute is being used.

### **The statutory definition of disability**

- 4.206 The definition contained in section 29(1) of the NAA 1948 is generally considered to be the principal definition of a disabled person in community care legislation:

Persons aged eighteen and over who are blind, deaf or dumb or who suffer from mental disorder of any description, and other persons aged 18 or over who are substantially and permanently handicapped by illness, injury, or congenital deformity or such other disabilities as may be prescribed by the Minister.<sup>228</sup>

- 4.207 This definition also applies to section 2 of the CSDPA 1970 and section 4 of the DP(SCR)A 1986 and can also be found in the Housing Grants, Construction and Regeneration Act 1996 and in almost identical form in section 17 of the Children Act 1989.
- 4.208 Although section 29(1) of the NAA 1948 makes no reference to partially sighted people, the guidance attached to the relevant approvals and directions makes it clear that such people are included.<sup>229</sup> Similarly, although section 29(1) makes no reference to people with impaired hearing, the guidance advises that the definition includes “those who (with or without a hearing aid) have some useful hearing and whose normal method of communication is by speech, listening and lip-reading”.<sup>230</sup>

<sup>228</sup> No further disabilities have been prescribed by the Minister.

<sup>229</sup> 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*, Appendix 4.

<sup>230</sup> As above, Annex 2 to Appendix 4.

### Other statutory client groups

- 4.209 Section 21 of the NAA 1948 refers to people over 18 “who by reason of age, illness, disability or any other circumstances are in need of care and attention, which is not otherwise available to them” as well as “expectant and nursing mothers” of any age. This is arguably a wider category than section 29(1) of the NAA 1948 since, for example, it includes disabled people without having to establish that the disability is permanent and substantial. The relevant directions also specifically refer to two categories of people who are covered by section 21 of the NAA 1948: people with a mental disorder; those who have been suffering from mental disorder; and people dependent on alcohol or drugs.<sup>231</sup>
- 4.210 Services provided under section 45 of the HSPHA 1968 are for “promoting the welfare of old people”. This was partly a response to concerns that older people who were not “substantially and permanently handicapped” were ineligible for services under section 29 of the NAA 1948. The term “old people” is not defined. There is considerable overlap between the HSHPA client group and the client groups established in other social care legislation, such as the NAA 1948 and the NHS Acts 2006.
- 4.211 Section 117 of the Mental Health Act 1983 imposes a joint duty on health and social services authorities to provide after-care services to people who are 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. Section 117 service users are also likely to be included in the categories used in other legislation, such as the NAA 1948 and the NHS Acts 2006.
- 4.212 The NHS Acts 2006 enable local authorities to provide certain services for “persons suffering from illness and for the after-care of persons who have been suffering from illness”.<sup>232</sup> Unlike section 29 of the NAA 1948, illness is not limited to substantial or permanent illness. The relevant approvals and directions also make specific reference to people who are or have been suffering from a mental illness as eligible for services under this legislation.<sup>233</sup>
- 4.213 The NHS Acts 2006 also include a duty to provide home help and a power to provide laundry services to households where help is needed due to illness, handicap and age. There is considerable overlap with the existing power under section 45 of the HSPHA 1968 to provide home help to old people and the duty under section 2 of the CSDPA 1970 to provide home help and laundry services for persons who are “substantially and permanently handicapped” under section 29 of the NAA 1948. There is also an overlap with services for carers, since help can be provided to a *household*.

<sup>231</sup> As above, Appendix 1.

<sup>232</sup> NHS Act 2006, sch 20, para 2(a) and the NHS (Wales) Act 2006, sch 15, para 2(a).

<sup>233</sup> 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*, Appendix 3, para 3(2).

### **Issues for reform**

- 4.214 The main advantage of using client groups is that it introduces an element of objectivity into the eligibility criteria for services. For example, in the case of blind and partially sighted people, eligibility for services under section 29 of the NAA 1948 can be proved on the basis of a medical certificate.<sup>234</sup> However, as noted in Part 2 of this report, the language used to describe these client groups can easily become outdated and offensive. It may also be inherently discriminatory to use categories such as disability as the basis for eligibility when many disabled people do not need additional help from social services. Also, the use of client groups adds to the complexity and confusion that pervades adult social care law.
- 4.215 We believe that the review should consider whether a single and up to date definition of disability should be established for the purposes of community care legislation. This will need to take into account alternative legal definitions of disability, for example section 1 of the Disability Discrimination Act 1995, which defines disability as: “a physical or mental impairment that has a substantial and long-term adverse effect on the ability to carry out normal day-to-day activities”. It would also be important to bear in mind that not all recipients of social care support are disabled people (according to the definitions in section 29(1) of the NAA 1948 and section 1 of the Disability Discrimination Act 1995) and therefore a broader definition or additional statutory client groups may be required.
- 4.216 However, the review would also consider whether a definition of disability, or indeed any such categories, are necessary at all for the purposes of adult social care law. An alternative approach would be for eligibility for services to depend entirely on a person being assessed as having an eligible need, which requires the provision of services, irrespective of whether or not they fit into any statutory definition of disability. This would, to a large extent, reflect the assessment process and rights to services established under section 47 of the NHSCCA 1990 and the statutory guidance in FACS and UFSAMC.

### **DIRECT PAYMENTS**

- 4.217 Direct payments allow local authorities to make payments to service users who have been assessed as having an eligible need, so that they can buy their own services directly in order to meet that need. Department of Health guidance states that the overall purpose of direct payments “is to give recipients control over their own life by providing an alternative to social services provided by a local council”.<sup>235</sup>

<sup>234</sup> As above, Appendix 4, para 6.

<sup>235</sup> Department of Health, *Direct Payments Guidance Community Care, Services for Carers and Children's Services (Direct Payments) England Guidance* (2003) p 3.

4.218 There has been a large increase in the number of people using direct payments but it remains very small compared to the total number of people using adult social care services. For example, in England there was an increase of 27% between 2005-06 and 2006-07 in the amount of money spent by local authorities on direct payments, but this equates to only just under 2% of the overall gross expenditure in 2006-07.<sup>236</sup> Moreover, there are considerable variations between local authorities in the provision of direct payments, so that actual take-up in many areas is substantially lower than the national average.<sup>237</sup>

4.219 A Department of Health sponsored study revealed that the attitude of local politicians, managers and staff is a strong predictor of successful implementation of direct payments, as is the use of a ring-fenced budget. Key factors believed to inhibit wider take-up of direct payments include concern about the ability of people to manage a payment, resistance to direct payments among local authority staff and a lack of personal assistants.<sup>238</sup> Other factors blamed for preventing wider take-up of direct payments include: conflicting attitudes towards the use of Criminal Record Bureau checks; the setting of high eligibility criteria by local authorities; partnership arrangements between health and social care failing to accommodate direct payments; and a perception that direct payments are more suitable for younger disabled clients.<sup>239</sup>

#### **The qualified duty to make direct payments**

4.220 Section 57 of the Health and Social Care Act 2001 gives the Secretary of State and the Welsh Ministers regulatory powers to enable local authorities to make direct payments to a person, with his or her consent, where the local authority has decided to provide a service following an assessment under section 47 of the NHSCCA 1990. 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.<sup>240</sup>

4.221 The regulations in England and Wales establish a duty on local authorities to make direct payments if the following conditions are satisfied:

- (1) the person appears to the local authority to be capable of managing a direct payment alone or with assistance;
- (2) the person is not subject to certain court orders under criminal justice legislation or certain orders under the Mental Health Act 1983;

<sup>236</sup> The Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2006-07* (2008).

<sup>237</sup> J Fernandez and others, "Direct Payments in England: Factors Linked to Variation in Local Provision" (2007) 36 *Journal of Social Policy* 97.

<sup>238</sup> London School of Economics Personal Social Services Research Unit, *Direct Payments: A National Survey of Direct Payments Policy and Practice* (2007).

<sup>239</sup> See Commission for Social Care Inspection, *Direct Payments: What are the Barriers?* (2004) and F Haslar and A Stewart, *Making Direct Payments Work: Identifying and Overcoming Barriers to Implementation* (2004).

<sup>240</sup> This also applies as a result of assessments under s 17 of the Children Act 1989.

- (3) 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 section 2 of the CDCA 2000; and
- (4) the local authority is satisfied that the person's need for the relevant service can be met by securing the provision of it by means of direct payment.<sup>241</sup>

4.222 The Health and Social Care Act 2008 extends direct payments to those who lack the capacity to consent to their receipt, as defined by the Mental Capacity Act 2005, by allowing a payment to be made to a *suitable person* who can receive and manage the payment on behalf of the person who lacks capacity. As part of the wider consultation on the regulations for the extension of direct payments to people lacking capacity, the Government is also consulting on further extending the scope of direct payments to people subject to the Mental Health Act 1983, including those on Supervised Community Treatment, guardianship, leave of absence and conditional discharge.<sup>242</sup> The proposed regulations would give local authorities a power, rather than a duty, to make direct payments to such people.

#### **Excluded services**

4.223 The regulations specify that 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 prescribed person's need for that service".<sup>243</sup>

<sup>241</sup> The Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2003, SI 2003 No 762 and the Community Care, Services for Carers and Children's Services (Direct Payments) (Wales) Regulations 2004, WSI 2004 No 1748.

<sup>242</sup> Department of Health, *Consultation on Direct Payment Regulations* (2008).

<sup>243</sup> The Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2003, SI 2003 No 762, reg 6 and the Community Care, Services for Carers and Children's Services (Direct Payments) (Wales) Regulations 2004, WSI 2004 No 1748, reg 7.

- 4.224 Direct payments 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 and cannot exceed 120 days a year.<sup>244</sup> The statutory guidance for local authorities in Wales also states that direct payments cannot be used to purchase a service from a local authority.<sup>245</sup> Although the equivalent English guidance<sup>246</sup> does not cover this point, the guide for receiving direct payments makes it clear that it is not the Department of Health's intention for direct payments to be used to purchase local authority services.<sup>247</sup>
- 4.225 Direct payments made under the Health and Social Care Act 2001 relate only to social care services and cannot be used to purchase NHS services. The Government has previously stated that there are no plans to extend direct payments or individual budgets (see below) to the NHS "since we believe this would compromise the founding principle of the NHS that care should be free at the point of need".<sup>248</sup> The NHS Next Stage Review led by Lord Darzi, however, announced that personal health budgets will be piloted in 2009.<sup>249</sup> The initial thinking outlined by the Department of Health is that health budgets will be piloted for those with long-term conditions, those receiving NHS Continuing Healthcare and users of mental health services. There will be three forms that health budgets could take: a notional personal budget; a real personal budget held on the patient's behalf; and a real budget as a cash entitlement.<sup>250</sup>

<sup>244</sup> The Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2003, SI 2003 No 762, reg 7 and the Community Care, Services for Carers and Children's Services (Direct Payments) (Wales) Regulations 2004, WSI 2004 No 1748, reg 8.

<sup>245</sup> Welsh Assembly, *Direct Payments Guidance Community Care, Services for Carers and Children's Services (Direct Payments) Guidance Wales* (2004) para 95.

<sup>246</sup> Department of Health, *Direct Payments Guidance Community Care, Services for Carers and Children's Services (Direct Payments) England Guidance* (2003). Although, unlike the Welsh guidance, this is not statutory guidance.

<sup>247</sup> Department of Health, *A Guide to Receiving Direct Payments From Your Local Authority: A Route to Independent Living* (2008) p 15.

<sup>248</sup> Our Health, Our Care, Our say: A New Direction for Community Services (2006) Cm 6737, para 4.39.

<sup>249</sup> High Quality Care For All: NHS Next Stage Review Final Report (2008) Cm 7432, p 10.

<sup>250</sup> Department of Health, *Personal Health Budgets: Initial Information Sheet* (2008).

## Individual budgets

4.226 Individual budgets were first proposed in a 2005 report by the Cabinet Office Strategy Unit<sup>251</sup> and this commitment was repeated in the Green Paper “Independence, Well-being and Choice”<sup>252</sup> and “Opportunity Age”, which is a UK-wide strategy for an ageing society.<sup>253</sup> They enable individuals who are eligible for these funds to:

Have a single transparent sum allocated to them in their name and held on their behalf rather like a bank account. They can choose to take this money out 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.<sup>254</sup>

4.227 Individual budgets were piloted between November 2005 and December 2007 in 13 local authorities in England. The resources allocated to the individual budget pilots included not just the funds an individual is entitled to under community care legislation but also funding relating to: Integrated Community Equipment Services;<sup>255</sup> Access to Work;<sup>256</sup> Independent Living Funds;<sup>257</sup> Disabled Facilities Grants;<sup>258</sup> and Supporting People.<sup>259</sup> The Department of Health has yet to decide which, if any, of these funding streams will be included in any rollout of individual budgets.

<sup>251</sup> Prime Minister’s Strategy Unit, *Improving the Life Chances of Disabled People: A Final Report* (2005).

<sup>252</sup> Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England (2005) Cm 6499.

<sup>253</sup> HM Government, *Opportunity Age: Meeting the Challenges of Ageing in the 21st Century* (2005).

<sup>254</sup> Our Health, Our Care, Our say: A New Direction for Community Services (2006) Cm 6737, para 4.32.

<sup>255</sup> This includes equipment such as a raised toilet seat or a grab rail provided together by both the NHS and social services.

<sup>256</sup> This can be used to pay for the cost of workplace adjustments to help a disabled person take up or retain paid work.

<sup>257</sup> Payments to disabled people administered by a non-departmental public body under the Department for Work and Pensions.

<sup>258</sup> Grants paid towards the cost of building works which are necessary to meet the needs of disabled people issued by the housing authority.

<sup>259</sup> Housing related support services for vulnerable people, provided under s 93 of the Local Government Act 2003.

- 4.228 Individual budgets are not specifically provided for in statute law, however, they would need to operate within social care legislation and guidance, including that relating to assessments and direct payments. For example, an individual budget would not bypass the duty of a local authority to carry out a community care assessment and the various legal requirements that accompany such an assessment, including a carer's right to a separate assessment and the prohibition on placing cost ceilings on care packages.<sup>260</sup>
- 4.229 The Department of Health has acknowledged that some aspects of the current legal framework may need to be updated to take into account the particular characteristics of an individual budget, particularly their inclusion of different funding streams.<sup>261</sup> The final report by the Independent Budgets Evaluation Network Programme also noted concerns that legislation prohibited integration of the funding streams at local level and that the FACS guidance was "poorly aligned" with several of the funding streams.<sup>262</sup>
- 4.230 The Department of Health responded to this report by stating that it was "encouraged" by the conclusions, which showed that "holding an individual budget was associated with better overall social care outcomes and higher perceived levels of control".<sup>263</sup> Despite some shortcomings, the Department confirmed that "the introduction of personal budgets in social care is the right approach".<sup>264</sup>

#### **Issues for reform**

- 4.231 We recommend that the review consider the legal framework for direct payments, including any changes introduced as a result of the current consultation on the regulations.<sup>265</sup> In particular, it would consider whether or not the regulations could be refined or simplified and whether some aspects of the regulations would be strengthened or otherwise benefit from being placed in statute law.
- 4.232 The review would also consider individual budgets and whether they should be specifically provided for in statute law. One option would be to consider whether or not a statutory duty to provide an individual budget should be introduced.

<sup>260</sup> For discussion of the relationship between community care law and individual budgets see L Clements, "Individual Budgets and Irrational Exuberance" (2008) 11 *Community Care Law Reports* 413.

<sup>261</sup> For example, the Department of Health has announced a review of the Fairer Charging guidance in relation to individual/personal budgets, see [http://networks.csip.org.uk/\\_library/Resources/Personalisation/Personalisation\\_advice/DH\\_Review\\_of\\_the\\_Fairer\\_Charging\\_Guidance.pdf](http://networks.csip.org.uk/_library/Resources/Personalisation/Personalisation_advice/DH_Review_of_the_Fairer_Charging_Guidance.pdf) (last visited 9 November 2008).

<sup>262</sup> C Glendinning and others, *Evaluation of the Individual Budgets Pilot Programme: Final Report* (2008) pp 243 and 247.

<sup>263</sup> Department of Health, *Moving Forward: Using the Learning from the Individual Budget Pilots: Response to the IBSEN evaluation from the Department of Health* (2008) p 4.

<sup>264</sup> As above, p 2.

<sup>265</sup> Department of Health, *Consultation on Direct Payment Regulations* (2008).

## CHARGING FOR SERVICES

### Charging for residential accommodation

- 4.233 Section 22 of the NAA 1948 places a general duty on local authorities to recover payments from a person for whom they provide residential accommodation under Part 3 of the Act. It also states that if a person is unable to pay the full cost then the local authority must assess the resident's ability to pay and determine what lower rate should be paid. The Act also provides that every resident must be allowed to retain a weekly allowance as prescribed by the Secretary of State and the Welsh Ministers. The charging procedure also applies to people placed by the local authority in residential accommodation provided by the independent sector.
- 4.234 In the case of temporary residents who stay in accommodation for less than eight weeks the local authority has discretion whether to apply the statutory charging procedure.
- 4.235 The rules for means testing care home residents are set out in the National Assistance (Assessment of Resources) Regulations 1992 as amended and the statutory guidance, *Charging for Residential Accommodation*.<sup>266</sup>

### Charging for domiciliary and community services

- 4.236 Unlike residential accommodation, local authorities are not under a duty to charge for domiciliary and community services. Section 17 of the Health Services and Social Security Adjudications Act 1983 provides that a local authority providing such a service "may recover such charge (if any) for it as they consider reasonable". The local authority in exercising this discretion cannot require a service user to pay more than what is *reasonably practicable* for him or her to pay. The relevant statutory guidance is contained in *Fairer Charging Policies for Home Care and other Non-Residential Social Services*.<sup>267</sup>
- 4.237 Most authorities use their discretion to charge but there are variations in how the charges are applied. Research by Age Concern England found large inconsistencies in, for example, how local authorities set their maximum charges, their charge per hour and the existence and amount of subsidies offered.<sup>268</sup>

<sup>266</sup> SI 1992 SI No 2977; Department of Health, *Charging for Residential Accommodation Guide* (2007); and the Welsh Assembly Government, *Charging for Residential Accommodation Guide* (2004).

<sup>267</sup> Department of Health (2003) and in Wales NAFWC 11/07.

<sup>268</sup> P Thompson and D Mathew, *Fair Enough? Research on the Implementation of the Department of Health Guidance Fairer Charging Policies for Home Care and Other Non-residential Social Services* (April 2004). This report is also considered in para 2.53 above.

- 4.238 Partly in response to concerns about the wide variation in charging policies operated in Wales and that charges are being set too high, the Welsh Assembly Government has published a proposal for a Legislative Competence Order relating to charging for non-residential social care.<sup>269</sup> This would enable the Welsh Assembly to ensure that local authority charges are in accordance with such requirements as may be specified and that some services may be provided for free if this is considered to be appropriate.<sup>270</sup>

### **Direct payments**

- 4.239 A duty is placed on local authorities to carry out a means test to determine whether a direct payment should be made as a gross payment or a net payment.<sup>271</sup> A gross payment is where the local authority makes a direct payment that is equivalent to their estimate of the reasonable cost of the service and subsequently seeks reimbursement of the assessed charge. Alternatively, a net payment involves the local authority deducting from their estimate the assessed charge before the payment is made.<sup>272</sup>
- 4.240 The proposed Legislative Competence Order in Wales relating to charging for non-residential social care would also encompass the charging arrangements for service users and carers in receipt of direct payments to secure non-residential social care.<sup>273</sup>

### **Services that must be provided for free**

- 4.241 Certain services must be provided free of charge and these exemptions are set out in various different legal provisions. These are summarised below:
- (1) all services, including residential accommodation and domiciliary and community services, provided under section 117 of the Mental Health Act 1983;
  - (2) intermediate care, which is defined as “a structured programme of care provided for a limited period of time to assist a person to maintain or regain the ability to live in his home ... for any period up to and including six weeks”,<sup>274</sup>

<sup>269</sup> The National Assembly for Wales (Legislative Competence) (No.4) Order 2008. See also Deputy Minister for Health and Social Services, *Explanatory Memorandum to the Proposed National Assembly for Wales (Legislative Competence) (No.4) Order 2008* (2008) paras 11 and 13.

<sup>270</sup> Deputy Minister for Health and Social Services, *Explanatory Memorandum to the Proposed National Assembly for Wales (Legislative Competence) (No.4) Order 2008* (2008) para 19.

<sup>271</sup> The Community Care, Services for Carers and Children’s Services (Direct Payments) (England) Regulations 2003, SI 2003 No 762, reg 5(2) and the Community Care, Services for Carers and Children’s Services (Direct Payments) (Wales) Regulations 2004, WSI 2004 No 1748, reg 6(2).

<sup>272</sup> Department of Health, *Direct Payments Guidance Community Care, Services for Carers and Children’s Services (Direct Payments) England Guidance* (2003) para 89.

<sup>273</sup> The National Assembly for Wales (Legislative Competence) (No.4) Order 2008.

<sup>274</sup> CC(DD)A (Qualifying Services) (England) Regulations 2003, SI 2003 No 1196, reg 4(2) and NAFWC 43/2002, *Intermediate Care Guidance*, para 22.

- (3) community equipment, which is defined as an aid, or a minor adaptation to property, for the purposes of assisting with nursing at home or aiding daily living;<sup>275</sup>
- (4) non-residential services to people suffering from any form of Creutzfeldt Jacob Disease,<sup>276</sup> and
- (5) advice about the availability of services or an assessment, including assessment of community care needs.<sup>277</sup>

### **Issues for reform**

- 4.242 We believe that the review should consider whether the different provisions on charging for services could be rolled into a single legal provision. This would not change who would have to pay for services but it would aim at simplifying the law. This could be achieved by replicating the existing power to charge for domiciliary services and the duty to charge for residential services in a single legal provision. Alternatively, a general power to charge for all services could be established, which would be likely to have the same effect in practice. We would expect that the vast majority of the detail on charging procedures would continue to be set out in regulations and guidance.
- 4.243 We would not seek to remove any of the current exemptions that apply to charging. However, we would consider whether the law could be clearer about which services are provided for free, for example by providing a clear statement in primary or secondary legislation. The review would also consider whether an enabling power should be included in adult social care law, giving the Secretary of State and the Welsh Ministers discretion to extend the provision of free social care services to additional groups.

## **THE HEALTH/SOCIAL CARE DIVIDE**

### **Health and social care services**

- 4.244 The division of health and social care provision dates back to the inception of the NHS, when the question of what is health and what is social care appeared relatively straightforward. The NAA 1948 applied to those in need of “care and attention”, as opposed to being in need of medical treatment under the NHS. In the ensuing years, however, this division has become increasingly blurred as a result of fundamental changes to the way that health and social care is provided:

<sup>275</sup> CC(DD)A (Qualifying Services) (England) Regulations 2003, SI 2003 No 1196. This does not apply in Wales.

<sup>276</sup> Department of Health, *Fairer Charging Policies for Home Care and Other Non-Residential Social Services: Guidance for Councils with Social Services Responsibilities* (September 2003) para 75 and NAFWC 11/07, *Fairer Charging Policies for Home Care and Other Non-Residential Social Services: Revised Guidance for Local Authorities*, para 63.

<sup>277</sup> As above, para 8 (England) and para 10 (Wales).

In practice the boundary between the two services has shifted over time, so that the long term care responsibilities of the NHS have reduced substantially, and people who in the past would have been cared for in NHS long stay wards are now often accommodated in nursing homes. This means that responsibility for funding long term care has to a major extent been shunted from the NHS to local authorities and individual patients and their families.<sup>278</sup>

4.245 This divide is significant for service users and their families because, in general terms, NHS services are provided free of charge, while social care services are subject to a means-tested charge. There are also financial implications for a local authority if what might be regarded as a healthcare provision falls within its responsibilities.

4.246 The divide is also significant because almost all of the duties placed on the NHS are general target duties owed towards the general population rather than individuals.<sup>279</sup> In contrast adult social care legislation includes a number of specific public law duties which are amenable to enforcement by individuals.<sup>280</sup> Whether a service is provided by health or social services, therefore, may determine whether an individual can enforce their right to that service.

4.247 There are three statutory bars on the provision of services by local authorities:

- (1) section 21(8) of the NAA 1948, which prevents local authorities from providing residential accommodation and other services provided in connection with accommodation, if such services are “authorised or required to be provided” under the NHS Acts 2006.<sup>281</sup>
- (2) section 29(6) of the NAA 1948, which prohibits local authorities from providing welfare services under this section, which are “required” to be provided under the NHS Acts 2006; and
- (3) section 49 of the Health and Social Care Act 2001, which prevents local authorities from providing nursing care by a registered nurse as part of the provision of community care services.

#### **Section 21(8) of the NAA 1948**

4.248 Most of the case law in this area focuses on the prohibition in section 21(8) of the NAA 1948 on local authorities providing residential accommodation and other services provided in connection with accommodation, if they are “authorised or required to be provided” under the NHS Acts 2006. One of the key difficulties, however, has been that the NHS Acts 2006 do not specify which services are required or authorised to be provided by the NHS.

<sup>278</sup> House of Commons Health Committee, NHS Continuing Care: Sixth Report of the Session 2004-05, Volume 1 (2005) HC 399-1, para 41.

<sup>279</sup> *R v Cambridgeshire HA ex p B* [1995] 1 WLR 898.

<sup>280</sup> Examples include s 2 of the CSDPA 1970 and s 117 of the Mental Health Act 1983.

<sup>281</sup> The NHS Acts 2006 replaced the NHS Act 1977.

4.249 Section 1(1) of the NHS Acts 2006 places the Secretary of State and the Welsh Ministers under a duty to continue to promote a comprehensive health service and section 3 sets out a general list of services which they are under a duty to provide.<sup>282</sup> However, this duty is subject to two important qualifications:

- (1) it is limited to services that the Secretary of State and the Welsh Ministers consider necessary to meet all reasonable requirements; and
- (2) in relation to services for illness, the Secretary of State and Welsh Ministers must consider if they are appropriate to be provided “as part of a health service”.

4.250 The courts have therefore recognised that in practice this gives the Secretary of State and the Welsh Ministers broad discretion and in exercising this discretion, they are “entitled to take into account the resources available ... and the demands on those resources”.<sup>283</sup> This has led to the identification of a gap between what can legally be provided by local authorities under section 21 of the NAA 1948 and which services are authorised or required to be provided under the NHS Acts 2006:

[Section 21(8) of the NAA 1948] should not be regarded as preventing a local authority from providing any health services. The subsection’s prohibitive effect is limited to those health services which, have in fact, been authorised or required to be provided to be provided under the [NHS Acts 2006]. Such health services would not therefore include services which the Secretary of State legitimately decided under section 3(1) [of the NHS Acts 2006] it was not necessary for the NHS to provide.<sup>284</sup>

#### ***The primary health need test***

4.251 In order to distinguish between services it is appropriate for the NHS to provide under the NHS Acts 2006 and those which a local authority may lawfully provide under section 21(8) of the NAA 1948, the courts have developed the so-called *quantitative/quantity* test. This provides that nursing services can be provided by a local authority if they are:

- (1) merely incidental or ancillary to the provision of the accommodation which a local authority is under a duty to provide pursuant to section 21 of the NAA 1948; and

<sup>282</sup> The list provides for: hospital accommodation; other accommodation for the purpose of the NHS Acts 2006; medical, dental, ophthalmic, nursing and ambulance services; appropriate services or facilities for women who are pregnant or breastfeeding and young children; appropriate services or facilities for the prevention of illness, people suffering from illness and the after-care of persons who have suffered from illness; and other services or facilities for the diagnosis and treatment of illness.

<sup>283</sup> *R v North and East Devon HA ex p Coughlan* [2001] QB 213 at 26.

<sup>284</sup> *R v North and East Devon HA ex p Coughlan* [2001] QB 213 at 29.

- (2) of a nature which it can be expected that an authority whose primary responsibility is to provide social services can be expected to provide.<sup>285</sup>
- 4.252 This test has since been adopted as *the primary health need test* in the NHS Continuing Healthcare (Responsibilities) Directions 2007<sup>286</sup> and the *National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care in England*.<sup>287</sup> It is also included in the *Draft National Framework for Continuing Healthcare in Wales*.<sup>288</sup>
- 4.253 NHS Continuing Healthcare means a package of care arranged and funded solely by the NHS “for a person aged 18 or over to meet physical or mental health needs which have arisen as a result of illness”.<sup>289</sup> It can be provided in any setting including a hospital, a care home or an individual’s own home. According to the National Framework the purpose of the primary health need test is:

To assist in deciding which treatment and other health services it is appropriate for the NHS to provide under the National Health Service Act 2006, and to distinguish between those and the services which [local authorities] may provide under section 21 of the National Assistance Act 1948.<sup>290</sup>

- 4.254 The National Framework goes on to state that:

There should be no gap in the provision of care, such that people might be in a situation where neither the NHS nor (subject to the person meeting the relevant means test) the relevant [local authority], separately or together, will fund care.<sup>291</sup>

### **Community services**

- 4.255 Clements and Bowen point out that what is sometimes overlooked is that “the exclusionary effect of section 21(8) [of the NAA 1948] is limited to people in residential accommodation and services provided ‘in connection with’ such accommodation”.<sup>292</sup> Therefore, a social services authority can provide all manner of community care services for a person living in the community who is entitled to NHS Continuing Healthcare such as:

- (1) services provided by local authorities under the NHS Acts 2006 to prevent people becoming ill;

<sup>285</sup> *R v North and East Devon HA ex p Coughlan* [2001] QB 213 at 30.

<sup>286</sup> Direction 2(7). These directions were issued under the NHS Acts 2006 and the Local Authority Social Services Act 1970.

<sup>287</sup> Department of Health (2007) para 24.

<sup>288</sup> Welsh Assembly Government (2007) para 18.

<sup>289</sup> NHS Continuing Healthcare (Responsibilities) Directions 2007, dir 1.

<sup>290</sup> Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care* (2007) para 16.

<sup>291</sup> As above, para 24.

<sup>292</sup> L Clements and P Bowen, “NHS Continuing Care and Independent Living” (2007) 10 *Community Care Law Reports* 343, 343.

(2) services under section 29 of the NAA 1948 and section 2 of the CSDPA 1970 to:

(a) people living at home, in respect of whom section 21(8) of the NAA 1948 does not apply; or

(b) people in residential care, where the services are not provided in connection with the residential accommodation.<sup>293</sup>

4.256 Section 29(6) of the NAA 1948 only prohibits local authorities from providing services which are “required” to be provided under the NHS Acts 2006, as opposed to those “authorised or required” to be provided in section 21(8) of the NAA 1948. This does not prohibit local authorities providing services:

Which could as a matter of law be provided by either the NHS or a local authority but which as a matter of policy the Secretary of State and the Welsh Ministers have decided should be provided by the NHS as NHS Continuing Healthcare (“authorised”).<sup>294</sup>

4.257 This analysis suggests that in relation to community services there is no gap between what the Secretary of State and Welsh Ministers are under a duty to provide as part of the NHS and “health services” that can be lawfully supplied by local authorities, but “rather an overlap”.<sup>295</sup>

4.258 The National Framework provides guidance on this point by suggesting that:

The [local authority] is, however, not prevented from providing services, as it sees fit. Indeed in some cases, there may to be individual arrangements reached between [local authorities] and [primary care trusts] with respect to the provision of services. This may be particularly relevant where the person is cared for in a community setting.<sup>296</sup>

### ***Issues for reform***

4.259 We recommend that the review consider the inter face between health and social services and how this might be expressed in any future consolidated adult social care statute. This would be a technical undertaking of examining how best to delineate the statutory boundary between health and social care and would not attempt to extend the remit of the NHS or social services.

<sup>293</sup> For example, education opportunities provided on another site.

<sup>294</sup> L Clements and P Bowen, “NHS Continuing Care and Independent Living” (2007) 10 *Community Care Law Reports* 343, 346.

<sup>295</sup> As above, 347.

<sup>296</sup> Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* (2007) para 76.

## Duty to co-operate

- 4.260 In recent years, there has been an increasing emphasis on achieving greater integration and joint working between health and social services as a core feature of government policy.<sup>297</sup> The positive reasons for joint working include the need to simplify the process for assessment and the provision of services, and to avoid duplication. A number of high-profile cases have also provided vivid reminders of the potentially tragic consequences when vulnerable adults fall between health and social services.<sup>298</sup>
- 4.261 Greater joint working has been achieved in a number of ways, including: the establishment of joint health and social services multi-disciplinary teams;<sup>299</sup> the development of a Single Assessment Process for older people's services;<sup>300</sup> the use of guidance to encourage joint working;<sup>301</sup> and the transfer of social care staff to Primary Care Trusts under T.U.P.E. arrangements.<sup>302</sup> There are also various strategic provisions, such as:
- (1) the NHS Acts 2006, which allow NHS bodies and local authorities to pool their resources, delegate functions and transfer resources to one another and enable a single provider to provide both health and local authority functions;
  - (2) the creation of care trusts pursuant to the Health and Social Care Act 2001; and

<sup>297</sup> See, for example, *Our Health, Our Care, Our Say: A New Direction for Community Services* (2006) Cm 6737, paras 5.26 to 5.33 and *High Quality Care For All: NHS Next Stage Review Final Report* (2008) Cm 7432, para 45.

<sup>298</sup> For example, in services for people with learning disabilities an investigation into alleged abuse in Cornwall found that "working relations between the [NHS] trust and Cornwall County Council had been poor for a considerable time" and that "social services had little involvement in the care provided by the trust, to the detriment of people with learning disabilities": Commission for Social Care Inspection/Healthcare Commission, *Joint Investigation into the Provision of Services for People with Learning Disabilities at Cornwall Partnership NHS Trust* (2006) p 7. In mental health services a review of mental health homicides identified a lack of partnership working as a common feature of official inquiries (and the fourth most important out of 12 contributing factors) – both in health and social care, as well as with the police, housing and the independent sector: A McCulloch and C Parker, "Inquiries, Assertive Outreach and Compliance: Is There a Relationship?" in N Stanley and J Manthorpe (eds), *The Age of the Inquiry: Learning and Blaming in Health and Social Care* (2004).

<sup>299</sup> For example, community mental health teams.

<sup>300</sup> HSC 2002/001 and LAC(2002)1, *Guidance on the Single Assessment Process for Older People*.

<sup>301</sup> For example, Department for Health, *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* (2008).

<sup>302</sup> Transfer of Undertakings (Protection of Employment) Regulations 1981, SI 1981 No 246 and the European Acquired Rights Directive 77/187/EEC, Official Journal L 061 of 05.03.1977 p 26.

- (3) the Local Government and Public Involvement in Health Act 2007, which places a duty on a local authority to prepare and submit a Local Area Agreement<sup>303</sup> and includes a requirement for a joint health and social care strategic needs assessment.<sup>304</sup>

4.262 In addition, statute law has been used as a vehicle to encourage health bodies and local authorities to work together. The main examples are listed below.

- (1) Section 82 of the NHS Acts 2006, which provides that:

In exercising their respective functions NHS bodies (on the one hand) and local authorities (on the other) must co-operate with one another in order to secure and advance the health and welfare of the people of England and Wales.

- (2) Section 47(3) of the NHSCCA 1990, which states that, where a community care assessment discloses a possible housing or medical need, the local authority must notify the relevant housing or health authority.
- (3) The joint duty on health and social services under section 117 of the Mental Health Act 1983 to provide after-care services to people who are 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.
- (4) The C(EO)A 2004, which provides that a local authority must request another body or health body to assist it in planning the provision of services to carers and the cared-for person. The other body must then give “due consideration” to such a request. It goes on to state that if the local authority forms the view that the carer’s ability to provide care might be enhanced by the provision of services by another authority or health body it may request that the other body provide the service. The other body must then give “due consideration” to such a request.

4.263 However, legislative duties to co-operate have been criticised as weak and difficult to enforce.<sup>305</sup>

<sup>303</sup> Local Government and Public Involvement in Health Act 2007, s 106. Local Area Agreements set out the priorities for a local area agreed between central government and a local area (the local authority and Local Strategic Partnership) and other key partners at the local level.

<sup>304</sup> Local Government and Public Involvement in Health Act 2007, s 116.

<sup>305</sup> P Bowen, *Access To Social Care: A Critique of the Domestic Law Framework* (2006) p 6, <http://www.doughtystreet.co.uk/files/socialcare-bowen.pdf> (last visited 9 November 2008).

### ***Issues for reform***

- 4.264 We believe the review should consider whether the existing duties to co-operate could be rolled into a single legal provision. This could be based on the existing legal provisions set out above. Alternatively, the same effect may be achieved by establishing in adult social legislation a general duty to co-operate. Consideration would also be given to whether such a duty should include organisations other than local authorities and health services, such as housing authorities and voluntary organisations, and what the remedies or sanctions (if any) could be for failure to co-operate.

### **SAFEGUARDING ADULTS FROM ABUSE AND NEGLECT**

- 4.265 Some adults may require additional protection against abuse and neglect because they are vulnerable or in vulnerable situations. Abuse can be perpetrated by a wide range of people including family, friends, professional paid staff, volunteers and other service users, and may also take many forms:

Abuse may consist of a single act or repeated acts. It may be physical, verbal, or psychological. It may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.<sup>306</sup>

- 4.266 There is a growing body of research into the abuse of people who use or may use services, for example:

- (1) the first national survey of abuse and neglect of older people in 2007 found that 2.6% of people aged 66 and over living in private households in the UK reported that they had experienced mistreatment involving a family member, friend or care worker during the past year. This equates to about 227,000 people aged 66 and over experiencing mistreatment, and around 1 in 40 of the older population. The overall prevalence increases to 4.0% when the enquiry is broadened to include incidents involving neighbours and acquaintances. It also reported that the proportion of mistreatment cases coming to the attention of Adult Protection services is likely to be small: approximately 3%.<sup>307</sup>

<sup>306</sup> Department of Health and Home Office, *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse* (2000) and National Assembly for Wales, *In Safe Hands: Implementing Adult Protection Procedures in Wales* (2000) para 6.2.

<sup>307</sup> O'Keefe and others, *UK Study of Abuse and Neglect of Older People: Prevalence Survey Report* (2007) and A Mowlam and others, *UK Study of Abuse and Neglect of Older People: Qualitative Findings* (2007).

- (2) an investigation into Sutton and Merton PCT found that institutional abuse was “prevalent in most parts of the learning disability service”.<sup>308</sup> An earlier investigation into NHS services for people with learning disabilities provided by Cornwall Partnership NHS Trust also found that institutional abuse was “widespread”,<sup>309</sup> and
- (3) a Department of Health survey conducted in 2004 based on adult protection referrals to local authorities found that most referrals concerned abuse against older people (4436 referrals), followed by abuse of those with learning disabilities (3047 referrals), mental ill health (1100 referrals) and physical disability (1086 referrals). The most common form of abuse reported was physical abuse (in 65.47% of authorities) followed by financial abuse.<sup>310</sup>
- 4.267 The existing legal framework for safeguarding adults from abuse and neglect is “neither systematic nor co-ordinated, reflecting the sporadic development of safeguarding policy over the last 25 years”.<sup>311</sup> Just as for any other citizen, recourse against abuse is available through the civil and criminal justice systems. The legal framework also includes the Mental Health Act 1983, the Mental Capacity Act 2005, the Safeguarding Vulnerable Groups Act 2006 and the inherent jurisdiction of the High Court.<sup>312</sup>
- 4.268 The provision of community care services by local authorities is also a crucial aspect of the legal framework for safeguarding adults. Indeed, it is likely that the provision of appropriate care packages may, except in the most serious cases, help to minimise the risk of abuse or neglect. In addition, local authorities have been given a number of specific powers relating to safeguarding adults and these are considered in more detail below.

### **Adult protection as a public duty**

- 4.269 Unlike in Scotland, there is no statutory duty placed on local authorities in England and Wales to investigate cases of abuse or potential abuse, equivalent to the child protection measures contained in the Children Act 1989. Instead the legal framework for responding to cases of suspected adult abuse and identifying responsible agencies is provided for through a combination of the common law and local authority guidance.

<sup>308</sup> Healthcare Commission, *Investigation into the Service for People with Learning Disabilities Provided by Sutton and Merton PCT* (2007) p 6.

<sup>309</sup> Commission for Social Care Inspection and the Healthcare Commission, *Joint Investigation into the Services for People with Learning Disabilities at Cornwall Partnership NHS Trust* (2006) p 5.

<sup>310</sup> Department of Health, *Action on Elder Abuse: Report on the Project to Establish a Monitoring and Reporting Process for Adult Protection Referrals Made in Accordance With ‘No Secrets’* (2005).

<sup>311</sup> Commission for Social Care Inspection, *Raising Voices: Views on Safeguarding Adults* (2008) para 2.1.

<sup>312</sup> Appendix B to this report provides a more detailed overview of the legal framework for safeguarding adults (excluding the specific powers given to local authorities which are outlined in paras 4.270 to 4.275 below).

### ***The common law***

4.270 In *X and another v Hounslow London Borough Council*,<sup>313</sup> the High Court held that a local authority had a duty of care to protect two vulnerable adults who were living in a flat provided by defendant local authority and where the authority was aware of a real, specific and serious risk of abuse from local youths. Although the Court rejected the imposition of a general duty of care to protect vulnerable adults from harm, it did impose a more targeted duty of care and referred to a series of cases where the courts had accepted that local authorities can owe children a duty of care to protect them from abuse:

In the present case the Claimants, though adults, both functioned in many ways like children. No adult of normal intellect and understanding was living in their household. The Defendant knew this, and had allocated a social worker to both their cases. In my judgment, the extension of a duty of care to the Claimants would involve a small step rather than a giant leap forward, and would not offend the “incremental” principle ... This is so particularly since ... the duty to be imposed, if any, would be of a very narrow and case-specific nature, and as such would not open the gates to a flood of future claims that would not otherwise have been brought.<sup>314</sup>

4.271 In *Re Z*,<sup>315</sup> which concerned a woman who was suffering from an incurable and irreversible condition and who wished to be assisted to commit suicide in Switzerland (where assisted suicide is legal), it was held that the duties which lay on a local authority when it learned that the welfare of a vulnerable adult in its area was seriously threatened by a decision taken by that person were:

- (1) to investigate the position of the vulnerable adult to consider what was her true position and intention;
- (2) to consider whether she was legally competent to make and carry out her decision and intention;
- (3) to consider whether any other (and, if so, what) influence could be operating on her position and intention and to ensure that she had all relevant information and knew all the available options;
- (4) to consider whether to invoke the inherent jurisdiction of the High Court so that the question of competence could be judicially investigated and determined;
- (5) in the event of the adult not being competent, to provide all such assistance as might be reasonably required both to determine and give effect to her best interests;

<sup>313</sup> [2008] EWHC 1168 (QB), [2008] All ER (D) 337 (May).

<sup>314</sup> As above, at [119], by Maddison J.

<sup>315</sup> [2004] EWHC 2817 (Fam), [2005] 3 All ER 280.

- (6) in the event of the adult being competent, to allow her in any lawful way to give effect to her decision although that should not preclude the giving of advice or assistance in accordance with what were perceived to be her best interests;
- (7) where there were reasonable grounds to suspect that the commission of a criminal offence might be involved, to draw that to the attention of the police; and
- (8) in very exceptional circumstances, to invoke the jurisdiction of the court under s 222 of the Local Government Act 1972.<sup>316</sup>

### **Local authority guidance**

- 4.272 In 2000 statutory guidance was issued in England, *No Secrets*, and in Wales, *In Safe Hands*, which provide structure and content for the development of local inter-agency policies, procedures and joint protocols for safeguarding adults.<sup>317</sup> They also offer definitions of “a vulnerable adult” and “abuse”.<sup>318</sup>
- 4.273 Both *No Secrets* and *In Safe Hands* are mainly concerned with process. They recommend, for example, the development of an inter-agency policy and strategy for the protection of vulnerable adults from abuse, with the local social services authority as the lead agency for co-ordinating such activity.<sup>319</sup> They also suggest that agencies may consider establishing a multi-agency adult protection management committee to determine policy, co-ordinate activity between agencies, facilitate joint training and monitor and review progress.<sup>320</sup>
- 4.274 Other non-statutory guidance has also been issued, for example:
- (1) in 2005 the Association of Directors of Social Services published a national framework of standards for safeguarding adults to try to reduce the variation across the country.<sup>321</sup> Although they are not obligatory, the Commission for Social Care Inspection refer to them when assessing the performance of local social services authorities; and

<sup>316</sup> This section provides that, where a local authority considers it expedient for the promotion or protection of the interests of the inhabitants of their area, it can prosecute or defend legal proceedings or make representations at a public inquiry.

<sup>317</sup> Department of Health and Home Office, *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse* (2000) and National Assembly for Wales, *In Safe Hands: Implementing Adult Protection Procedures in Wales* (2000).

<sup>318</sup> The definition of a vulnerable adult is set out in para 4.280 below. The term “abuse” is described in both sets of guidance as “a violation of an individual’s human and civil rights by another person or persons” and includes: physical abuse; sexual abuse; psychological abuse; financial or material abuse; neglect and acts of omission; and discriminatory abuse. As above, paras 2.5 to 2.6 (England) and paras 7.4 to 7.6 (Wales).

<sup>319</sup> As above, paras 3.2 and 3.18 (England) and paras 3.1 to 3.2 (Wales).

<sup>320</sup> As above, para 3.4 (England) and para 5.5 (Wales).

<sup>321</sup> Association of Directors of Adult Social Services, *Safeguarding Adults: A National Framework of Standards* (2005).

- (2) a joint protocol has been issued by the Commission for Social Care Inspection, the Association of Directors of Social Services and the Association of Chief Police Officers setting out the roles of the key agencies in multi-agency procedures.<sup>322</sup>
- 4.275 In 2007 the Department of Health announced that *No Secrets* will be reviewed and a consultation paper was published in October 2008.<sup>323</sup> The three main reasons given for the review were: the change in the policy environment since 2000; a number of weaknesses which have been identified in the implementation of *No Secrets*; and the need to examine the case for legislative change.<sup>324</sup> The Welsh Assembly Government has also announced a review of *In Safe Hands*.

### **Criticisms of the legal framework**

#### THE LACK OF STATUTORY PROVISION

- 4.276 The current legal framework for safeguarding adults has been criticised for its lack of statutory provision and this has been compared, unfavourably, to the legislative provisions for safeguarding children at risk of significant harm. For example:
- (1) the chair of the Serious Case Review into the murder of Steven Hoskin has argued that because the framework for safeguarding adults is only set out in guidance, this has created a perception that compliance is not obligatory and that, therefore, the framework needs to be in statute law;<sup>325</sup> and
- (2) the lack of statutory provision has been identified as having a negative impact on the status and effectiveness of safeguarding adults procedures:

The safeguarding systems for children and adults are poles apart in terms of profile, performance and working in partnership ... safeguarding adults is a poor relation in terms of profile, funding and resources.<sup>326</sup>

<sup>322</sup> Commission for Social Care Inspection, Association of Directors of Adult Social Services and Association of Chief Police Officers, *Safeguarding Adults Protocol and Guidance* (2007).

<sup>323</sup> Department of Health, Home Office and the Ministry of Justice, *Safeguarding Adults: A Consultation on the Review of the 'No Secrets' Guidance* (2008).

<sup>324</sup> As above, p 3.

<sup>325</sup> M Flynn, "How the NHS is Failing Vulnerable Adults" (8 April 2008) *Health Service Journal*, [http://www.hsj.co.uk/opinion/2008/04/adult\\_protection\\_and\\_the\\_nhs.html](http://www.hsj.co.uk/opinion/2008/04/adult_protection_and_the_nhs.html) (last visited 11 November 2008).

<sup>326</sup> Cornwall Adult Protection Committee, *The Murder of Steven Hoskin: A Serious Case Review, Executive Summary* (December 2007) para 7.2.1.

- 4.277 Many organisations have pointed to the need for a statutory duty on local authorities to investigate cases of actual or suspected abuse or neglect. For example, in 1995 the Law Commission proposed that local social services authorities should have a new duty to investigate where they have “reason to believe that a vulnerable adult in their area is suffering or is likely to suffer significant harm or serious exploitation”.<sup>327</sup> These proposals were not implemented in the Mental Capacity Act 2005, which was the direct outcome of the Commission’s report.
- 4.278 Since then, the Adult Support and Protection (Scotland) Act 2007 has been passed which places a duty on councils to investigate where an adult may be at risk. It also includes powers to enter premises where the abuse of adults is thought to be taking place, banning orders to remove perpetrators from those premises and establishing statutory adult protection committees.
- 4.279 There have also been calls for other aspects of the legal framework for safeguarding adults to be given statutory status. For example:
- (1) it has been argued that adult safeguarding committees or boards should be placed on a statutory footing and that there should be a duty to contribute to serious case reviews; and
  - (2) that there should be a duty to ensure multi-agency co-operation in cases of actual or alleged abuse or neglect.<sup>328</sup>

#### THE DEFINITION OF A VULNERABLE ADULT

- 4.280 *No Secrets* and *In Safe Hands* define a “vulnerable adult” as a person aged 18 years or over and:

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.<sup>329</sup>

- 4.281 In 2004, the Health Committee noted criticism that the *No Secrets* definition appears:

To exclude those individuals who do not require community care services and who can care for themselves. It is based on a health/social care model and assumes that the vulnerable person must be in need of external support.<sup>330</sup>

- 4.282 It accordingly recommended that the definition should be broadened to include:

<sup>327</sup> Mental Incapacity (1995) Law Com No 231, para 9.16.

<sup>328</sup> 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.

<sup>329</sup> As above, para 2.3 and National Assembly for Wales, *In Safe Hands: Implementing Adult Protection Procedures in Wales* (2000) p 14.

<sup>330</sup> Elder Abuse, Second Report of the Session 2003-04 Volume 1, House of Commons Health Committee (2007) HC 111-I, para 8.

Those individuals who do not require community care services, for example older people living in their own homes without support of health or social services, and those who can take care of themselves.<sup>331</sup>

4.283 A number of additional concerns have also been raised about use of the term *vulnerable adult* in this context, for example:

- (1) “it seems to locate the cause of abuse with the victim, rather than placing responsibility with the acts or omissions of others”,<sup>332</sup> and
- (2) it suggests that vulnerability is an inherent characteristic of a person, for example with learning disabilities, and does not recognise that it might be the context, the setting or the place which makes such a person vulnerable.<sup>333</sup>

4.284 The *Safeguarding Adults* guidance issued by the Association of the Directors of Adult Social Services emphasises that there has been a shift in thinking since *No Secrets*:

There have been some significant legal and policy changes to adult social and health care, together with a re-focusing of its language and philosophy. In particular, Fair Access to Care ... stresses “risk to independence 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 and 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.<sup>334</sup>

4.285 The guidance adopts the concept of an “adult at risk”, which reflects this move away from the term *vulnerable adult*. An *adult at risk* is defined as:

Every adult “who is or may be eligible for community care services” (National Health Service and Community Care Act 1990) and whose independence and wellbeing is at risk due to abuse or neglect.<sup>335</sup>

4.286 Although this definition includes reference to eligibility for community care services, which is a form of words criticised by the Health Committee, the guidance emphasises that it:

<sup>331</sup> As above, para 14.

<sup>332</sup> Association of Directors of Adult Social Services, *Safeguarding Adults: A National Framework of Standards* (2005).

<sup>333</sup> Commission for Social Care Inspection, *Raising Voices: Views on Safeguarding Adults* (2008).

<sup>334</sup> Association of Directors of Adult Social Services, *Safeguarding Adults: A National Framework of Standards* (2005) p 5.

<sup>335</sup> As above, p 5.

Specifically includes those people who are assessed as being able to purchase all or part of their community care services, as well as those who are eligible for community care services but whose need – in relation to safeguarding – is for access to mainstream services such as the police.<sup>336</sup>

4.287 The Adult Support and Protection (Scotland) Act 2007 Act has also moved away from the concept of a *vulnerable adult* and instead uses the term “adults at risk”, who are defined as:

- (1) unable to safeguard their own well-being, property, rights or other interests;
- (2) at risk of harm; and
- (3) 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.

4.288 This definition makes no reference to community care services. It also adopts a comparative approach to vulnerability – that is, it asks whether a person is more susceptible to abuse than a person who is not affected by disability, mental disorder, illness or physical or mental infirmity.

4.289 The Scottish Act also defines “harm” as where:

- (1) another person’s conduct is causing (or is likely to cause) the adult to be harmed; or
- (2) the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

4.290 An alternative approach is taken in the Safeguarding Vulnerable Groups Act 2006 whereby vulnerability is understood purely through the situation an adult is placed. Thus, a person is a vulnerable adult if they are 18 or over and:

- (1) is in residential accommodation;
- (2) is in sheltered housing;
- (3) is receiving domiciliary care;
- (4) is receiving any form of health care;
- (5) is detained in lawful custody;
- (6) is in contact with probation services;
- (7) is receiving a welfare service;

<sup>336</sup> As above, p 5.

- (8) is receiving any service or participating 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 (age-related needs includes needs associated with frailty, illness, disability or mental capacity);
- (9) is receiving direct payments in lieu of social care services; or
- (10) requires assistance in the conduct of his or her affairs.

### ***Issues for reform***

- 4.291 We recommend that our review should consider the issues outlined in paragraphs 4.292 and 4.293 (below) to the extent that it can helpfully add to the Government reviews currently underway.
- 4.292 The review should consider whether giving a statutory basis to some aspects of the current legal framework for safeguarding adults might help to ensure greater legal clarity and consistency. The review should also consider whether *No Secrets* and *In Safe Hands* need to be bolstered by the introduction of a statutory duty on local authorities in England and Wales to investigate in cases of actual or suspected abuse and neglect. In particular, the review would need to take into account any early evidence on the operation of the Adult Support and Protection (Scotland) Act 2007, which was implemented on 29 October 2008.
- 4.293 The review should also consider the legal definition of a vulnerable adult. We recognise the danger that a tightly constructed definition might serve as a barrier to services, whereas one that is too broad may lead to local authorities having considerable increased demands placed upon them. It will therefore be particularly important to consult with stakeholders on this matter. The review would also need to consider whether this definition should be set out in statute law or remain in guidance.

### **Compulsory removal of people from home**

- 4.294 Section 47 of the NAA 1948 enables a local authority to seek an order from a magistrates' court for the removal of a person from his or her place of residence to a hospital or other place for the purpose of securing the necessary care and attention. The relevant grounds are that:
- (1) the person is suffering from grave, chronic disease, or, being aged, infirm or physically incapacitated, is living in insanitary conditions;
  - (2) he or she is unable to devote to themselves, and are not receiving from other persons, proper care and attention; and
  - (3) a certificate has been provided by the medical officer of health (community physician) that removal is necessary either in the interests of the person, or for the prevention of injury to the health of, or serious nuisance to, other persons.
- 4.295 However, this section cannot be used where:

- (1) an order has been made by the Court of Protection authorising the managing authority of a hospital or care home to provide the person with proper care and attention; or
- (2) the person is subject to the deprivation of liberty safeguards under Schedule A1 to the Mental Capacity Act 2005 or where the managing authority of the hospital or care home are under a duty to request a standard authorisation.<sup>337</sup>

4.296 In most cases seven days notice must be given to the person before a court can consider the application. However, the period of notice can be dispensed with, if the medical officer of health and another registered medical practitioner certify that it is necessary in the interests of the person to remove him or her without delay. In such cases the initial period for the order is three weeks, and no application for its revocation may be made.<sup>338</sup>

4.297 The order can authorise the person's detention for up to three months and can be renewed for further periods of up to three months indefinitely. Six weeks after the making of an order, the person who has been removed or someone acting on their behalf can apply to the court for the order to be revoked.

***Criticisms of section 47 of the NAA 1948***

4.298 The limited evidence available indicates that section 47 is rarely used and regarded as largely obsolete. The Department of Health does not routinely collect information about the use of section 47 orders, however, it has reported that "some authorities use orders perhaps once or twice a year as a last resort".<sup>339</sup>

4.299 A number of studies, mainly conducted in the 1980s, highlight a marked decrease in the use of these orders. For example, one study in relation to older people found that 91 orders were made in 1985 to 1986,<sup>340</sup> and another reported 165 orders made between 1988 to 1991 (of which 85% involved people over 65).<sup>341</sup> There was also considerable variation in the use of section 47 orders between the different authorities, with some making no use of the power, leading one commentator to the following conclusion:

<sup>337</sup> NAA 1948, s 47 (1A) to (1C). These amendments were made by the Mental Health Act 2007.

<sup>338</sup> National Assistance (Amendment) Act 1951.

<sup>339</sup> Department of Health, *Letter to the Regional Directors of Public Health* (2000).

<sup>340</sup> J A Muir, "Section 47:Bradford 1925 – United Kingdom 1988" (1990) 12 *Journal of Public Health Medicine* 28.

<sup>341</sup> P Nair and J Mayberry, "The Compulsory Removal of Elderly People in England and Wales Under Section 47 of the National Assistance Act and its 1951 Amendment: A survey of its Implementation in England and Wales in 1988 and 1989" (1995) 24 *Age and Ageing* 180.

Although the rate at which the powers are used is falling, perhaps as a result of improvements in domiciliary services and changing attitudes towards its use, suggesting that section 47 might, like many another piece of legislation, fall into desuetude, it is surely inappropriate for a piece of legislation drafted in the Town Clerk's Office in Bradford in 1925 and little changed since then to be used in such a sporadic and unrecorded fashion.<sup>342</sup>

4.300 It is likely that one of the reasons why section 47 of the NAA 1948 is rarely used is that authorities rely on powers available under other legislation. These include: powers to detain people with a mental disorder or place people on guardianship under the Mental Health Act 1983; powers to remove and detain people with notifiable diseases under the Public Health (Control of Disease) Act 1984; and best interests decisions under the Mental Capacity Act 2005. From April 2009, the deprivation of liberty safeguards will be in force, allowing certain people who lack capacity to be deprived of their liberty in care homes and hospitals under the Mental Capacity Act 2005, if this is considered to be in their best interests. This will provide a further alternative for dealing with such cases.<sup>343</sup>

4.301 The following concerns have been raised about the compatibility of detentions under section 47 of the NAA 1948 with the ECHR:

(1) Article 5 of the ECHR provides that no one shall be deprived of his or her liberty except in six specific circumstances and in accordance with a procedure prescribed by law. The relevant circumstance comes under paragraph (1)(e) which authorises "the lawful detention of persons for the prevention of spreading diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants". A detention under section 47 of the NAA 1948 could, however, extend to persons who are of "sound mind" and have the appropriate level of decision-making capacity to decide how they want to live and are not otherwise diagnosed as mentally disordered but are merely:

- (a) suffering from grave, chronic disease (without being infectious);  
or
- (b) infirm, aged or physically incapacitated (without being "alcoholics, drug addicts or vagrants") and living in insanitary conditions.

<sup>342</sup> J A Muir, "Section 47: Bradford 1925 – United Kingdom 1988" (1990) 12 *Journal of Public Health Medicine* 28, 29 to 30.

<sup>343</sup> Indeed, section 47 of the NAA 1948 cannot be used if, for example, the person is subject to the deprivation of liberty safeguards, see para 4.295 above.

- (2) Article 5(4) of the ECHR also 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”. The lack of specific provision for an appeal against an urgent three-week order may be incompatible with this requirement, as might the six weeks time limit before a non-urgent order can be challenged. In such cases, procedures such as habeas corpus and judicial review may not be seen as adequate for the purposes of Article 5(4) of the ECHR, especially where the detention is on the ground of unsoundness of mind.<sup>344</sup>
- (3) There is a possibility of removal for a lengthy period as a result of a hearing at which the person may not be present, based on the authority of limited medical evidence. This may engage the Article 5 ECHR requirement that a detention on the ground of unsoundness of mind must be based on objective medical expertise,<sup>345</sup> and the right to a fair trial under Article 6 of the ECHR.

### **Issues for reform**

- 4.302 We recommend that the review consider whether section 47 of the NAA 1948 is still necessary given that: it is rarely used; alternative legislative provisions appear to exist; and concerns have been raised about its ECHR compliance.

### **Powers to enter premises**

- 4.303 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.<sup>346</sup> Authorities are empowered to enter premises in order to protect property and recover any reasonable expenses incurred.
- 4.304 In addition, section 115 of the Mental Health Act 1983 empowers an Approved Mental Health Professional<sup>347</sup> to enter and inspect premises where a mentally disordered patient is living, where there is reasonable cause to believe that the patient is not under proper care. It does not provide the professional with authority to force entry into the premises, or to override the owner’s refusal to give permission to enter, or to remove the patient. If entry were refused, without reasonable cause, obstruction would constitute an offence under section 129 of the Mental Health Act 1983.

<sup>344</sup> See *HL v United Kingdom* (2005) 40 EHRR 32 (App No 45508/99).

<sup>345</sup> *Winterwerp v Netherlands (A/33)* (1979-80) 2 EHRR 387.

<sup>346</sup> 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”: NAA 1948, s.48(1).

<sup>347</sup> The Approved Mental Health Professional (AMHP) is a statutory role created for the purposes of the Mental Health Act 1983. AMHPs have a number of key functions under the Act, including the making of applications to detain patients in hospital. The AMHP can be a social worker, nurse, occupational therapist or psychologist. The AMHP was introduced by the Mental Health Act 2007 and replaced the role of the Approved Social Worker.

- 4.305 In 1995, the Law Commission’s final report on mental incapacity recommended that a sensible improvement on the model provided by section 115 of the 1983 Act would be to give social workers a power to enter premises and interview a vulnerable person who is believed to be at risk.<sup>348</sup> The proposals also included a power to apply to court for a warrant to enter premises, a compulsory assessment order and a temporary power to remove a person to a safe place in exceptional circumstances.<sup>349</sup>
- 4.306 Although these reforms were not subsequently implemented in the Mental Capacity Act 2005 in England and Wales,<sup>350</sup> they were included in the Adult Support and Protection (Scotland) Act 2007, which includes a range of protection orders including assessment orders, removal orders and banning orders.<sup>351</sup>
- 4.307 The current review of *No Secrets* also refers to the suggestion that legislation should be introduced to amend section 17 of the Police and Criminal Evidence Act 1984 to allow “entry where there are reasons to believe that a vulnerable adult is being subjected to abuse”.<sup>352</sup> This might just be for police or could be extended to include social workers and other professionals.

#### ***Issues for reform***

- 4.308 We believe that the review should consider whether or not to incorporate the section 48 duty to protect property into any new legislation. The review should also consider whether wider powers are needed for social workers and other professionals to enter domestic property premises when there are reasonable grounds to suspect that an adult is being abused.<sup>353</sup>

#### **STRATEGIC PLANNING AND INFORMATION TO THE PUBLIC**

- 4.309 Adult social care law places a number of planning obligations on local authorities to ensure that social service departments meet the needs of the local population. These can be subdivided into three categories: (1) the preparation of strategic plans; (2) a register of disabled people; and (3) a duty to provide information on available services.

<sup>348</sup> Mental Incapacity (1995) Law Com No 231, para 9.19.

<sup>349</sup> As above, paras 9.21 to 9.34.

<sup>350</sup> The Mental Capacity Act 2005 does, however, provide protection from any legal liability for actions such as entering premises, assessment and even the removal of a person lacking capacity (including the use of restraint) if this is considered to be in the person’s best interests and subject to the restrictions placed on such actions (for example, the prohibition on actions that amount to a deprivation of liberty).

<sup>351</sup> See ss 11 to 34.

<sup>352</sup> Department of Health, Home Office and the Ministry of Justice, *Safeguarding Adults: A Consultation on the Review of the ‘No Secrets’ Guidance* (2008) pp 46 to 47.

<sup>353</sup> This recommendation was included in the Association of the Directors of Adult Social Services’ 7 point plan for strengthening the law to help protect adults from abuse, September 2007, <http://www.adss.org.uk/pres/2007/vulnerable.shtml> (last visited 25 June 2008).

## Strategic planning

- 4.310 Until the 1990s, responsibility for the strategic planning of adult social care services was placed squarely on local authorities. Section 1 of the CSDPA 1970 requires local authorities to “inform themselves” of the number of persons in their area to whom section 29 of the NAA 1948 applies “in order that they can formulate satisfactory plans for developing their services”.<sup>354</sup> This was strengthened by section 46 of the NHSCCA 1990, which gave the Secretary of State powers to direct local authorities to prepare and publish a plan for the provision of community care services in their area, in consultation with the health authority, housing authority and voluntary organisations.<sup>355</sup>
- 4.311 The statutory regime for strategic planning was added to by section 4 of the Local Government Act 2000. This section imposes a duty on every local authority to prepare a community strategy for “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”.
- 4.312 The period since 1990 has seen a proliferation in the number of local strategic plans, mainly as a result of the increased emphasis on partnership between health and social services. Some have been issued under the Local Government Act 2000 or other statutes, while others are non-statutory in origin and are contained in a range of circulars and guidance. The range of plans and planning mechanisms has included or continues to include:
- (1) Community Care Charters;<sup>356</sup>
  - (2) Health Improvement and Modernisation Plans;<sup>357</sup>
  - (3) Local Health Partnership and Modernisation Board Plans;<sup>358</sup>
  - (4) Joint Investment Plans for Health and Social Services;<sup>359</sup>
  - (5) Carers Strategies;<sup>360</sup>
  - (6) Better Care Higher Standards charters;<sup>361</sup>

<sup>354</sup> DHSS circular 12/70, *Chronically Sick and Disabled Persons Act 1970*, para 5.

<sup>355</sup> This was given effect by the Community Care Plans Directions 1991 and the accompanying guidance LAC(91)6.

<sup>356</sup> The Community Care Plans Directions 1991 and Department of Health, *The Framework for Local Community Care Charters in England* (1994).

<sup>357</sup> First introduced as Health Improvement Programmes in the White Paper *The New NHS: Modern, Dependable* (1997) Cm 3807 and in Department of Health, *Modernising Health and Social Services: National Priorities 2000/01 to 2002/03* (1 January 1999).

<sup>358</sup> Department of Health, *NHS Plan Implementation Programme* (2000).

<sup>359</sup> Set out in an executive letter from the Department of Health: EL(97)62, *Better Services for Vulnerable People*.

<sup>360</sup> Department of Health, *Caring About Carers: A National Strategy for Carers* (1999) and HM Government, *Carers at the Heart of 21st Century Families and Communities: A Caring System on Your Side, A Life of Your Own* (2008).

- (7) Local Strategic Partnerships and Local Community Strategies;<sup>362</sup>
  - (8) Best Value Performance Indicators;<sup>363</sup>
  - (9) National Service Frameworks;<sup>364</sup>
  - (10) Local Area Agreements;<sup>365</sup> and
  - (11) Joint Strategic Needs Assessments.<sup>366</sup>
- 4.313 During this period, the directions issued under section 46 of the NHSCCA 1990, which established a duty to prepare community care plans, were disapplied by the Community Care Plans (England) Directions 2002. However, in Wales the section 46(1) obligation remains although it has been updated by regulations to require these plans to be integrated with “Health, Social Care and Well-being Strategies” produced by health and social services.<sup>367</sup>
- 4.314 In addition to strategic planning, councils are set non-statutory targets which are audited in England by the Commission for Social Care Inspection who give each council a star rating based on how they are perceived to be delivering adult social care in line with government policy.
- 4.315 The complexity and range of strategic plans and planning mechanisms could be criticised as creating a significant barrier for services users, carers and other members of the public who wish to play an active role in shaping and delivering adult social care services. Some of these plans have been formally abandoned but others have not, and it is not always immediately clear which plans are currently in use.

### ***Issues for reform***

- 4.316 We believe the review should consider whether the various strategic plans and planning mechanisms could be streamlined into a single legal provision. We would also seek to establish whether there should be a statutory requirement placed on local authorities to prepare a strategic plan which is contained in adult social care law or whether this area should continue to be governed primarily by section 4 of the Local Government Act 1999.

<sup>361</sup> Department for Health, Department for the Environment, Transport and the Regions, *Better Care, Higher Standards* (1999).

<sup>362</sup> Department for the Environment, Transport and the Regions, *Local Strategic Partnerships: Government Guidelines* (2001).

<sup>363</sup> The Local Government (Best Value) Performance Indicators and Performance Standard Order 2003 SI No 530 and The Local Government (Best Value Performance Indicator) (Wales) Order 2008 SI No 503 (W44).

<sup>364</sup> For example, Department of Health, *National Service Framework for Older People* (2001).

<sup>365</sup> Strong Local Leadership: Quality Public Services (2001) Cm 5237.

<sup>366</sup> Department of Health, *Guidance on Joint Strategic Needs Assessments* (2007).

<sup>367</sup> Health, Social Care and Well-Being Strategies (Wales) Regulations 2003, WSI 2003 No 154.

### Registers of disabled people

- 4.317 Section 28(4)(g) of the NAA 1948 and the relevant directions<sup>368</sup> place a duty on local authorities to compile and maintain registers of disabled people, as defined under section 29(1) of the NAA 1948, who are ordinarily resident in their area. This is supplemented by a duty on local authorities under section 1(1) of the CSDPA, to “inform themselves” of the number of persons in their area to whom section 29 of the NAA 1948 applies.
- 4.318 The purpose of the registers, according to the guidance which is attached to the directions, is to assist local authorities in planning their services and to establish eligibility for certain benefits unconnected with section 29 of the NAA 1948.<sup>369</sup> The guidance is clear that registration is not a pre-requisite to giving assistance and that where a person has indicated a specific wish not to have their name included in the formal register this wish must be respected.<sup>370</sup>
- 4.319 Very few disabled people choose to register with their local authority. For example, data from the Family Resources Survey estimates there are 9.7 million disabled adults in Great Britain,<sup>371</sup> but only 1.6 million people are registered with local authorities as disabled.<sup>372</sup> These figures should be treated with caution since the definition of disability used in the Family Resources Survey is more inclusive than the section 29 definition, but they do raise legitimate concerns about the accuracy of registers. It has been also been estimated by the Government that approximately as few as 25% of those who are registrable as blind have chosen to register.<sup>373</sup> As an indication of the numbers of disabled people in an area, therefore, the registers appear to have little value.
- 4.320 If the purpose of the register is to assist a local authority to plan their services, then the list should arguably be expanded beyond section 29 of the NAA 1948 to include all people who meet the eligibility criteria for services in the area. However, this does not address the problem that very few disabled people choose to be included in the register and therefore any such list is likely to be inaccurate. Compulsory registration is of course not an option. It is unlikely therefore that registers will ever accurately reflect the numbers of disabled people and their usefulness for strategic planning purposes is limited.

<sup>368</sup> 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*, Appendix 2, para 2(2).

<sup>369</sup> As above, Appendix 4.

<sup>370</sup> As above, Appendix 4, para 3.

<sup>371</sup> Department for Work and Pensions, *Press Release: Updated Estimate of the Numbers of Disabled People Including People with Limiting Longstanding Illnesses, and their Associated Spending Power* (9 February 2006), <http://www.workandpensions.gov.uk/mediacentre/pressreleases/2006/feb/drc-015-090206.asp> (last visited 9 November 2008).

<sup>372</sup> Figures for 2003-04: Written Answer, *Hansard* (HC), 28 February 2006, vol 443, col 690W (Mrs McGuire).

<sup>373</sup> *Hansard* (HL), 14 April 2000, vol 612, col 404 (Lord Burlison).

- 4.321 There are a small number of specific benefits that are available only to those who are registered as disabled. These include an income tax allowance and TV licence discount for people who are registered blind. Registration may also make it more straightforward for someone to claim the benefits and concessions to which they are entitled as a disabled person. These include VAT exemptions on goods and services related to disability, disabled person's railcard, reduced price or free public transport and concessions at theatres and cinemas.

#### ***Issues for reform***

- 4.322 We recommend that the review assesses whether the requirement to compile and maintain a register of disabled people should continue or whether this type of information could just as easily be obtained, for example, by surveys and statistics. The review should also consider whether the benefits that are available only to those registered as disabled could be provided through alternative means or whether the register should be maintained for the sole purpose of proving eligibility for these benefits.

#### **Duty to provide information about available services**

- 4.323 Section 29(4)(a) of the NAA 1948 and the relevant directions issued under this section give local authorities the power to inform disabled people of the services available to them under that section.<sup>374</sup> This was strengthened by the duty on local authorities under section 1(2) of the CSDPA 1970 to publish information as to the services available in their area under section 29 of the NAA 1948 and to ensure that service users are informed of any other relevant services that are available, including those provided by other local authorities or organisations.
- 4.324 The duty to publicise services is also mentioned in various policy and practice guidance, for example:
- (1) practice guidance issued under the NHSCCA 1990 stresses the need to ensure that service users and carers are given information on services available;<sup>375</sup>
  - (2) practice guidance *Better Care Higher Standards* in England emphasises that local authorities should develop a jointly agreed strategy for the provision of information about long term services across health, social services and housing;<sup>376</sup>

<sup>374</sup> 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*, Appendix 2, para 2(1).

<sup>375</sup> Department of Health, *Community Care in the Next Decade and Beyond: Policy Guidance* (1990) para 2.25 and Department of Health and Social Services Inspectorate/Scottish Office Social Work Services Group, *Care Management and Assessment: A Practitioner's Guide* (1991) paras 1.2 to 1.3.

<sup>376</sup> LAC(2001)6 and HSC 2001/006, *Better Health Higher Standards: Guidance for 2001-02*.

- (3) statutory guidance FACS and UNFSAMC advise that information about access, eligibility and services should be provided in a range of languages and formats;<sup>377</sup> and
- (4) practice guidance aimed at specific client groups, such as the Single Assessment Process for older people and Valuing People Strategy for learning disability, emphasises the need to provide information appropriate to the particular needs of the client groups.<sup>378</sup>

### ***Issues for reform***

- 4.325 We believe the review should consider whether or not a single statutory duty to provide information about local services should be established in adult social care law. The advantage of such a duty is that it promotes awareness of the range of community care services available and encourages people to approach the local authority for an assessment when they need such services. However, it might be argued that this requirement is already covered adequately in various guidance and does not need a statutory basis.

### **CARE STANDARDS AND REGULATION**

- 4.326 The regulation of care providers in England and Wales is governed by the Care Standards Act 2000 (CSA 2000). The range of services covered by the CSA 2000 includes: children's homes; independent hospitals; independent clinics; independent medical agencies; care homes; residential family centres; domiciliary care agencies; fostering agencies; nursing agencies; voluntary adoption agencies; and adult placement schemes.<sup>379</sup> The regulations issued under the CSA 2000 include a number of requirements for service providers, which include the following areas: employment checks; staff competencies and training; handling of medicines; restraint; adaptations and equipment for disabled people; and facilities and services.<sup>380</sup>

<sup>377</sup> LAC(2002)13, *Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care* at para 29 and NAFWC 09A/2002, *Health and Social Care for Adults: Creating a Unified and Fair System for Assessing and Managing Care*, para 2.17 and Annex 10.

<sup>378</sup> HSC 2002/001/LAC(2002)1, *Guidance on the Single Assessment Programme for Older People*, Annex E and Valuing People: A New Strategy for Learning Disability for the 21<sup>st</sup> Century (2001) Cm 5086, para 4.30.

<sup>379</sup> CSA 2000, ss 1 to 4.

<sup>380</sup> See, for example, the Care Homes Regulations 2001, SI 2001 No 3965 and the Care Homes (Wales) Regulations 2002, WSI 2002 No 327.

- 4.327 The Commission for Social Care Inspection and the Care and Social Services Inspectorate Wales both have responsibility for the registration and inspection of most of these services and operate a complaints procedure.<sup>381</sup> The CSA 2000 gives the Secretary of State and the Welsh Ministers powers to publish national minimum standards, which the Commission for Social Care Inspection and the Care and Social Services Inspectorate Wales must take into account when making their decisions.<sup>382</sup>
- 4.328 The Health and Social Care Act 2008 will create a new Care Quality Commission by merging the Commission for Social Care Inspection with the Healthcare Commission, which regulates health services, and the Mental Health Act Commission, whose function is to safeguard the interests of people subject to the Mental Health Act 1983. The new body would also have some additional functions. In particular, NHS services would be subject to registration for the first time and it would have tougher enforcement powers, such as the power to issue penalty notices.
- 4.329 The CSA 2000 also established the General Social Care Council and the Care Council for Wales.<sup>383</sup> These bodies are responsible for: maintaining a register of social workers and other social care workers; producing codes of good practice for social care workers and for employers of such staff; setting standards of conduct and practice for social care workers and their employers; regulating the workforce; and regulating social work education and training. As a result of the CSA 2000, the title *social worker* has been protected by law and all qualified social workers are required to register. If misconduct is found that is judged serious enough to question the registrant's suitability to remain on the register, the Councils can remove or suspend them from the register or place an admonishment on their registration.

#### **Issues for reform**

- 4.330 Since this area has been subject to recent and ongoing reform, we do not consider that it should be considered as part of the review. We also believe that in order to reinforce the perceived and actual independence of the regulatory system, there are strong arguments in favour of keeping this area of law separate from legislation concerning the provision of adult social care services.

### **COMPLAINTS AND REDRESS**

#### **Current framework**

- 4.331 There are a number of avenues available for individuals to complain about a community care issue. These include:
- (1) a complaint via the local authority complaints procedures;
  - (2) a complaint via the NHS complaints procedures;

<sup>381</sup> The exceptions being independent hospitals, independent clinics and independent medical agencies which come under the Healthcare Commission.

<sup>382</sup> CSA 2000, s 23.

<sup>383</sup> CSA 2000, Part 4.

- (3) a complaint to the Local Government Ombudsman;
- (4) an application to the High Court for judicial review; and
- (5) an application under section 7 of the Human Rights Act 1998.

4.332 These avenues are discussed in turn below.

***Local authority complaints procedures***

4.333 As noted in Part 2, complaints about a local authority's discharge or failure to discharge a relevant function are handled according to the Local Authority Social Services Complaints (England) Regulations 2006 in England and the Social Services Complaints Procedure (Wales) Regulations 2005 in Wales.<sup>384</sup>

4.334 The regulations in both England and Wales set out a three-stage process for dealing with complaints:

- (1) Stage 1: local resolution, whereby a local authority must take all reasonable steps to resolve the complaint informally;<sup>385</sup>
- (2) Stage 2: investigation of the complaint,<sup>386</sup> and
- (3) Stage 3: review panel.<sup>387</sup>

<sup>384</sup> SI 2006 No 1681 and WSI 2005 No 3366. These Regulations are made by the Secretary of State pursuant to s 114 of the Health and Social Care (Community Health and Standards) Act 2003. In addition to these Regulations, statutory guidance has been issued in both England and Wales. See Department of Health, *Learning from Complaints: Social Services Complaints Procedure for Adults* (2006) and Welsh Assembly Government, *Listening and Learning: A Guide to Handling Complaints and Representations in Local Authority Social Services in Wales* (2006).

<sup>385</sup> Local Authority Social Services Complaints (England) Regulations 2006, SI 2006 No 1681, reg 7 and Social Services Complaints Procedure (Wales) Regulations 2005, WSI 2005 No 3366, reg 18. Note the English Regulations require complaints to be resolved within 20 days, whereas the Welsh regulations prescribe 10 days.

<sup>386</sup> As above, regs 8 to 10 (England), regs 19 to 20 (Wales).

<sup>387</sup> As above, regs 11 to 13 (England) and regs 21 to 27 (Wales). In Wales this is referred to as an "Independent Panel". See also Department of Health, *Learning From Complaints: Social Services Complaints Procedure for Adults* (2006) paras 3.10 to 3.11.

4.335 The expectation of the Department of Health is that the majority of complaints should be considered and resolved at stage 1. However, if the local authority or complainant believes that it would not be appropriate to consider the complaint at stage 1, they can agree to move directly to stage 2.<sup>388</sup> In terms of stage 3, the review panel should not reinvestigate the complaint, nor should it consider any substantively new complaint that has not been considered at stage 2.<sup>389</sup> In both England and Wales, the complainant must be notified of their right to bring their complaint to the Local Government Ombudsman or Public Services Ombudsman for Wales, respectively.<sup>390</sup>

#### **NHS complaints procedures**

4.336 The NHS complaints procedures remain separate from those applied by social services authorities and are governed by the National Health Service (Complaints) Regulations 2004.<sup>391</sup> The regulations sets out a two-stage procedure for dealing with complaints, including:

- (1) investigation of a complaint;<sup>392</sup> and
- (2) independent review by the Healthcare Commission in England or the Independent Review Secretariat in Wales.<sup>393</sup>

<sup>388</sup> Department of Health, *Learning From Complaints: Social Services Complaints Procedure for Adults* (2006) para 3.5. The Welsh guidance provides that the complainant can decide at any time to dispense with local resolution and move on to the next stage: Welsh Assembly Government, *Listening and Learning: A Guide to Handling Complaints and Representations in Local Authority Social Services in Wales* (2006) para 6.5.5.

<sup>389</sup> Department of Health, *Learning From Complaints: Social Services Complaints Procedure for Adults* (2006) para 3.11.

<sup>390</sup> Local Authority Social Services Complaints (England) Regulations 2006, SI 2006 No 1681, reg 14 and Social Services Complaints Procedure (Wales) Regulations 2005, WSI 2005 No 3366, reg 28.

<sup>391</sup> National Health Service (Complaints) Regulations 2004, SI 2004 No 1768, as amended by the National Health Service (Complaints) Amendment Regulations 2006, SI 2006 No 2084. See also Department of Health, *Guidance to Support Implementation of the National Health Service (Complaints) Regulations 2004* (2004) and Welsh Assembly Government, *Complaints in the NHS: A Guide to Handling Complaints in Wales* (2003).

<sup>392</sup> National Health Service (Complaints) Regulations 2004, SI 2004 No 1768, reg 12.

<sup>393</sup> As above, reg 16.

### **Overlap between social care and NHS complaints**

- 4.337 A complaint will often concern a matter relating to social services functions of a local authority and services provided by the NHS. In England, where a complaint involves both a local authority and an NHS body, the complaint can be made in its entirety to any one of the bodies involved.<sup>394</sup> In these circumstances, the NHS body and the local authority have a duty to co-operate “with a view to the complainant receiving a co-ordinated response to his complaint”.<sup>395</sup> The Welsh guidance also urges co-operation in these circumstances.<sup>396</sup>
- 4.338 The Department of Health is currently considering reform to the complaint-handling processes for health and adult social care, in line with its commitment to develop “a single system across health and social care by 2009”.<sup>397</sup> The Department has proposed a new framework for health and social care complaints, consisting of two stages: local resolution and independent investigation by the Health Services Ombudsman or Local Government Ombudsman.<sup>398</sup>

### **Ombudsman**

- 4.339 A person who claims to have suffered an injustice as a result of maladministration in connection with any action taken by or on behalf of a local authority may complain to the Local Government Ombudsman in England<sup>399</sup> or the Public Services Ombudsman for Wales.<sup>400</sup>

<sup>394</sup> Department of Health, *Learning From Complaints: Social Services Complaints Procedure for Adults* (2006) para 7.5.

<sup>395</sup> Local Authority Social Services Complaints (England) Regulations 2006, SI 2006 No 1681, reg 15.

<sup>396</sup> Welsh Assembly Government, *Listening and Learning: A Guide to Handling Complaints and Representations in Local Authority Social Services in Wales* (2006) para 5.4.

<sup>397</sup> Department of Health, *Making Experiences Count: The proposed New Arrangements for Handling Health and Social Care Complaints – Detailed Policy Background* (2007) para 1.4 quoting from *Our Health, Our Care, Our say: A New Direction for Community Services* (2006) Cm 6737, para 7.18.

<sup>398</sup> Department of Health, *Making Experiences Count: The Proposed New Arrangements for Handling Health and Social Care Complaints – Response to Consultation* (2008). See also Department of Health, *Making Experiences Count: A New Approach to Responding to Complaints – A Document for Information and Comment* (2007) and Department of Health, *Making Experiences Count: The Proposed New Arrangements for Handling Health and Social Care Complaints – Detailed Policy Background* (2007).

<sup>399</sup> Local Government Act 1974, s 25. Note the Health Service Ombudsman in England may also have jurisdiction.

<sup>400</sup> Public Services Ombudsman (Wales) Act 2005.

- 4.340 Before investigating a complaint, the ombudsman must satisfy himself that the complaint has been drawn to the attention of the local authority in question and the authority has been afforded a reasonable opportunity to investigate and reply to the complaint.<sup>401</sup> In practice, the ombudsman will investigate a complaint before the statutory process has been exhausted where there has been a break down in trust between the complainant and authority, or where both parties agree.<sup>402</sup>
- 4.341 In relation to remedies, the general objective of the ombudsman is to put the complainant in the position he or she would have been in but for the maladministration.<sup>403</sup> The ombudsman can recommend that the local authority take various actions, including providing an explanation, reconsidering a decision and providing compensation.<sup>404</sup> They can also recommend specific action, which in the sphere of community care complaints may include:

The carrying out of a community care or carer's assessment; providing disabled facilities; reinstating services to implement a care plan; providing an independent advocate for an especially disadvantaged service user; providing an apology for a service failure, and so on.<sup>405</sup>

### ***Judicial review***

- 4.342 A complainant may apply to the High Court for a review of the lawfulness of a decision, action or failure to act in relation to the exercise of a public function, including by local authorities and NHS bodies.<sup>406</sup>
- 4.343 The High Court can find that a decision is unlawful on the grounds that it is illegal, irrational or procedurally flawed. In such circumstances, the Court has the discretion to order the decision-maker to act, or abstain from acting, in a specified manner or can quash a decision and may remit or substitute its own decision. The court may also make a declaration or grant an injunction preventing or compelling action by a public body. The High Court may award damages in judicial review cases, but only in very limited circumstances.

<sup>401</sup> Local Government Act 1974, s 26; Public Services Ombudsman (Wales) Act 2005, s 9.

<sup>402</sup> J White, "Community Care and the Local Government Ombudsman for England" (2006) 9 *Community Care Law Reports* 8, 8.

<sup>403</sup> Local Government Ombudsman, *Remedies: Guidance on Good Practice* 6 (2005) p 3.

<sup>404</sup> J White, "Community Care and the Local Government Ombudsman for England" (2006) 9 *Community Care Law Reports* 8, 11.

<sup>405</sup> As above, 11.

<sup>406</sup> Civil Procedure Rules, r 54.1(2). A broad range of administrative decision-making is amenable to judicial review.

- 4.344 It has been observed that judicial review has limitations as a remedy for many community care disputes of a factual nature. One commentator has suggested that courts undertaking judicial review are “reluctant to interfere with local authority discretion over the *outcome* of decisions, with judgment confined to the *process* whereby decisions are made”.<sup>407</sup> Mr Justice Collins acknowledged in *Gunter v South Western Staffordshire PCT* that judicial review was an “unsatisfactory means” of dealing with cases where there are judgments to be made and factual issues in dispute:

At best, it can identify failures to have regard to material considerations and a need for a reconsideration. Very rarely if ever will it result in mandatory orders to the body which has the responsibility to reach the relevant decision.<sup>408</sup>

### **Human Rights Act 1998**

- 4.345 The Human Rights Act 1998 makes it unlawful for a public authority to act in a way that breaches a person’s “Convention rights”.<sup>409</sup> Procedurally, an individual can bring an application for judicial review in the Administrative Court alleging that a public authority has breached section 6 of the Human Rights Act 1998. If the court finds the public authority has engaged in an unlawful act, it may grant such relief or remedy, or make such order within its powers as it considers just and appropriate.<sup>410</sup>

### **Issues for reform**

- 4.346 As a Law Commission, the rules of substantive law are our primary concern. However, we also recognise the importance of making sure that there are sufficient mechanisms to ensure effective monitoring and enforcement of the law and the substantive law reform proposals.
- 4.347 There are various ways to ensure this monitoring and enforcement. One component of facilitating feedback is to ensure that there are effective mechanisms in place for individuals to complain when services have not been good enough and that there is appropriate redress to remedy any problems caused by poor service or other administrative actions.
- 4.348 We believe one aspect of the review should be to consider the efficacy of the legal structures in place for complaining about, and seeking redress for, failures in decision-making and service provision by local authorities. This would include consideration of whether there is a need to establish a tribunal to provide independent merits review of local authority community care decisions, analogous to that provided by the Special Education Needs and Disability Tribunal in England and the Special Education Needs Tribunal for Wales.

<sup>407</sup> S Braye and M Preston-Shoot, “Accountability, Administrative Law and Social Work” (1999) 23 *Journal of Social Welfare and Family Law* 235, 237.

<sup>408</sup> [2005] EWHC 1894 (Admin), 86 BMLR 60 at [19]. See also Mr Justice Collins, “Community Care and the Administrative Court” 9 *Community Care Law Reports* 5.

<sup>409</sup> Defined in s 1 of the Human Rights Act 1998. The Convention rights most relevant in the community care context are arts 2, 3, 5, 6, 8 and 14 of the ECHR.

<sup>410</sup> Human Rights Act 1998, s 8(3).

- 4.349 As noted earlier, we are aware of the Department of Health's current review of health and social care complaint handling, and their proposals to move to a two-stage process consisting of local resolution and ombudsman investigation.<sup>411</sup> As yet the legislation has not been changed, as it is believed the existing law is sufficiently flexible to accommodate the proposals.<sup>412</sup> Our review would take the Government's reforms into account and any recommendations that are made which require changes to the law. We would also take into account the Law Commission's current inquiry on administrative redress.<sup>413</sup>
- 4.350 As outlined in Part 3, one of our goals in reforming adult social care law is resource neutrality. If we anticipated that any of our proposals for reform would require extra government funding, such proposals would be subject to rigorous scrutiny as part of the impact assessment we will undertake.

### **CONCLUSION**

- 4.351 This Part has set out the key areas for review that we propose for the substantive project on adult social care. We seek to emphasise at this stage that our views are preliminary only and the possible issues for reform, and the direction that any reform may take, are not set in stone. The scoping report is distributed for information purposes only and no response is sought from interested individuals and organisations at this stage. We expect to publish a consultation paper as part of the substantive inquiry.

<sup>411</sup> See Department of Health, *Making Experiences Count: The Proposed New Arrangements for Handling Health and Social Care Complaints – Response to Consultation* (2008).

<sup>412</sup> Department of Health, *Complaints Policy*, <http://www.dh.gov.uk/en/Managingyourorganisation/Legalandcontractual/Complaintspolicy/index.htm> (last visited 9 July 2008).

<sup>413</sup> See Law Commission, *Administrative Redress: Public Bodies and the Citizen – A Consultation Paper* (CP 187).

## **PART 5**

### **IMPACT ASSESSMENT**

- 5.1 The following provides an early assessment of the likely impact of the law reform proposals discussed in this scoping report. The costs and benefits set out in this section are preliminary estimates and will be refined as the project develops.

#### **OBJECTIVE**

- 5.2 Our objective is to review the law under which residential care services, domiciliary and community services, support for carers and adult protection is provided. The ultimate aim would be to provide a coherent legal structure, preferably in the form of a single statute, for these services.

#### **BACKGROUND**

- 5.3 In June 2008 the Law Commission announced its Tenth Programme of law reform. This was the result of a long process of consultation during which Government departments, Parliamentary Committees, the judiciary, the academic community, other interested bodies and specialist organisations, and the general public were consulted as to areas of law that they considered to be in need of reform. We received a total number of 191 responses constituting 119 potential projects. Among the new projects included in the Tenth Programme was the reform of adult social care law.
- 5.4 The project is split into three phases. The first phase is a scoping report. This will aim to delineate clearly the scope of the project and provide it with a detailed agenda for reform. The second stage would be the substantive project. This would involve the Commission developing law reform proposals in a consultation paper, and consulting on those proposals. A report would be produced at the end of this second stage. This would give both Government and Commission the opportunity to consider the desirability of the third stage, the drafting of a bill.

#### **RATIONALE FOR LAW REFORM**

- 5.5 The legislative framework for adult residential care, domiciliary and community care, support for carers and adult protection is inadequate, often incomprehensible and outdated. It remains a confusing patchwork of conflicting statutes enacted over a period of 60 years. There is no single, modern statute to which service providers and service users can look to understand whether (and, if so, what kind of) services can or should be provided.
- 5.6 Due to a lack of clear and accurate information about the availability of support, disabled people and carers are less likely to make an informed decision about whether they are eligible for services. This results in market failure. Law reform would help to ensure the provision of accurate and complete information about whether support services can or must be provided.
- 5.7 The current legal framework also causes inefficiency in the allocation of resources. Law reform would help to ensure an increase in equity, the avoidance of stress and cost of some disputes and legal cases, and hopefully some reduction in the need for assessments to be duplicated.

## **CONSULTATION**

### **With Government**

- 5.8 There has been consultation with the Department of Health throughout the early development of this project. A seminar was held to discuss the scoping report with the Department of Health and other departments with an interest in adult social care.

### **Public Consultation**

- 5.9 No public consultation has been undertaken at this point. The second stage of this project would involve consultation with stakeholders and members of the public.

## **OPTIONS**

- 5.10 The following options for the reform of adult social care law have been identified:

- (1) Option 1: Do nothing; and
- (2) Option 2: Establish a coherent legal structure

### **Option 1: Do nothing**

- 5.11 Under this option, adult social care law would remain unchanged. The legal framework would continue to be fragmented and spread out across a variety of separate statutes, which often over-lap and are sometimes contradictory.
- 5.12 The law would also remain difficult to understand and apply, both for services users and service providers. For these reasons, we believe that doing nothing is not in the interests of service users, carers, local authorities or the public at large.

### **Option 2: Establish a coherent legal structure**

- 5.13 This is our preferred option. Although the scoping report does not include detailed law reform proposals, which would be developed in the next stage of the project, it does point towards the general need to establish a coherent and comprehensive legal framework. We would anticipate that law reform proposals would need to cover the following key areas:
- (1) statutory principles;
  - (2) community care assessments;
  - (3) carers' assessments;
  - (4) hospital discharge assessments;
  - (5) the provision of services;
  - (6) direct payments;
  - (7) charging for services;
  - (8) safeguarding adults from abuse and neglect;

- (9) strategic planning and information to the public; and
- (10) complaints and redress.

## **COSTS AND BENEFITS**

### **Sectors and groups affected**

- 5.14 There are a variety of sectors involved in providing adult social care, including the NHS, local authorities, businesses, the voluntary sector and informal carers. In 2006 to 2007, local authorities in England spent £14.2 billion on social care for all adults. From 2001-02 to 2005-06 the percentage of gross expenditure on care services with private and voluntary providers grew from 59% to 72%. It is estimated that £5.9 billion was spent by private individuals on personal care support for older people alone.<sup>1</sup>
- 5.15 Between 2006 to 2007 social services in England spent £8.6 billion on older people, £3.2 billion on people with learning difficulties, £1.4 billion on physically disabled people, £1 billion on people with mental health problems, £270 million on other adults, and £200 million on asylum seekers.<sup>2</sup>
- 5.16 The principal efficiency savings of simpler and more certain assessment and decision-making about services will accrue to local authority social services departments. We would also expect to see savings in terms of less need for legal advice and litigation. The transitional education and training costs will be correspondingly higher here, but once the costs of the initial transition are incurred, the cost of continuing training and education should be less rather than more than at present.
- 5.17 There should be no additional costs to individual users or carers. Indeed, by simplifying the law, making the rules more transparent and promoting joint working between health and social care services, costs – both financial and time costs – incurred by users and carers may be reduced.
- 5.18 Voluntary organisations that provide advice on adult social care should benefit from the project in the long term, as it is easier to advise on simpler and more rational law, which should reduce costs. However, there may be significant transition costs. The main cost to voluntary organisations will be in acquainting themselves with new legislation and raising awareness of it with their members. However, given that most organisations generally provide guidance and advice to their members as part of their on-going activity, they may consider that the need to advise on a new law would not impose new costs.

<sup>1</sup> Commission for Social Care Inspection, *The State of Social Care in England 2006-07* (2008).

<sup>2</sup> Information Centre, *Personal Social Services Expenditure and Unit Costs England, 2006-07* (2008).

## **Costs**

### ***Option 1: Do nothing***

- 5.19 There will be no additional policy or administrative costs associated with option 1 in the immediate future. However, as more people live longer, the consequences of an ageing population will lead to increases in demand for social care services and the problems associated with uncertain social care law will become more apparent.<sup>3</sup>
- 5.20 There is a social and economic cost in the continuation of an inefficient, fragmented and confusing legal framework.

### ***Option 2: Establish a coherent legal structure***

- 5.21 The principal costs would be the transitional costs of education and training. There would be some costs for provision of information to users and carers, but these would be higher than the existing cost of public information only in the very short term. To the extent that it provides materials for initial information and education, there will be transitional costs for the Department of Health. There may also be some marginal increased costs for judicial training.
- 5.22 We estimate that the majority of the issues raised in the scoping report would be broadly expenditure neutral. Many of the law reform proposals are likely to be aimed at clarifying existing legal rights rather than seeking to extend them. One exception to this general approach may be any proposal made to establish a community care tribunal. However, if there is greater uptake of care services, due to improved information, easier to comprehend law and media attention, then this may increase financial pressures for local authorities.

## **Benefits**

### ***Option 1: Do nothing***

- 5.23 There are no additional benefits of this option. However, a failure to address the complex, inconsistent and convoluted legal framework will mean the continuation of the current problems and burdens created by the law.

### ***Option 2: Establish a coherent legal structure***

- 5.24 The key benefit of this project is long term efficiency savings arising from more certain, predictable, comprehensible and rational law. Simplifying and codifying the law into a coherent legal structure would reduce the time and money required to understand and apply the law. This would lead to savings in both time and cost for service users, carers and professionals working in adult social care. The principal efficiency savings of simpler and more certain assessment and decision-making about services will accrue to local authority social services departments. We would also expect to see savings in terms of less need for legal advice and litigation, as well as general savings in the time and money spent on negotiating complex, outdated and inconsistent law.

<sup>3</sup> The 2001 census for example showed that the proportion of people over 60 has risen from 16% to 21% of the population in the past 50 years, while the proportion of under 16s has fallen from 24% to 20%: Office for National Statistics, *2001 Census of Population* (2002).

- 5.25 Law reform would provide clarity for service users, carers and local authorities about entitlements to services and which services are available. Confusion and inconsistency in the law can lead to arbitrary differences in legal rights to services for service users and carers. A simple, consistent and consolidated legal framework should assist professionals' understanding and use of the law, and should increase the awareness of available services for individuals and their carers. This should have an additional benefit of increasing public confidence in the fairness, transparency and accountability of the law.
- 5.26 The benefits to service users and carers will be consistency in the application of the law, the avoidance of stress and cost of some disputes and legal cases, and hopefully some reduction in the need for assessments to be duplicated. Greater understanding of when and what services are available should help promote and facilitate greater choice and control over the services received.
- 5.27 If there are fewer complaints under the reformed law, there should be corresponding savings to the Commission for Social Care Inspection, the Care and Social Services Inspectorate Wales, the General Care Standards Council and the Local Government Ombudsman. Less litigation will bring savings to the HM Court Service budget, and Legal Aid.
- 5.28 Law reform would also bring adult social care in line with modern understandings of disability. It would be an opportunity to eradicate the discriminatory and stigmatising concepts that persist in the law and develop legislation that is more in line with the Disability Discrimination Act 1995 and the Human Rights Act 1998.

#### **COMPETITION ASSESSMENT**

- 5.29 We do not believe that these proposals will have any significant impact on competition. By improving the clarity of the legal framework and improving the information available to service users and carers, the proposals should in fact serve to enhance competition by increasing the incentive for commissioners of social care to design services that better match individual patient needs.

#### **SMALL FIRMS IMPACT TEST**

- 5.30 Many small businesses operate in the market for social care services. No significant costs to the small business sector are anticipated and it is unlikely that law reform would restrict or deter new entry into care and residential homes.

#### **LEGAL AID IMPACT ASSESSMENT**

- 5.31 Any proposals in relation to redress and enforcement mechanisms, particularly to establish a community care tribunal, may have an impact on the Legal Aid budget since the majority of community care cases are currently publicly funded through the provision of Legal Aid. The availability of Legal Aid for users of any proposed tribunal would remain a policy decision for the Government.

## **HUMAN RIGHTS IMPACT ASSESSMENT**

- 5.32 One of the main purposes for the review would be to establish whether aspects of adult social care law are incompatible with the ECHR. For example the scoping report raises concerns about the compatibility of section 47 of the NAA 1948 with Articles 5 and 6 of the ECHR.

## **HEALTH IMPACT ASSESSMENT**

- 5.33 The reform of adult social care is expected to make a positive contribution to health improvement. There will be greater clarity about rights to care services and when services must legally be provided.

## **EQUALITY IMPACT ASSESSMENT**

### **Age equality impact assessment**

- 5.34 Some adult social care statutes apply to children as well as adults. One proposal that might be considered in the review would be to draw a line between the law concerning the provision of social care services to adults and services to children. This would impact on children since they would lose legally enforceable rights to services. An alternative could be to maintain the existing level of enforceable rights that are given to children.
- 5.35 Adult social care law applies in the same way to all people aged 18 and over. However, older people are more likely to be affected by law reform because of the correlation between increased age and needs that require the provision of social care services.

### **Race equality impact assessment**

- 5.36 Law reform is not expected to impact in any different way on different racial or ethnic groups. It may be however that some groups are under-represented in the provision of social care services. Greater legal clarity about rights and access to services may therefore encourage uptake of services amongst these groups.

### **Disability equality impact assessment**

- 5.37 Reform of adult social care would have a positive impact on disability equality. Indeed, the reform of adult social care law will mainly benefit disabled people since there would be greater legal clarity about rights to services. Moreover, reform would be an opportunity to address some of the discriminatory and stigmatising concepts that persist in the law.

### **Gender equality impact assessment**

- 5.38 Adult social care law operates in an identical way regardless of gender. It is anticipated, however, that since a large number of service users are older people, more women than men may be affected by law reform since women tend to live longer than men do and, at higher ages, and conditions such as dementia tend to be higher in women compared to men. There is also a higher number of female carers who would be affected by law reform proposals.<sup>4</sup>

### **Sexual orientation equality impact assessment**

- 5.39 There is no evidence to suggest that law reform would have a differential impact on people according to their sexual orientation. However, there is an increasing awareness that lesbian, gay, bisexual and transgender people may be less likely to access mainstream services, and may have particular issues regarding the provision of care services.<sup>5</sup>

### **Religion or belief equality impact assessment**

- 5.40 We do not consider that law reform would be likely to impact disproportionately on groups of a particular religion or belief. It may be however that some groups are under-represented in the provision of social care services and law reform may encourage uptake of services by these groups.

### **Rural proofing impact assessment**

- 5.41 We have considered the likely effects of these proposals on rural populations and do not believe that the impact would be disproportionate or disadvantageous.

### **Caring responsibilities equality impact assessment**

- 5.42 Law reform would be expected to have a positive impact on people who care for adults since one of the primary aims would be to help carers by providing a clear legal framework about their rights to services.

## **ENFORCEMENT, SANCTIONS AND MONITORING**

- 5.43 In the next stages of the project we will consider, with the Department of Health and the Welsh Assembly Government, what monitoring and evaluation would be most practical.

<sup>4</sup> There are 3.4 million women carers compared to 2.5 million men: Office for National Statistics, *2001 Census of Population* (2002).

<sup>5</sup> See, for example, <http://www.ageconcern.org.uk/openingdoors/> (last visited 9 November 2008).

## **PART 6**

### **CONCLUSION**

- 6.1 We recommend that the Government approves a substantive law reform project as outlined in this report, on terms of reference to be agreed between the Commission and the Government.

# **APPENDIX A**

## **ACTS OF PARLIAMENT: ADULT SOCIAL CARE**

National Assistance Act 1948

Health Services and Public Health Act 1968

Chronically Sick and Disabled Persons Act 1970

Local Authority Social Services Act 1970

Health and Social Services and Social Security Adjudications Act 1983

Mental Health Act 1983

Disabled Persons (Services, Consultation and Representation) Act 1986

Children Act 1989

NHS and Community Care Act 1990

The Carers (Recognition and Services) Act 1995

Community Care (Direct Payments) Act 1996

Housing Grants, Construction and Regeneration Act 1996

Community Care (Residential Accommodation) Act 1998

Data Protection Act 1998

Health Act 1999

Human Rights Act 1998

Carers and Disabled Children Act 2000

Care Standards Act 2000

Local Government Act 1972

Local Government Act 2000

Health and Social Care Act 2001

Community Care (Delayed Discharges) Act 2003

Health and Social Care (Community and Health Standards) Act 2003

Carers (Equal Opportunities) Act 2004

Children Act 2004

Disability Discrimination Act 2005

Mental Capacity Act 2005

Commissioner for Older People (Wales) Act 2006

Equality Act 2006

NHS Act 2006

Safeguarding Vulnerable Groups Act 2006

The Local Government and Public Involvement in Health Act 2007

Mental Health Act 2007

Health and Social Care Act 2008

## **APPENDIX B**

### **SAFEGUARDING ADULTS**

- B.1 This Appendix provides a brief overview of some of the main legal provisions for safeguarding adults from abuse and neglect, excluding the specific powers given to local social services departments.<sup>1</sup> The expectation of the scoping review is that these provisions would not be included in any future consolidated adult social care legislation, but would continue to co-exist in separate law.

#### **PREVENTING UNSUITABLE PEOPLE FROM WORKING WITH VULNERABLE ADULTS**

- B.2 Part 7 of the CSA 2000 requires the Secretary of State and the Welsh Ministers to maintain a list of people who have been found to be unsuitable to work with vulnerable adults (the POVA list). The scheme currently extends to people working in care homes, domiciliary care and adult placement schemes. Providers of care must refer to the Secretary of State or the Welsh Ministers any worker who has been suspended, dismissed or placed in a non-caring position because of misconduct that harmed a vulnerable adult or placed them at risk. The Commission for Social Care Inspection and the Care and Social Services Inspectorate Wales also have the power to refer, if they consider that a person has been guilty of such misconduct. The person is then placed on the list provisionally while a decision is made to include the person or remove him or her from the list. Care providers have a duty to check the POVA list and must not offer employment if the person is included on the list.
- B.3 The Safeguarding Vulnerable Groups Act 2006 will introduce a new scheme replacing the POVA list and the equivalent children scheme established under the Protection of Children Act 1999. This will cover those who work or volunteer, or seek to work or volunteer, with children or vulnerable adults, if the work is authorised by a regulated activity provider. People will be automatically placed on the new lists if they have been convicted of certain offences, or following a decision by the Independent Safeguarding Authority. Implementation is set for Autumn 2008.
- B.4 Section 115 of the Police Act 1997 provides for enhanced disclosure where a certificate is required for people whose work includes caring for, training, supervising or being in sole charge of children or vulnerable adults.

#### **CARE STANDARDS**

- B.5 The National Minimum Standards issued under the CSA 2000 have a number of standards that relate to abuse. For example, standard 18 of the National Minimum Standards for Care homes for Older People provides that:

<sup>1</sup> These are discussed in Part 4 above. Some other areas of law have also been omitted from this discussion, including general criminal justice law and detention powers under the Mental Health Act 1983.

The registered person must ensure that service users are safeguarded from physical financial or material, psychological or sexual abuse, neglect, discriminatory abuse or self harm, inhuman or degrading treatment, through deliberate intent, negligence or ignorance, in accordance with written policies.<sup>2</sup>

- B.6 There are also detailed standards on the safeguarding of service users' money and financial affairs for care homes and domiciliary care.<sup>3</sup>
- B.7 The Commission for Social Care Inspection has responsibilities for enforcing standards through their regulatory and performance assessment functions.<sup>4</sup> The Commission has the power to cancel the registration of a care home where a condition of registration has been breached, where a regulatory requirement has been breached or where a relevant offence has been committed.<sup>5</sup> The Commission can also apply to a justice of the peace for the immediate cancellation of registration or change in the conditions of registration of an establishment or agency. The justice may only make the order where it appears to them that unless the order is made there is a serious risk to a person's life, health or well-being.<sup>6</sup>

#### **HEALTH BASED INTERVENTIONS**

- B.8 The Public Health Act 1936 gives local authorities powers of entry in respect of certain public health issues, which include: filthy, unwholesome, verminous premises; verminous person or clothing (including removal of person); and cleaning or destroying filthy or verminous articles. There is also a power to require vacation of premises during fumigation.
- B.9 Part 2 of the Public Health (Control of Disease) Act 1984 allows the courts to order the medical examination of a person thought to have, or to be carrying, a notifiable disease, and for the removal to hospital of a person with a notifiable disease, and his or her detention there. A notifiable disease is defined as cholera, plague, relapsing fever, smallpox and typhus and has been extended by regulations to a number of other diseases. There is a right of appeal against such orders to the Crown Court. The Health and Social Care Act 2008 repealed Part 2 of the Public Health (Control of Disease) Act 1984 and replaced it with similar provisions, which apply not only to infectious diseases but also contamination. It will also introduce a general regulation-making power for taking actions to prevent and protect against the spread of disease.

<sup>2</sup> Department of Health, *Care Homes for Older People: National Minimum Standards: Care Home Regulations: 3rd Edition* (2003).

<sup>3</sup> As above, Standards 34 to 35.

<sup>4</sup> As a result of the Health and Social Care Act 2008, the Commission for Social Care Inspection will be merged, along with the Healthcare Commission and Mental Health Act Commission, into the Care Quality Commission.

<sup>5</sup> CSA 2000, s 14.

<sup>6</sup> CSA 2000, s 20.

## **WHISTLEBLOWING**

- B.10 The Public Interest Disclosure Act 1998 amended the Employment Rights Act 1996 to give workers who raise concerns about abuses and malpractice protection from dismissal and victimisation. The Act extends to the raising of concerns about crime, civil offences (including negligence, breach of contract, breach of administrative law), miscarriage of justice, danger to health and safety or the environment and the cover-up of any of these. It applies to all employees in almost all professions. Protection in the event of infractions by employers is available through the industrial tribunal system. Remedies include unlimited financial compensation and orders requiring companies to retain the employee in his or her job.

## **MENTAL CAPACITY ACT 2005**

- B.11 The Act created a new Court of Protection which has the full powers of the High Court to make decisions on financial or welfare matters affecting people who lack the relevant decision-making capacity. It also has powers to appoint deputies to act on behalf of an incapacitated person or remove court appointed deputies or donees of a Lasting Power of Attorney and an Enduring Power of Attorney.
- B.12 The Act also established a new statutory office, the Public Guardian, who amongst other matters, is responsible for investigating (or making referrals to the appropriate agencies) where it is alleged that a donee of a Lasting Power of Attorney or Enduring Power of Attorney or a court-appointed deputy is abusing or exploiting the donor or person subject to deputyship.
- B.13 Regulations under the Mental Capacity Act 2005 give local authorities and NHS bodies the power to appoint an Independent Mental Capacity Advocate where it is alleged that the person is or has been abused or neglected by another person, or the person is abusing or has abused another person.
- B.14 The Mental Capacity Act 2005 was amended by the Mental Health Act 2007 to provide new safeguards to enable people who lack capacity to consent to the arrangements made for their care or treatment, to be deprived of their liberty in a care home or a hospital if it is considered necessary in their best interests. These are known as the "deprivation of liberty safeguards" and are due to be implemented in April 2009.

## **MENTAL HEALTH ACT 1983**

- B.15 Guardianship enables people with a mental disorder to receive care in the community where it cannot be provided without the use of compulsory powers. The guardian, who is often the local authority, can require the person to live at a specified place and attend certain appointments. The guardian can also require that access to the person should be given at the place where they are living to a doctor or Approved Mental Health Professional. However, it gives no power to impose medical treatment without consent. Although guardianship does not give authority for force to be used to ensure compliance with most of the conditions, it does give authority for a patient to be returned to the place where it has been specified they must live, should they go absent without the permission of the guardian.

- B.16 Supervised Community Treatment (SCT) allows patients detained under section 3 of the 1983 Act (and some other treatment orders) to be discharged into the community whilst remaining liable to recall to hospital for treatment. Certain conditions can be attached to SCT, for example that the patient: resides at a particular place; makes themselves available for medical treatment; and abstains from particular conduct. SCT was introduced into the 1983 Act by the Mental Health Act 2007 and was implemented in November 2008.

### **INHERENT JURISDICTION OF THE HIGH COURT**

- B.17 Although the High Court has traditionally used its inherent jurisdiction to intervene in the lives of adults who lack capacity,<sup>7</sup> a number of recent cases have broadened the scope of intervention to include those who have capacity but are “vulnerable.”<sup>8</sup> This was set out in *Re SA* by Mr Justice Munby as follows:

The inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real or genuine consent.<sup>9</sup>

- B.18 Although initially reluctant to define “vulnerable adult”, his Lordship went on to say that,

In the context of the inherent jurisdiction I would treat as a vulnerable adult someone who, whether or not mentally incapacitated, and whether or not suffering from any mental illness, or mental disorder, 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 congenial deformity. This, I emphasise, is not and is not intended to be a definition. It is descriptive, not definitive; indicative rather than prescriptive.<sup>10</sup>

- B.19 The court’s powers when exercising the inherent jurisdiction in relation to adults are wide and can include declaratory relief and the use of injunctions.<sup>11</sup>

<sup>7</sup> The Mental Capacity Act 2005 has formalised and developed the common law.

<sup>8</sup> See: *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam), [2007] 2 FCR 563; *G (An Adult) (Mental Capacity: Court’s Jurisdiction)* [2004] EWHC 2222, [2004] All ER (D) 33 (Oct); and *Sunderland CC v PS and CA* [2007] EWHC 623 (Fam), [2007] 10 Community Care Law Reports 295.

<sup>9</sup> *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam), [2007] 2 FCR 563 at [77].

<sup>10</sup> As above, at [82].

<sup>11</sup> As above, at [86].

## **CRIMINAL OFFENCES**

B.20 The criminal offences relating to vulnerable adults include a number of provisions which are listed below.

- (1) Section 4 of the Fraud Act 2006 makes it an offence for a person who occupies a position where he or she is required to safeguard, or not act against, the financial interests of another person, to dishonestly abuse that position, with the intent of self benefit or to benefit others.
- (2) Section 44 of the Mental Capacity Act 2005 created the offence of ill-treatment or wilful neglect by: a person who has the care of someone who lacks capacity; a donee of a Lasting or Enduring Power of Attorney; or a deputy. The maximum penalty is five years' imprisonment.
- (3) Section 5 of the Domestic Violence, Crime and Victims Act 2004 makes it an offence to cause or allow the death of a child or vulnerable adult. A vulnerable adult is defined as a person aged 16 or over whose ability to protect himself or herself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise. This applies if:
  - (a) the person lived in the same household and had frequent contact with the victim;
  - (b) there was significant risk of serious physical harm and the person either caused the victim's death, or was or ought to have been aware of the risk and failed to take steps to protect the victim; and
  - (c) the act occurred in circumstances that the person foresaw or ought to have foreseen.

The maximum penalty is fourteen years' imprisonment. The purpose of the offence is to overcome the problem of showing which of two perpetrators committed the act when, for example, each is blaming the other and the evidence is otherwise inconclusive.

- (4) Section 146 of the Criminal Justice Act 2003 imposed a duty on the criminal courts to increase the sentence for any offence aggravated by hostility based on the victim's disability or perceived disability.
- (5) The Sexual Offences Act 2003 established a range of criminal offences relating to:
  - (a) the inability of a person with a mental disorder to refuse sexual activity where he or she lacks capacity or is unable to communicate refusal;
  - (b) where a person with a mental disorder is induced, threatened or deceived into sexual activity where the perpetrator knows or could reasonably be expected to know that the person is suffering from a mental disorder; and

- (c) situations involving care workers and sexual activity with mentally disordered people.
  - (6) Section 127 of the Mental Health Act 1983 created three offences of ill-treatment or neglect of mentally disordered persons by: an employee or manager of a hospital or care home; a Guardian or some other person who has custody or care; or any person in respect of a person subject to supervised discharge. The maximum penalty was extended from two to five years' imprisonment as a result of the Mental Health Act 2007.
- B.21 In addition, there are provisions to support vulnerable witnesses giving evidence in court. Many of these are contained in the Youth Justice and Criminal Evidence Act 1999, including the right to have an intermediary when being interviewed or giving evidence. The Police and Criminal Evidence Act 1984 also gives a vulnerable adult the right to have an appropriate adult present while in police custody.

## **APPENDIX C GLOSSARY**

CC	County Council
CC(DD)A 2003	Community Care (Delayed Discharges Etc.) Act 2003
CDCA 2000	Carers and Disabled Children Act 2000
C(EO) 2004	Carers (Equal Opportunities) Act 2004
C(RS)A 1995	Carers (Recognition and Services) Act 1995
CSA 2000	Care Standards Act 2000
CSDPA 1970	Chronically Sick and Disabled Persons Act 1970
ECHR	European Convention on Human Rights
EL	Executive Letter
DHSS	Department of Health and Social Services
DP(SCR)A 1986	Disabled Persons (Services, Consultation and Representation) Act 1986
FACS	Fair Access to Care Services guidance
General duties	Duties which are expressed towards the local population rather than being owed to any individual. Also known as target duties.
HC	House of Commons
HL	House of Lords
HSC	Health Service Circular
HSPHA 1968	Health Services and Public Health Act 1968
LAC	Local Authority Circulars
LBC	London Borough Council
LEA	Local Education Authority
MBC	Metropolitan Borough Council
MHRT	Mental Health Review Tribunal
NAA 1948	National Assistance Act 1948

NAFWC	National Assembly for Wales Circular
NASS	National Asylum Support Service
NHS	National Health Service
NHS Acts 2006	NHS Act 2006 and the NHS (Wales) Act 2006
NHSCCA 1990	National Health Service and Community Care Act 1990
PCT	Primary Care Trust
POVA	Protection of Vulnerable Adults
Practice guidance	Guidance which is not issued under section 7(1) of the Local Authority and Social Services Act. 1970 and is weaker in status.
Self-funders	People who fund their own social care services without any financial assistance from a local authority.
SENDIST	Special Education Needs and Disability Tribunal
SCT	Supervised Community Treatment
Statutory guidance	Guidance issued under section 7(1) of the Local Authority and Social Services Act 1970 which must be complied with unless there is good reason not to.
Specific duty	Duties set out in statute law, which are owed to and can be enforced by individuals.
UFSAMC	United and Fair System for Assessing and Managing Care (Wales) guidance.
WOC	Welsh Office Circular