

The Law Commission

(LAW COM No 326)

ADULT SOCIAL CARE

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THE LAW COMMISSION

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

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The text of this report is available on the Adult Social Care project page of the Law Commission website at www.lawcom.gov.uk

THE LAW COMMISSION
ADULT SOCIAL CARE
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THE LAW COMMISSION

ADULT SOCIAL CARE

To the Right Honourable Kenneth Clarke QC, MP, Lord Chancellor and Secretary of State for Justice

PART 1

INTRODUCTION TO THE REPORT

- 1.1 It is now well over 60 years since the passing of the National Assistance Act 1948 which remains to this day the bedrock of adult social care. Since then, adult social care law has been the subject of countless piecemeal reforms including new Acts of Parliament and a constant stream of regulations, circulars, directions, approvals and guidance. The intervening years have also seen the implementation of the Human Rights Act 1998, devolution, the restructuring of social services departments and numerous landmark legal judgments.¹ It is of little surprise that not only does the law perplex service users and social workers, but also the judiciary. Adult social care law, including how it relates to other legislation, has been described at various times by judges as “piecemeal ... numerous”, “exceptionally tortuous”, “labyrinthine” and as including some of the “worst drafted” subordinate legislation ever encountered.²
- 1.2 The disparate range of legislative provisions in this area reflects the differing policy imperatives and understandings that have been current at various times in the period since 1948. Many of these provisions have now become outdated and difficult to justify in modern times. For example the core definition of disability for the purposes of community care law continues to be that contained in section 29 of the National Assistance Act 1948, which refers to “welfare arrangements for blind, deaf, dumb and crippled persons”. Moreover, some aspects of the law are relics from the old poor law, such as the power to remove people from their homes who are living in “insanitary conditions” under section 47 of the 1948 Act; this provision is based on local legislation drafted for Bradford in 1925 to assist with slum clearance and is incompatible with the European Convention on Human Rights.
- 1.3 Finally, the proliferation of law has led to inefficiency in the system, as much time is required to negotiate the complex and outdated law, and the end result is often uncertain and unclear. Complex law also has the effect of stifling innovation, and the multiple layers of law can make it difficult to promote flexibility and new policy approaches in practice.
- 1.4 This project represents a major and unique opportunity to reform this legal

¹ See Law Commission, *Adult Social Care: Scoping Report* (2008) Part 2.

² *A v London Borough of Lambeth* [2001] EWHC Admin 376, [2001] 2 FLR 1201 at [24] by Scott Baker LJ; *R (F) v Wirral Borough Council* [2009] EWHC 1626 (Admin), (2009) 12 CCLR 452 at [8] by McCombe J; *Crofton v NHS Litigation Authority* [2007] EWCA Civ 71, (2007) 10 CCLR 123 at [111]; and *Ryan v Liverpool Health Authority* [2001] All ER (D) 15 at [5] by Munby LJ (when he was a High Court judge).

framework and address these problems. The recommendations set out in this report will create a clear, modern and effective legal framework for the provision of adult social care both now and for the future.

WHAT IS ADULT SOCIAL CARE?

- 1.5 *Adult social care* means the care and support provided by local social services authorities pursuant to their responsibilities towards adults who need extra support. This includes older people, people with learning disabilities, physically disabled people, people with mental health problems, drug and alcohol misusers and carers. Adult social care services include the provision by local authorities and others of *traditional services* such as care homes, day centres, equipment and adaptations, meals and home care. It can also extend to a range of so-called *non-traditional services* – such as gym membership, art therapy, life coaching, personal assistants, emotional support, and classes or courses. Adult social care also includes services that are provided to carers – such as help with travel expenses, respite care, and career advice. Finally, adult social care also includes the mechanisms for delivering services, such as assessment, personal budgets and direct payments.

STRUCTURE OF THE PROJECT

- 1.6 The adult social care project was announced in the Law Commission's Tenth Programme of Law Reform in June 2008.³ The project was seen as a major undertaking, requiring the Law Commission to devote considerable resources to it. We therefore considered that it was of the first importance for there to be a continuing and positive commitment from the Government. Accordingly, the project was split into three phases, providing break points for both the Commission and Government to consider the desirability of continuing on to the next stage. The stages were:

Stage 1: Scoping Review	
June – November 2008	Scoping review, delineating the scope of the project and providing an agenda for reform
November 2008	Publication of the scoping report
Stage 2: Substantive Project	
February 2010	Publication of consultation paper with provisional proposals for reform
February – July 2010	Public consultation on the proposals
July 2011	Publication of a report with final recommendations for reform
Stage 3: Drafting a Bill	
July 2012	Production of a draft bill to implement the recommendations of the report

³ Tenth Programme of Law Reform (2008) Law Com No 311 HC 605.

- 1.7 In June 2010, the Law Commission agreed, at the request of the Government, to bring forward the timetable for delivery of the final report to May 2011, so as to co-ordinate better with the Commission on funding of long-term care. The Government has set out its intention to:

bring together the conclusions of the Law Commission and the Commission on funding of long-term care, along with our vision, into a White Paper in 2011, with a view to introducing legislation in the second session of this Parliament to establish a sustainable legal and financial framework for adult social care.⁴

- 1.8 As this timetable makes clear, there will be no third phase. From the Law Commission's point of view, this is the most positive outcome, in that Government will be implementing what they accept in this report much more quickly than would be the case if we were to produce draft legislation. Therefore the Law Commission, in this report, formally concludes that there should be no third stage.
- 1.9 Throughout this project we have benefited greatly from a strong and ongoing commitment by both Governments to the goals of reforming adult social care law. Throughout the life of the project, we have met on a regular basis with officials from the Department of Health, as the sponsoring department for this project. These meetings have been invaluable in providing an opportunity both to update the Department on the progress of the project and for officials to update us on developments in Government policy. We have also met on a number of occasions with Welsh Assembly Government officials in Cardiff.

Public consultation

- 1.10 Our consultation paper was published on 24 February 2010, which set out 57 provisional proposals and 25 consultation questions on the reform of adult social care. The public consultation ran until 1 July 2010. During this period, we attended 72 events covering the breadth of England and Wales. These events covered a wide audience, including service users, carers, social workers, NHS staff, academics, lawyers, charities and campaigning organisations.
- 1.11 At each of the consultation events we attended, we received a wide range of views on various different aspects of our proposals. As a general observation, we were struck by the widespread support for this project and the need to reform this area of law as a matter of priority. Many consultees shared with us the difficulties they were experiencing as a result of the complexities of the law; such as a lack of clarity over basic legal entitlements and long-standing disputes with local authorities. We received 231 written responses to the consultation paper, from a range of different individuals and organisations. As a result of consultation all of our proposals have been reviewed, and the vast majority have been revised or altered, some substantially. The most obvious examples are our approach to statutory principles (Part 4) and the definition of community care services (Part

⁴ Equity and Excellence: Liberating the NHS (2010) Cm 7881, para 1.19. The Commission on funding of long-term care is an independent body launched in July 2010 to review the funding system for social care in England. It is due to report in July 2011.

8). The consultation analysis was published on 31 March 2011. We extend our gratitude to all those who participated in our consultation process.

POLITICS AND LAW REFORM

- 1.12 A fundamental issue for this project has been the delineation of the respective roles of the Law Commission and Government. The Law Commission undertakes law reform. We have a statutory function to review the law with a view to its systematic development and reform. Political policy, on the other hand, is a matter for Government. It is Government that must make political judgements about spending priorities and rights and responsibilities.
- 1.13 However, drawing a clear distinction between law reform, on the one hand, and political policy on the other is not always easy. Political policy works through and influences law. The form of legal structures can enable or limit both the delivery of policy and its development. Some things are clearly law reform, others are clearly political policy. But where the two meet it can be difficult to disentangle them. Our approach throughout this project has been that if our proposals represent a major shift from the current legal framework and/or have major resource implications, then this would put them in the political arena and thus outside our remit. While navigating the line between law reform and political policy has been difficult at times, we are confident that the recommendations put forward in this report are properly within the realm of law reform.

POLICY DEVELOPMENTS

- 1.14 We have acknowledged throughout this project that law reform must operate within the broader context of Government policy. The difficulty with adult social care is that policy has been in a state of flux over the lifetime of this project, and will continue to develop following publication of our report. One key development is the Government policy of personalisation.
- 1.15 Although it is difficult to define personalisation precisely, the core idea is said to be that “everyone who receives social care support, regardless of their level of need, in any setting ... will have choice and control over how that support is delivered”.⁵ It is frequently contrasted with the “monolithic, top-down, paternalism” of the *traditional social care system*, where the state acts as both a commissioner and provider of services. Thus, the Government describes personalisation in the following terms:
- Individuals not institutions take control of their care. Personal budgets, preferably as direct payments, are provided to all eligible people. Information about care and support is available for all local people, regardless of whether or not they fund their own care.⁶
- 1.16 Critics of personalisation argue that it fails to address the needs of most older people, as opposed to younger physically disabled people, and that in practice it

⁵ LAC(DH)(2008)1, *Transforming Social Care*, para 16.

⁶ Department of Health, *A Vision for Adult Social Care* (2010) p 15.

adds to the responsibilities and burdens of families and friends.⁷ It is notable that Wales has adopted a more cautious approach to personalisation than England. The Welsh Assembly Government has stated that “the label ‘personalisation’ has become too closely associated with a market-led model of consumer choice”, and instead has committed to developing a model of self-directed support.⁸

- 1.17 A particular issue for this project is the relationship between personalisation and existing legal entitlements. As we have made clear above, in the context of adult social care we see fundamental shifts in legal rights as the responsibility of political policy, not law reform. At the same time, at least some ways of presenting the development of personalisation appear to imply a conflict with existing legal rights, such as the right to an assessment on the appearance of need. As will become clear as we outline our approach in this report, we do not think this conflict is insurmountable.
- 1.18 Accordingly, while we accept the importance of our scheme being able to accommodate personalisation, we maintain our view that it would be a mistake to bind our recommendations to a particular philosophy or policy. As our scoping report demonstrates, the history of adult social care law is littered with examples of statutes which have attempted to implement prevailing policies but which now look increasingly out of date.⁹ In our view, the better approach is to create, as far as possible, a neutral legal framework that is not wedded to any particular policy and is capable of accommodating different policies and practices in the future. Underpinning this framework are the core entitlements and rights that are crucial to the existing legal framework. This is the approach we have adopted in this report.

STRUCTURE OF THE REPORT

- 1.19 This report is divided into twelve Parts. Parts 2 and 3 consider preliminary issues such as defining adult social care (Part 2) and the structure of reform adopted in our scheme (Part 3).
- 1.20 Parts 4 through to 8 set out our core recommendations for how our scheme will govern social care provision. Thus Part 4 considers the role of statutory principles in providing an overall framework for decision making; Part 5 considers the role of community care assessments in determining a person’s needs; Part 6 considers eligibility for services; Part 7 explores the equivalent assessment and eligibility processes for carers; and Part 8 considers the provision of services. Part 9 considers local authority adult protection functions under our scheme.
- 1.21 Finally, Parts 10 to 12 consider other issues, including ordinary residence and portability (Part 10); areas where adult social care overlaps with other areas of law (Part 11); and other outstanding issues (Part 12).

⁷ For example, L Clements “Social Care Law Developments: A Sideways Look at Personalisation and Tightening Eligibility Criteria” (2011) 1 *Elder Law Journal* 47.

⁸ Welsh Assembly Government, *Sustainable Social Services for Wales* (2011) paras 3.16 and 3.17.

⁹ Law Commission, *Adult Social Care: Scoping Report* (2008) Part 2.

PART 2

DEFINING ADULT SOCIAL CARE

INTRODUCTION

- 2.1 How should the law define adult social care? The NHS Acts 2006 define the central purpose of health services in England and Wales as securing improvement in physical and mental health, and in the prevention, diagnosis and treatment of illness.¹ There is no equivalent statement in law which defines adult social care. Instead, the law attempts to define the scope of adult social care by delineating the extent of the duties and powers of local authorities to provide adult social care services. It does this through a series of *processes* (primarily assessments, eligibility decisions and care planning) and *definitions* (such as lists of services, user group categories and prohibitions).
- 2.2 The consultation paper argued that of these two approaches, the legal processes are the most significant factors in determining the scope of adult social care. For example, it is the process of determining eligible needs that identifies not only when a duty to provide service arises, but also the type of service that must be provided by identifying the outcome that the service should achieve. In contrast, the legal definitions of community care services and user groups are too broad and fail to delineate in any meaningful way the scope of adult social care.
- 2.3 Consequently, we argued that the most effective way of providing a coherent legal framework is to establish tightly defined processes for determining the scope of adult social care. Accordingly, we put the community care assessment, eligibility decision and care planning process at the centre of our proposed statute and asked for views on whether an approach based on tightly defined processes was sufficient and appropriate.²

CONSULTATION RESPONSES

- 2.4 The majority of responses to this question argued that our proposed approach was sufficient to determine the scope of adult social care.³ However, some consultees argued that as well as defining processes, the statute should define what adult social care is. Others were concerned that our proposed approach would perpetuate a service-led rather than outcome-led care system, and may restrict creative support planning. Several responses argued that the proposal does not take sufficient account of the policy of personalisation and our approach should be wider than simply focusing on those with assessed needs and include advice, signposting and services for those who fall below the eligibility criteria.

DISCUSSION

- 2.5 Consultation has persuaded us to revise significantly our approach to defining adult social care. First, although it is neither possible nor desirable to define

¹ NHS Act 2006, s 1 and NHS (Wales) Act 2006, s 1.

² Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 2.19 to 2.25.

³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 22.

precisely what adult social care is, we believe that the statute should provide greater clarity about its purpose. In Part 4 (Statutory Principles) we recommend the introduction of a single overarching principle that adult social care must promote or contribute to the well-being of the individual. This would provide a positive statement about the nature and purpose of adult social care, around which all the other elements of the statute must be organised. This would be supported by a list of outcomes to which the well-being principle must be directed (see Part 8 (The Provision of Services)).

- 2.6 Second, we have also revised our approach to the scope of adult social care to accommodate the needs of people who are not eligible for services; a group of people whose number is likely to increase significantly if budgetary pressures force local authorities to raise eligibility thresholds to the highest level. In our view, the duty to provide adult social care services should exist on two levels: first, the local authority's wider responsibilities to provide universal services; and second, services provided for individuals following an assessment. In order to divert people, where appropriate, from the second to the first level, there should be a general duty in the statute which would require local authorities to provide information, advice and assistance. The general duty would operate specifically in the context of adult social care, and would be in addition to the wider responsibilities of local authorities to provide universal services.
- 2.7 In summary, under our scheme the *purpose* of adult social care is defined as promoting or contributing to the well-being of the individual (see Part 8).
- 2.8 The *scope* of adult social care would be defined as:
- (1) universal services; and
 - (2) services provided for individuals following an assessment (see Part 5 (Assessments)).
- 2.9 The extent of the duty to provide services for individuals is then defined by:
- (1) an assessment of a person's needs and the outcomes they wish to achieve (see Part 5);
 - (2) identifying eligible needs by reference to an eligibility framework set out in regulations, and locally determined eligibility criteria (see Part 6 (Eligibility)); and
 - (3) the provision of community care services, as defined by a list of services and outcomes (see Part 8) and subject to a number of prohibitions on the types of services that can be provided (see Part 11 (Overlap Issues)).

PART 3

STRUCTURE OF REFORM

INTRODUCTION

- 3.1 This Part considers the overall structure of our recommended legislative framework for adult social care. In particular, it considers whether there should be a single adult social care statute; our general approach to the hierarchy of rules; and the guidance issued in our scheme.

A SINGLE ADULT SOCIAL CARE STATUTE

- 3.2 The legislative framework for adult social care is a confusing patchwork of conflicting statutes, built up over the past 60 years. There is no single modern statute to which local authorities, service users, carers and others can look to understand whether services can or should be provided. The consultation paper proposed that the best way to achieve a simple and consistent legal framework would be to introduce a unified adult social care statute. This would mean that the existing provisions under which adult social care is provided would be consolidated and reformed into a single piece of legislation. This includes the relevant provisions in the National Assistance Act 1948, the Chronically Sick and Disabled Persons Act 1970, the NHS and Community Care Act 1990 and carers' legislation.
- 3.3 The consultation paper also considered whether there should be one unified statute for England and Wales, or one for England and a separate one for Wales. We proposed a single adult social care statute for England and Wales, unless policy in Wales diverges enough to require separate statutes for England and for Wales. While there are differences in the law that applies in England and in Wales, we did not consider they were currently such as to require separate statutes for each country. However, we also stated our intention to monitor any divergence in policy between England and Wales throughout our project given the various reviews underway in each country, and to take account of any change to the devolution settlement following a referendum on fuller legislative powers for the National Assembly, which took place on 3 March 2011.¹

Consultation responses

- 3.4 The vast majority of responses to this proposal agreed that there should be a single adult social care statute.² There was strong support for the need to consolidate the existing legal framework for adult social care, with many consultees pointing to the complexity and confusion caused by the vast amount of statutes currently regulating the sector. Consultees suggested that a single statute would make the law clearer and more accessible for local authorities, service users and carers.

¹ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 2.8 to 2.12.

² See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 10.

- 3.5 In relation to the issue of whether there should be single or separate statutes for England and Wales, the vast majority of those who responded supported a single statute covering England and Wales. However, some consultees questioned this aspect of the proposal, mainly on the basis that policy is diverging between England and Wales and is likely to continue to do so in the future, and that separate statutes would facilitate future development better. For example, the Government expressed the view that it would be preferable to have separate statutes as this would be in line with the approach taken in other areas recently, including NHS legislation, and would in the longer term “provide for clearer law if further policy divergences emerge”. However, they stated they would need to revisit this issue in the light of the outcome of the referendum on fuller legislative powers for the Assembly. In contrast, the Welsh Assembly Government preferred to hold its position in relation to a single or separate statute, given the current work taking place on the future policy direction for adult social care in Wales.

Discussion

- 3.6 Consultation has confirmed our view that the existing legal framework for adult social care urgently needs to be consolidated and simplified. The confusing and often incoherent patchwork of legislation makes interpretation and application of the law complex and time consuming. In our view, consolidation and simplification would be best achieved by establishing a unified adult social care statute.
- 3.7 Opinion was divided, however, over whether separate statutes are needed in England and in Wales. In our view, this issue has been settled in practice by the outcome of the referendum on fuller legislative powers for the National Assembly, which was held on 3 March 2011. Prior to this referendum, the legislative competence of the National Assembly to legislate was governed by Part 3 of the Government of Wales Act 2006. Competence depended on the existence of a usually quite precisely drafted *matter* within a broadly defined *field*. For example, one such field was *social welfare*, and one of the matters included within this field was the charges levied by local authorities for social care services.³ The existence of a matter gave the National Assembly legislative competence to pass *Assembly Measures*, such as Social Care Charges (Wales) Measure 2010, which sets out charging rules for non-residential services. If the Assembly Government wished to make laws on another matter within the field, it was required to ask the UK Parliament for its agreement to give it legislative competence.
- 3.8 Following the “yes” vote in the referendum, Part 4 of the Government of Wales Act 2006 has now been brought into force. This gives the National Assembly competence within certain *subjects*, which are defined in similar or identical terms to the *fields* set out in Part 3 of the Act. The relevant subject for our purposes is social welfare, which is defined to include social services and the care of vulnerable persons and older persons.⁴ Under Part 4, the National Assembly has therefore gained a general legislative competence to legislate for adult social care, and can now pass Acts of the National Assembly for Wales.

³ Government of Wales Act 2006, Schedule 5, Field 15, Matter 15.1.

⁴ Government of Wales Act 2006, Schedule 7, Subject 15.

- 3.9 In our view, it would be constitutionally infelicitous to propose that the UK Parliament legislate for Welsh adult social care, whether in one UK bill covering both England and Wales, or in separate Westminster bills for each country. Given that Part 4 has now been brought into force, we recommend that our proposals be implemented in Wales by means of an Act of the National Assembly. This would allow for the legislation itself to be made in Wales and would give the Welsh Assembly the freedom to implement our recommendations in the way they preferred.⁵ They would also be able to introduce further provisions into our recommended legislation – such as compulsory and emergency powers in adult protection – if they considered that desirable. Although the introduction of Part 4 does not affect the continued operation of Measures which were passed under the Part 3 regime⁶ – which would include the Social Care Charges (Wales) Measure 2010, for example – we would anticipate that in drafting a bill to introduce the recommendations set out in this report, the National Assembly would take the opportunity to repeal and re-enact those measures already passed that should be integrated into the instrument for our scheme.
- 3.10 All of the recommendations we put forward in this report are intended for both England and Wales. We think it would be desirable, so far as possible, to have consistent statutes in both countries.

Recommendation 1: There should be single statutes for adult social care for each of England and Wales. In Wales this should be implemented by an Act of the National Assembly for Wales.

OUR GENERAL APPROACH TO THE HIERARCHY OF RULES

- 3.11 The consultation paper noted that adult social care is currently regulated through a range of mechanisms including primary legislation, regulations, directions and approvals, statutory guidance and practice guidance. The range of powers available to the Secretary of State (and now the Welsh Ministers) in adult social care is particularly striking. Fundamental statutory provisions are subject to directions and approvals, such as the power to provide “welfare services” in section 29 of the National Assistance Act 1948 (“a local authority may, with the approval of the Secretary of State, and to such extent as he may direct ...”). Statutory guidance is issued under section 7 of the Local Authority Social Services Act 1970, which provides that local authorities “shall, in the exercise of their social services functions, including the exercise of any discretion ... act under the general guidance of the Secretary of State”. Section 7A of the same Act requires the exercise of those functions “in accordance with such directions as may be given ... by the Secretary of State”. Consequently, it is rare that a statute by itself, or even in combination with statutory instruments made under it, provides the answer to whether a local authority has a power or a duty to provide services; a number of other instruments also have to be taken into account.
- 3.12 In developing our proposals in the consultation paper, we adopted a more straightforward approach to the hierarchy of rules, putting forward a three-level

⁵ Alternatively it would be open to the Welsh Assembly Government to agree to legislation for Wales in Westminster, if they so chose.

⁶ See Government of Wales Act 2006, s 106(2).

structure for the regulation of adult social care. The first level was a single statute setting out the duties and powers on local authorities, which were not subject to further direction and approval by the Secretary of State and Welsh Ministers. The second level was statutory instruments such as regulations, to be used where more detail or prescription was required, and a reasonable degree of flexibility is necessary. The third level was statutory guidance, which could be used to guide the exercise of social services functions and discretions by local authorities.⁷

Consultation responses

- 3.13 The majority of consultees who expressed a view agreed that our three-level structure for the regulation of adult social care was appropriate.⁸ Many consultees suggested that our approach would have the benefits of clarity, transparency and greater accessibility, and should reduce unnecessary litigation.
- 3.14 Some consultees criticised the use of approvals and directions in the existing legal framework. However, the Government – while agreeing that the current system “is confusing and lacks transparency” – argued that there was still “a role for directions in the social care system” and suggested that this power should be retained to deal with issues arising in individual authorities and to enable binding instructions to be given on issues relating to the exercise of social services functions not covered by a regulation-making power.

Discussion

- 3.15 Consultation has confirmed our view of the benefits of adopting a clear and straightforward legal structure for the regulation of adult social care. In terms of the first level, the core duties and powers of local authorities should be set out on the face of the legislation itself and where necessary expanded on or implemented in regulations made under the statute. In our view it would undermine our goals of simplification and consistency to continue to allow for directions and approvals to establish parallel systems of legal entitlements.
- 3.16 Furthermore, the general power to issue directions in section 7A of the Local Authority Social Services Act 1970 should be repealed as it relates to our scheme. The Secretary of State and Welsh Ministers already have the appropriate tools to intervene in the circumstances raised by the Government and we do not consider that a broad, directions-making power is necessary. For example, both Governments would continue to be able to guide local authorities in the exercise of their functions by issuing statutory guidance (discussed below); while not creating binding instructions, the statutory guidance would have strong legal status and could only be departed from by local authorities where they have a good reason, but without freedom to take a substantially different course. Alternatively, if there are systematic failings at a local authority, both Governments have powers to intervene, including a power to direct that a specified function of the authority shall be exercised by the Secretary of State and Welsh Ministers or a person nominated by them.⁹ To retain a broad

⁷ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 2.13 to 2.17.

⁸ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 15.

⁹ Local Government Act 1999, s 15 and Local Government (Wales) Measure 2009, s 29.

directions-making power could lead to duplication and excessive layers of law, which is what our new legal framework is trying to avoid.

- 3.17 We maintain that the second level of our three-level structure should be statutory instruments, such as regulations, for two main reasons. The first is because we wish to prescribe some element of the legal framework in a level of detail which we regard as more appropriate for regulations than for primary statute. In deciding whether there should be a duty or a power to make regulations in these areas, we have been guided by the principle that there should be a duty where the legal framework depends on the regulations being made. An example here is the duty to make regulations prescribing the eligibility framework which local authorities must use to determine eligible needs (see Part 6 (Eligibility)). It is essential that these regulations are made, as they will be the sole mechanism for determining eligibility for the provision of services in our scheme.
- 3.18 The second reason why we have put forward regulations in some areas is to allow expressly for the development of policy in the future. In these areas, we recommend giving the Secretary of State and Welsh Ministers a power to require or authorise certain matters in regulations; an example is our approach to charging set out in Part 8 (The Provision of Services). This structure will provide both Governments with the appropriate levers to deliver policy while still future-proofing the legislation. There are also some instances where we put forward duties which can be implemented via the introduction of regulations but only when and if the Government and the Welsh Assembly Government decides to do so. We have taken this approach to give both Governments the flexibility to introduce a duty in the future, should policy develop in this direction; an example is our approach to advocacy set out in Part 12 (Other Issues).
- 3.19 A final matter to note about the regulations is that while in each area the Secretary of State and Welsh Ministers have been given a discrete duty or power to make the regulations, it may be that in practice one set of regulations is made pursuant to some or even all of these duties or powers. For example, it might be possible for a single set of regulations to govern how community care assessments, carers' assessments and adult protection enquiries are conducted. In our view, it would be desirable for reasons of clarity to have consolidated instruments as far as possible. However, this matter would be decided by the relevant policy maker.
- 3.20 The third level of our scheme, statutory guidance, is discussed separately below.

Recommendation 2: Adult social care should be regulated through a three-level structure of statute, regulations and guidance issued under the statute. The general power to issue directions under section 7A of the Local Authority Social Services Act 1970 should be repealed as it relates to our scheme.

THE GUIDANCE IN OUR SCHEME

Code of practice

- 3.21 In the consultation paper we put forward the general proposition that any consolidation of the law provides a valuable opportunity to consolidate and revise any associated guidance. Furthermore, we suggested that there may be merit in placing a duty on the Secretary of State and Welsh Ministers to prepare a code of

practice to accompany the adult social care statute. We envisaged that this would provide the form under which statutory guidance was issued in our scheme and would mean that the current obligations placed on local authorities in statutory guidance could be consolidated into a single instrument.¹⁰

Consultation responses

- 3.22 There was overwhelming support for placing a duty on the Secretary of State and Welsh Ministers to prepare a single code of practice in adult social care, with a number of consultees pointing to the difficulties with the amount of guidance in this area and the confusion that this can cause.¹¹
- 3.23 On the other hand, a small number of consultees argued that the overriding concern is that there is *consolidated* guidance; whether this takes the form of a code or another instrument is of secondary importance. For example, the Government agreed that “people should be able easily to find all the relevant guidance”, and that it should be “coherent”, “up-to-date” and “in one place”, but argued this did not necessarily mean formulating it as a code of practice, “which could be unduly cumbersome”.
- 3.24 Finally, several consultees expressed concern that currently the language used in statutory guidance is often too vague to be instructive and contains policy exhortations rather than legal guidance. Many participants at consultation events expressed confusion about the precise legal status of the various pieces of guidance, such as practice guidance. Furthermore, some consultees suggested that too often policy documents such as *Putting People First* and *Valuing People Now* were becoming more important to adult social care than statutory guidance, and that the legal status of these documents was often unclear to them.

Discussion

- 3.25 It would be undesirable, in our view, to retain current practice which enables both Governments to issue a range of disparate and unconnected pieces of statutory and practice guidance. Instead, the Secretary of State and Welsh Ministers should have a duty to issue consolidated guidance on the adult social care statute. Whether this guidance is achieved through a single document (for each country) or, for example, through a consolidated series of documents, would be a matter to be determined by each Government. If multiple documents were issued then they should be published in a form which allows them to be presented as a coherent whole, and they should be available in a single accessible location, such as on one webpage (for each country).
- 3.26 The purpose of the consolidated guidance would be to guide social services authorities on the exercise of their functions under the statute, including the exercise of any discretion conferred by the Act. In our view this extends to guidance about the implementation and operation of the legislation, giving concrete examples where that helps to explain what is required and clarifying the correct legal interpretation of aspects of the law (for example, by summarising case law). The purpose of the guidance does *not* extend to policy exhortations or

¹⁰ Adult Social Care (2010) Law Commission Consultation Paper No 192, para 2.18.

¹¹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 19.

vague statements about the "direction of travel" of social services functions.¹² The consolidated guidance should set out the course of action that a social worker or other decision maker should take, unless there is a good reason for not taking that course of action.

- 3.27 The duty to issue consolidated guidance set out in the statute should be the only means through which statutory guidance on our scheme can be issued. Accordingly, section 7(1) of the Local Authority Social Services Act 1970 should be repealed as it relates to our scheme. This would not affect the Governments' powers to issue statutory guidance on other areas of adult social care not covered by our scheme (such as complaints and regulation) or on children's social services.
- 3.28 In our view, it is important that the statute should specify three matters about the guidance: the legal status of the consolidated guidance; the Parliamentary scrutiny it should be subject to; and requirements for consultation in preparing or revising the consolidated guidance.
- 3.29 As noted above, consultees expressed confusion about the legal status of existing guidance. In our view, it is essential that the statute itself is clear about the legal status of the guidance issued under it, and to whom it will apply. We consider that the legal status should be the same as statutory guidance issued under section 7 of the Local Authority Social Services Act 1970. That is, it must be followed by social services authorities in exercising their functions and it can only be deviated from where there is good reason to do so, but without freedom to take a substantially different course.¹³ This legal status is similar to the codes of practice issued under the Mental Health Act 1983 and Mental Capacity Act 2005.¹⁴ Furthermore, the statute should specify the people who must have regard to the guidance; that is, any decision maker acting under the legislation.
- 3.30 We also consider that the guidance should be subject to Parliamentary oversight through the negative resolution procedure. This would mean that any alteration of the guidance, including the issuing of new guidance, would need to be laid before Parliament or the National Assembly for 40 days and will come into force unless a resolution annulling it is passed. The guidance plays a crucial role in our scheme as it will be the means by which the Secretary of State and Welsh Ministers can guide the exercise of local authority functions under the statute, and it will carry substantial legal force. Accordingly, it is important that any changes are given an appropriate degree of scrutiny. This is consistent with the approach adopted by the Mental Health Act 1983 and Mental Capacity Act 2005.
- 3.31 This raises a further point as to terminology. Although there is nothing to stop *guidance* being laid before Parliament or being subject to Parliamentary scrutiny, we are not aware of this happening in practice, at least in the social welfare field. In contrast, a statutory *code of practice* is typically laid before Parliament and often is subject to a negative or affirmative resolution procedure. Given this

¹² *R (Broster) v Wirral* [2010] EWHC 3086 (Admin).

¹³ See *R v Islington London Borough Council ex p Rixon* (1997-98) 1 CCLR 119, 123(J), by Sedley LJ (when he was a High Court judge).

¹⁴ Mental Health Act 1983, s 118 and Mental Capacity Act 2005, s 42.

precedent, it would be clearer and consistent with current practice to adopt the form and terminology of a code of practice to refer to the guidance issued under the statute. This does not presuppose that the Government or the Welsh Assembly Government must issue a *single* code of practice; whether it issues a single code or a series of codes is a matter of practice to be determined by them. Accordingly, throughout this report, we will refer to the guidance issued in our scheme as a *code of practice*. But we emphasise that, Parliamentary scrutiny apart, we see no difference in principle between a *code of practice* and *statutory guidance*.

- 3.32 The final area that the statute should specify is any requirement for consultation before the guidance is issued or revised. Most relevant statutes which require the Government or the Welsh Assembly Government to produce a code also include a requirement for consultation in preparing or revising the code. For example, the Mental Capacity Act 2005 provides that before preparing a code, the Lord Chancellor must consult the National Assembly for Wales and “such other persons as he considers appropriate” and the Mental Health Act 1983 provides that before preparing the code, “the Secretary of State [and Welsh Ministers] shall consult such bodies as appear to him to be concerned”.¹⁵ Furthermore, the 1983 Act specifies that, in England, the Care Quality Commission “may at any time make proposals to the Secretary of State as to the content of the code of practice”.¹⁶ In our view, the statute should require both Governments to consult with appropriate bodies and persons before issuing or revising the code of practice issued under the statute. A requirement to consult should not impose a significant new burden, as both Governments already consult routinely before issuing or revising statutory guidance.

Recommendation 3: The statute should:

- (1) require the Secretary of State and Welsh Ministers to prepare and from time to time revise a code of practice to provide guidance for social services authorities on the exercise of their functions under the statute;**
- (2) require consultation with concerned bodies and other persons before any code is prepared or revised;**
- (3) provide that the code of practice, and any revisions made to it are subject to the negative resolution procedure in Parliament or the National Assembly; and**
- (4) specify that the code of practice must be followed by decision makers acting under the legislation and can only be deviated from where there are good reasons to do so, but without freedom to take a substantially different course.**

Section 7(1) of the Local Authority Social Services Act 1970 should be repealed insofar as it relates to our scheme.

¹⁵ Mental Capacity Act 2005, s 43(1) and Mental Health Act 1983, s 118(3).

¹⁶ Mental Health Act 1983, s 118(7).

Practice guidance and policy guidance

- 3.33 There are two final points about guidance that warrant attention. First, consultation has impressed upon us the confusion and complexity that is caused by the proliferation of practice guidance issued by both Governments. This confusion is exacerbated by the guidance not being marked as practice guidance and widespread confusion about the legal status of practice guidance. Practice guidance is weaker in status than statutory guidance, although it is something “to which regard must be had” by local authorities in carrying its statutory functions.¹⁷ Our intention is that our scheme will minimise the need to have multiple types of guidance issued in relation to it. If, however, practice guidance is issued, then we recommend that any such guidance should be kept to a minimum and the legal status of the guidance should be clarified and stated clearly in the guidance itself.
- 3.34 Second, we share the concerns at consultation that increasing importance is being given to policy documents in areas where legal guidance is needed. For example, significant changes to adult social care, such as the introduction of personal budgets and resource allocation systems, have been developed largely through policy documents rather than changes to the law.¹⁸ Furthermore, the status of these policy documents can be unclear. Further confusion can be caused by linking such policy documents to statutory guidance; for example, the revised statutory guidance on eligibility criteria in England is linked explicitly in its title to the policy document *Putting People First*. This can lead to confusion about which of the documents is the legally effective instrument and which is the policy statement, and may give the impression that both documents are statutory guidance or, conversely, that both are policy documents. In our view it would be beneficial if policy documents state that they are not legal documents and should be understood as indicating the direction of Government policy.

Recommendation 4: If practice guidance is issued in relation to our scheme, it should be kept to a minimum and the legal status of the guidance should be clarified and stated clearly in the guidance itself. Future policy documents should state that they are not legal documents and should be understood as indicating the direction of Government policy.

¹⁷ *R v Islington London Borough Council ex p Rixon* (1997-98) 1 CCLR 119, 131(E) by Sedley LJ (when he was a High Court judge).

¹⁸ See, for example, HM Government and others, *Putting People First* (2007).

PART 4

STATUTORY PRINCIPLES

INTRODUCTION

- 4.1 Statutory principles are intended to give legislative expression to the underlying purpose of the statute in question, and to guide decision makers acting under the legislation. Social welfare statutes that include a statement of fundamental principles include the Children Act 1989 and Mental Capacity Act 2005.
- 4.2 While *statutory principles* is the general term used to describe all principles set out in legislation, there are in fact different types of statutory principles, which differ in their legal effect and nature. A principle can be drafted in such a way that gives it primacy; such as the *welfare principle* of the Children Act 1989 or the *best interests principle* of the Mental Capacity Act 2005. The interpretation of both of these principles is assisted by a checklist of factors that should be considered and weighed against each other.¹ A principle can also establish a rule that directs the decision maker to consider a particular point. For example, section 1(5) of the Children Act directs a court not to make an order unless “doing so would be better for the child than making no order at all”. Alternatively, principles can set out statutory assumptions, which are phrased in mandatory terms but contain general caveats or are broadly worded to give decision makers sufficient flexibility. Thus, section 1(2) of the Mental Capacity Act provides that a person must be assumed to have capacity unless it is established that they lack capacity.
- 4.3 The consultation paper argued that there is a compelling case for a statement of principles on the face of the statute, and put forward for discussion the following general concepts with a view to considering whether they are capable of forming the basis of statutory principles:
- (1) decision makers must maximise the choice and control of service users;
 - (2) person-centred planning;
 - (3) a person's needs should be viewed broadly;
 - (4) the need to reduce or remove future need;
 - (5) independent living;
 - (6) an assumption of home-based living;
 - (7) dignity in care; and
 - (8) safeguarding adults from abuse and neglect.²

¹ Children Act 1989, ss 1(1) and 1(3) and Mental Capacity Act 2005, ss 1(5) and 4.

² Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 3.5 to 3.51.

CONSULTATION RESPONSES

- 4.4 The overwhelming majority of responses to the proposal agreed that the statute should include a statement of principles. However, there was no such clear consensus over the content of the principles.³
- 4.5 Most consultees who expressed a view supported the inclusion of a choice and control principle. However, some argued that the principle needed to acknowledge the importance of *informed choice*. Others argued that greater control may not always be applicable or welcome; for instance, some people may not wish to take on the additional burden of arranging and managing their own care and should be able to choose to have *traditional services*, delivered in the *traditional way*.
- 4.6 A majority of those who expressed a view were in favour of including a principle based on person-centred planning. It was recognised, however, that this concept may be too broad and insufficiently precise to form the basis of a statutory principle.
- 4.7 Most consultees who expressed a view supported the inclusion of a principle which provides that a person's needs should be viewed broadly. However, some consultees argued that this principle is better provided for by having the scope of an assessment in regulations. It was also argued that although a comprehensive assessment is often best practice, it is important to adopt a proportionate approach to assessment based on the individual circumstances of the case.
- 4.8 A majority of those who expressed a view were in favour of including a principle based on the need to remove or reduce future need. However, some consultees were unclear about how this principle would operate alongside local authority eligibility criteria, and others pointed out that responsibility for prevention services extends beyond social care.
- 4.9 A small majority of consultees who expressed a view argued that the statute should include a principle based on independent living, often on the basis that it would ensure rights to *full citizenship* for disabled people. However, others argued that independent living is too subjective, and could clash with the choice and control principle if, for example, a disabled person wants to be cared for in a communal setting.
- 4.10 A majority of those who expressed a view opposed the inclusion of a principle based on the assumption of home-based living. Most argued that the individual's wishes and feelings should be the key factors in determining their living arrangements.
- 4.11 A large majority of consultees who expressed a view argued there should be a principle in the statute based on dignity in care. Some consultees went further and argued this should be the primary principle of the statute. However, others were concerned by the imprecise nature of dignity and argued there might be unnecessary overlap with the choice and control principle.

³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) pp 25 to 69.

- 4.12 A large majority of responses to the question argued there should be a principle in the statute based on the need to safeguard adults at risk of abuse and neglect. Some went further and argued this should be the primary principle of the statute. However, some consultees contended that such a principle is of no substantive benefit if adult protection is prescribed in detail elsewhere in the statute. On the other side, it was argued that safeguarding and adult protection are connected but essentially different; with one relating to the prevention of abuse and the other relating to intervention once abuse has occurred, and consequently there would be merit in including a safeguarding principle.
- 4.13 Some consultees suggested alternative principles for the statute, including principles based on non-discrimination, respect for diversity and human rights. Others suggested that the principles should recognise the role of carers and include a clear statement that social care is a core responsibility of the state and that decision makers must use the resources available to them in the most effective, efficient and equitable way. Finally, some consultees suggested a principle based on the least restrictive form of intervention.
- 4.14 Finally, the Association of Directors of Adult Social Services, Social Care Institute for Excellence and Local Government Association argued that the statute could be built around a single organising principle, the counterpart for adults of the *welfare principle* of the Children Act 1989. The equivalent in the adults' field could be the principle that adult social care should *promote or contribute to the well-being of the individual and support people to be active citizens*. With the exception of some people who lack capacity, an adult would be presumed the best judge of their own well-being. Common elements of well-being would include personal identity; autonomy and self-determination; dignity, privacy and respect; physical and mental health; security and freedom from abuse; and economic and social inclusion.

DISCUSSION

- 4.15 Consultation has persuaded us to revise significantly our approach to statutory principles. We accept that not only should there be consistency between each of the individual principles, but that taken as a whole the principles should establish a coherent purpose for adult social care. As noted in Part 2 (Defining Adult Social Care), currently the law does not provide a core definition of adult social care. This is best illustrated by the construction of the statutory prohibitions (see Part 11 (Overlap Issues)), whereby adult social care is defined largely by reference to what services are not being provided by other organisations under different legislation. We believe there is considerable merit in providing a single unifying purpose around which adult social care could be organised.

The well-being principle

- 4.16 The idea that a principle should confirm the importance of adult social care as a core function of the state is an interesting suggestion. As currently worded, this concept is probably too vague to be included as a proposition of law and would be better placed in a policy document. However, an alternative approach, which would also confirm the importance of adult social care, could be the inclusion of a primary well-being principle in our legislation. This would establish clearly in law that the overarching purpose of adult social care is to promote or contribute to the

well-being of the individual. In effect, individual well-being must be the basis for all decisions made and actions carried out under the statute.

- 4.17 We are, however, dubious of the limb of the proposal discussed above which refers to supporting people to be active citizens, which does not appear to be sufficiently precise to be capable of operating in legislation. There are also potential tensions between the two that would sit unhappily with the core idea of a *single* overarching principle.
- 4.18 A primary well-being principle would provide a positive statement about the nature and purpose of adult social care. This principle would operate on two levels. First, when general decisions are being made under the legislation which do not relate directly to an individual (such as when local authorities commission services or set their eligibility criteria), decision makers would be required to ensure that in a broad sense adult social care promotes the well-being of individuals. Second, the principle would also apply when decisions are being made in relation to individuals.
- 4.19 In both instances, the well-being principle would be worded to operate as a *rule* which applies to every decision made under the statute. We note that the eligibility decision in relation to an individual person is not a decision for the purposes of the well-being principle, but rather is part of the process of determining the appropriate well-being of the person concerned.
- 4.20 The term *well-being* would not be defined precisely in the legislation. No single definition could offer an exhaustive account of what would promote or contribute to a person's well-being in any given circumstance covered by the statute; the intention is that the individual person and their circumstances should determine the result. In some instances, the well-being of the individual may best be promoted by the provision of a comprehensive care package; in other cases (for example, where the person falls below the local authority eligibility criteria) well-being may best be secured through advice, information and signposting to universal services.
- 4.21 Rather than defining well-being, the statute would set out a broad list of outcomes to which the well-being principle must be directed – for example, health and emotional well-being and protection from harm (see Part 8 (The Provision of Services)). Furthermore, the statute should provide a checklist of factors which must be considered before a decision is made in relation to an individual. In effect, the checklist establishes the process for determining which action or decision would promote or contribute to the well-being of the person concerned.

The checklist

- 4.22 The checklist would support the well-being principle by setting out a number of factors that must be considered when giving effect to the principle. These factors would not operate as legal *rules* but would, for example, direct the decision maker to consider a particular point or establish certain assumptions, which are either phrased in mandatory terms but contain general caveats, or are broadly worded to give decision makers sufficient flexibility.
- 4.23 This flexibility would allow, for example, resources to be taken into account where appropriate. Thus, resources would be relevant to *how* the well-being principle is

applied, not whether it is applied at all. A decision maker could have a number of options available, and would in most circumstances be entitled to take resources into account when making the decision – so long as the decision promoted the person’s well-being. We do not intend the checklist to be hierarchical. The weight attached to the various factors will differ according to the individual circumstances of the particular case. Moreover, the checklist would not provide an exhaustive list of factors that need to be taken into account by the decision maker. Material that falls outside the checklist may still be a relevant factor in determining the well-being of the person. In formulating the checklist, we have reviewed the principles discussed at consultation.

- 4.24 We believe there is merit in establishing a clear assumption that people with capacity are the best judges of their own well-being. This would help to ensure that the starting point for decision makers is always the capacitous views of the individual concerned. This assumption can be overridden only if there are good reasons to do so. For example, there may be safeguarding concerns or resource considerations which lead the decision maker to conclude that an alternative decision or action is necessary to secure or promote the person’s well-being.
- 4.25 Choice and control are important concepts that are relevant to many aspects of our scheme, for example direct payments and the choice of accommodation provisions. However, we accept the argument that it is choice rather than control that is the key principle. Acting in accordance with a person’s views, wishes and feelings will, in many cases, ensure greater control but there will be instances where people do not want control and it is important that the checklist reflects this. We, therefore, consider that in giving effect to the well-being principle, decision makers should be required to consider the individual’s views, wishes and feelings and follow them wherever practicable and appropriate. We accept that in order to make this principle meaningful it will be important to ensure that individuals can make informed decisions. Our recommendation in Part 5 (Assessments) for a general duty to provide information, advice and assistance will play an important role in ensuring that people are given sufficient information to make informed decisions.
- 4.26 To some extent this principle would overlap with the assumption that people with capacity are the best judges of their own well-being. Our intention is that in many cases the two principles would interact so that if a person is considered to be the best judge of their own well-being, then decision makers must follow their views, wishes and feelings wherever practical and appropriate. However, the need to follow the individual’s views, wishes and feelings is a broader principle that would extend to those who lack capacity. Even if the person lacks capacity, their views, wishes and feelings should still be taken fully into account – whether expressed in the past or now – and followed, subject to the general caveat of wherever *practical and appropriate*, which would allow decision makers to take into account wider concerns such as safeguarding and resource issues.
- 4.27 We agree that person-centred planning could not form the basis of a statutory principle for the reasons noted above. However, there are two elements of this process that would be capable of operating in law:
- (1) decisions must be based upon the individual circumstances of the person and not blanket assumptions on the basis of, for example, their age,

appearance or condition; and

- (2) service users and carers must be given the opportunity to be involved, as far as is practicable in the circumstances, in assessments, planning, developing and reviewing their care and support.

4.28 The second element is similar to the existing requirement contained in the Community Care Assessment Directions 2004, which requires a local authority to consult with a service user and carer when undertaking a community care assessment. While we recommend in Part 5 (Assessments) that this specific instance of consultation is brought across to the statute itself, we also consider that it would be beneficial to include a more general requirement for involvement and consultation in the checklist, since this would have broader application to all aspects of the statute and not just the assessment process.

4.29 It is important to consider how the well-being principle would be put into effect if there is more than one person involved. As a general rule the well-being principle relates to the subject of the decision. If there are competing interests, such as those of the carer, these would only be relevant insofar as they related to determining the well-being of the subject of the decision. In cases where two people are being assessed and their well-being is incompatible (such as a carer and a service user), then the decision maker would be required to seek a solution that balances the well-being of both parties. For example, if a person with dementia wants to remain living at home (and it is agreed that this would contribute to their well-being) and their carer wants them to move into a care home (and it is agreed that this would contribute to the carer's well-being) – then the solution that balances the well-being of both parties may be the provision of respite care on a regular basis. We therefore think there is merit in including a requirement in the checklist that decision makers may need to achieve some *balancing* of the well-being of one person against that of another.

4.30 We are persuaded that there is a need to include a principle based on safeguarding in addition to the specific adult protection provisions of the statute. This would serve as a reminder to local authorities in the context of mainstream assessment and service provision, of the need to consider interventions that prevent abuse and neglect, in addition to the need to intervene and investigate in cases where abuse and neglect has occurred.

4.31 The least restrictive course principle would also be capable of operating in law and has already been applied successfully as a statutory principle in the Mental Capacity Act 2005 and to a more limited extent, in the Children Act 1989.⁴ Including such a principle in the adult social care statute will be an important way of reminding local authorities, especially when undertaking adult protection interventions, of the need to approach such action with sensitivity and a proper appreciation of the limited extent of their powers, as well as helping to alleviate the fears of service users and carers that they will be the subject of coercive action.⁵ It also reflects the fact that some decisions by local authorities will necessarily be more restrictive of a person's rights and freedoms than alternative

⁴ Mental Capacity Act 2005, s 1(6) and Children Act 1989, s 1(5).

⁵ See *A Local Authority v A* [2010] EWHC 978 (Fam), (2010) 13 CCLR 404 at [51] to [55].

courses of action; for example, a care home placement may be more restrictive than a home-based care package.

- 4.32 The wording of this principle would need, however, to ensure that it did not undermine the views, wishes and feelings principle, and that it did not suggest that a local authority can impose restrictions where they cannot. However, there is scope for the principles in the checklist to pull in different directions. For instance, following the views and wishes of the person concerned may not accord with the safeguarding principle, and in such cases decision makers would need to achieve the appropriate balance in light of the circumstances of the case. The single unifying purpose of the individual factors in the checklist would be their relationship with the overarching well-being principle.
- 4.33 The evidence from consultation makes a convincing case that it is important to consider a wide range of needs when undertaking an assessment. However, we are not persuaded that this could form the basis of a statutory principle. First, it is not of general application to the rest of the statute and would apply mainly to an assessment. Second, it is important to allow local authorities to adopt a proportionate approach to assessment and not be overly prescriptive in legislation. This could allow for a comprehensive assessment in some cases or a simple assessment in others. This is discussed in more detail in Part 5 (Assessments).
- 4.34 We agree that the provision of prevention and early intervention services is a key aspect of adult social care and should form a central element of the statute. However, we take the view that this would be better achieved through general duties to provide these services rather than a statutory principle. This is also discussed further in Part 5 (Assessments). We also consider that the need to encourage multi-agency working should be taken forward as a statutory duty rather than a principle and we have proposed elsewhere statutory duties to co-operate (see Part 11 (Overlap Issues)).
- 4.35 We have also reviewed the other principles put forward at consultation. We remain concerned that concepts such as *dignity* and *independent living* are too imprecise to be expressed as statutory principles. The notion of dignity has been used by the courts in judgments which are addressing texts which do not use the word *dignity*. This suggests that while a legal structure can be constructed in a way that is conducive to *dignity* – or even in a way which undermines it – it is difficult to build a legal structure on the imprecise notion of dignity.
- 4.36 At consultation, a principle based on *independent living* was often seen as a means of establishing enforceable legal rights to services. In our view, this is not the purpose of statutory principles. Furthermore, this concept is covered adequately by Articles 8 and 19 of the United Nations Convention on the Rights of Persons with Disabilities. We agree that a principle based on an assumption of home-based living would not be suitable to be included as a principle in the statute. The key issue should be the person's wishes and feelings, and in effect this principle could skew choice in one particular direction.
- 4.37 We are not persuaded that statutory principles are necessary to promote non-discrimination and human rights. This would simply repeat unnecessarily the provisions of the Equality Act 2010 and the European Convention on Human

Rights. There is also a substantial body of case law on the application of anti-discrimination legislation and the European Convention to adult social care. We do not consider that a principle promoting efficiency or equity would be sufficiently precise to be capable of operating as a proposition of law.

Recommendation 5: The statute should:

- (1) set out a single overarching principle that adult social care must promote or contribute to the well-being of the individual; and**
- (2) state that in deciding how to give effect to this principle in relation to individuals, decision makers must:**
 - (a) assume that the person is the best judge of their own well-being, except in cases where they lack capacity to make the relevant decision;**
 - (b) follow the individual's views, wishes and feelings wherever practicable and appropriate;**
 - (c) ensure that decisions are based upon the individual circumstances of the person and not merely on the person's age or appearance, or a condition or aspect of their behaviour which might lead others to make unjustified assumptions;**
 - (d) give individuals the opportunity to be involved, as far as is practicable in the circumstances, in assessments, planning, developing and reviewing their care and support;**
 - (e) achieve a balance with the well-being of others, if this is relevant and practicable;**
 - (f) safeguard adults wherever practicable from abuse and neglect; and**
 - (g) use the least restrictive solution where it is necessary to interfere with the individual's rights and freedom of action wherever that is practicable.**

PART 5

ASSESSMENTS

INTRODUCTION

- 5.1 This Part considers the legal framework for community care assessments. It starts by considering the place of assessment in the adult social care system and then turns to the detail of the assessment: the duty to carry out an assessment; the focus of the assessment; the process of assessment; self-assessment and delegation of assessment; and links with other assessments.
- 5.2 At consultation, the use of the phrase *community care assessment* was criticised on several occasions for reflecting an outdated service-led approach to assessment. We recognise that the language in adult social care legislation should be updated, where appropriate, to reflect the modern approach and goals of adult social care. However, we have continued to use the phrase *community care assessment* in this report, in order to reference the assessment introduced under section 47 of the NHS and Community Care Act 1990 and to distinguish these assessments from carers' assessments. We do so without prejudice to the renaming of the relevant assessments in any legislation following this report.

THE PLACE OF ASSESSMENT IN ADULT SOCIAL CARE

- 5.3 The approach we took in the consultation paper was to put assessments at the centre of the legal framework for adult social care. This reflected the current law, which establishes an assessment as a core legal right and a crucial feature of adult social care. It operates both as a service in its own right, and as the gateway to the provision of services. Furthermore, assessment is instrumental – along with the eligibility framework and care planning – in determining the scope of adult social care in practice (see Part 2 (Defining Adult Social Care)).
- 5.4 This approach was supported by many consultees during the consultation.¹ Many agreed with our proposals to simplify the complexity of the existing legal framework for assessment by providing a single, clear duty to assess with a low threshold for triggering the duty. More generally, consultation confirmed that the right to an assessment is regarded as a significant and valued legal right.
- 5.5 However, during consultation, the centrality of assessment was questioned by advocates for greater personalisation. As discussed in Part 1 (Introduction), personalisation is the dominant policy approach currently to adult social care within both central and local Government in England. Advocates of personalisation adopted a broader conception of local authority responsibilities in which authorities have a wider role in ensuring that there is a full range of universal services available within their area – which can be accessed without an assessment – to support people to maintain their independence and well-being, and to reduce or delay the need for more targeted social care interventions.

¹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 70.

- 5.6 Under this approach, assessment is not seen as the first step of a process which must lead to decisions on eligibility and service provision, but rather as a service in its own right, akin to a consultation with a GP in the NHS. The focus would not be on rating a person's needs, but rather how to assist the individual to achieve well-being within their own resources and through universal services, and (perhaps residually) through services provided or arranged by the social services authority. For example, the assessment service could offer support in considering the person's overall situation; identifying adjustments required to restore well-being; and providing information, advice and advocacy to identify problems and consider options. For people with higher levels of needs, the assessment would also act as an entry point for more complex multi-disciplinary assessment, support, treatment and safeguarding provision.

Where do we see the place of assessment in adult social care?

- 5.7 We do not see our role as adjudicating between these different policy approaches to assessments. Nor do we see it as our role to produce a personalisation statute. However, at the same time, our framework should not squeeze out broader approaches to adult social care which do not necessarily depend on an assessment, and which play an increasingly important role in prevention and maintaining well-being.
- 5.8 Our role is to build a structure that does not require a particular policy approach but is capable of being inhabited by different policies at different times and indeed at the same time in different places. To do this, we must find a way of reconciling the broader perspective of personalisation with the continued existence of a legal right to a low-threshold assessment process, which acts as a gateway to state funding. With some important modifications to the provisional proposals we put forward in the consultation paper, we are confident our scheme achieves this. Our scheme contemplates that there are two levels at which adult social care services, broadly conceived, could be provided: at a universal level and a more targeted level.

Level 1: Universal services

- 5.9 The *Prioritising Need* statutory guidance encourages councils in England to "consider their strategy for investing in a more universal approach, which prevents or delays the need for more specialist social care interventions".² This might include things like advice on what paid-for services are available in the area, and assistance in accessing them; signposting people to welfare benefit advice or community support groups; *low-level* services for helping carers have a life outside caring; luncheon clubs; befriending; healthy living support; employment advice; physical recreation and leisure pursuits; housing support; and transport. It is stated that these interventions "can support people to maintain their independence and well-being and reduce or delay the need for more targeted social care interventions".³ The guidance also encourages councils to consider, before proceeding to determine eligible needs, whether an individual

² Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 33.

³ As above, paras 34 and 36. See also Welsh Assembly Government, *Sustainable Social Services for Wales* (2011) para 3.22.

might benefit from “a short period of re-ablement or intermediate care to increase what they are able to do for themselves before an assessment of longer-term need is undertaken”.⁴ We envisage that this position would be retained in our scheme, and stated clearly in the code of practice, subject to a specific right to re-ablement services being introduced, which is discussed in Part 12 (Other Issues).

5.10 Only a minority of universal services will be funded through social care. The local authority would have a responsibility to work with service providers, health partners and voluntary and community organisations to “stimulate the development and provision of sufficient types of services and support, which should relate not just to personal care needs but to overall quality of life”.⁵

5.11 The significance of the local authority roles of providing information, advice, assistance and shaping the local market is reflected in policy documents in England and in Wales. For example, the Coalition Government’s policy document *A Vision for Adult Social Care* provides:

To have real autonomy and choice people need information and advice. Lack of good, accessible information to help support their choices is a real concern for people. Councils’ role here is to ensure that everyone ... can get the information and advice they need.

Social care already involves a diverse range of providers, including the voluntary and private sectors. ... Councils have a role in stimulating, managing and shaping this market, supporting communities, voluntary organisations, social enterprises and mutuals to flourish and develop innovative and creative ways of addressing care needs.⁶

5.12 We accept the view that the functions of information, advice and assistance, as well as market shaping, should be expressed as duties, not merely powers. As we discuss in this Part and Parts 6 (Eligibility) and 8 (The Provision of Services), the provision of targeted care through assessment, eligibility and care planning is currently based on duties and would continue to be under our recommended scheme. If we are to see the provision of information, advice and assistance as well as shaping and stimulating the local market for services as of comparable importance in the overall delivery of social care, it is apposite that they, too, should be duties.

Recommendation 6: The statute should place duties on local authorities to provide information, advice and assistance services in their area and to stimulate and shape the market for services.

⁴ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 41.

⁵ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) paras 36 and 37. See also Department of Health, *Practical Approaches to Market and Provider Development* (2010).

⁶ Department of Health, *A Vision for Adult Social Care* (2010) paras 4.8 and 5.2. See also Welsh Assembly Government, *Sustainable Social Services for Wales* (2011) paras 3.18, 3.24 and 3.45.

Level 2: Targeted community care services

- 5.13 The availability of local services, and information, assistance and advice in accessing those services, may be sufficient to address the needs of many people. However, the problem at present is that if the system was operated in accordance with the law, anyone with whom the local authority came into contact who had the appearance of any level of need would have to be assessed (albeit a proportionate assessment), despite the fact that access to universal services, including advice, assistance and brokerage, might not depend on assessment.
- 5.14 We think the answer to this lies in two reforms to the existing legal framework. First, there is the proposal for the Secretary of State and Welsh Ministers to make regulations as to the way in which the assessment process should be structured. This would ensure that the need for a proportionate assessment is recognised in legislation, rather than being left to statutory guidance, and would allow for the formal development of a much more proportionate system of assessment, so that even if someone is within the requirement for an assessment, the process need not be overly bureaucratic. For example, if an existing service user requests an increase in their home care hourly provision, a community care assessment could consist of:
- (1) an assessment consisting of the conversation with the service user and carer recorded in the notes;
 - (2) an eligibility decision based on a quick chat with the manager; and
 - (3) an adjustment to the existing care plan.
- 5.15 Second, we also think it would greatly assist if the law on when people can refuse to be assessed can be clarified and codified. The advantage of codifying the refusal of assessment is that it would allow people to self-divert themselves away from assessment, while still taking advantage of universal services and advice and assistance. This is discussed in more detail below.

Enabling policy outcomes: an illustration

- 5.16 With these modifications, our scheme gives policy makers the tools they need to promote legitimate policy choices. On the following pages we present two diagrams representing possible ways in which the regime could be configured. Diagram A shows a system based on the NHS and Community Care Act 1990 approach, accomplished in the context of our scheme. Diagram B shows an alternative, personalisation-friendly configuration, which makes use of the ability of potential service users to refuse an assessment to formalise more general, non-assessment based routes to services. This approach would also be possible under our scheme.

Diagram A: The 1990 Act approach

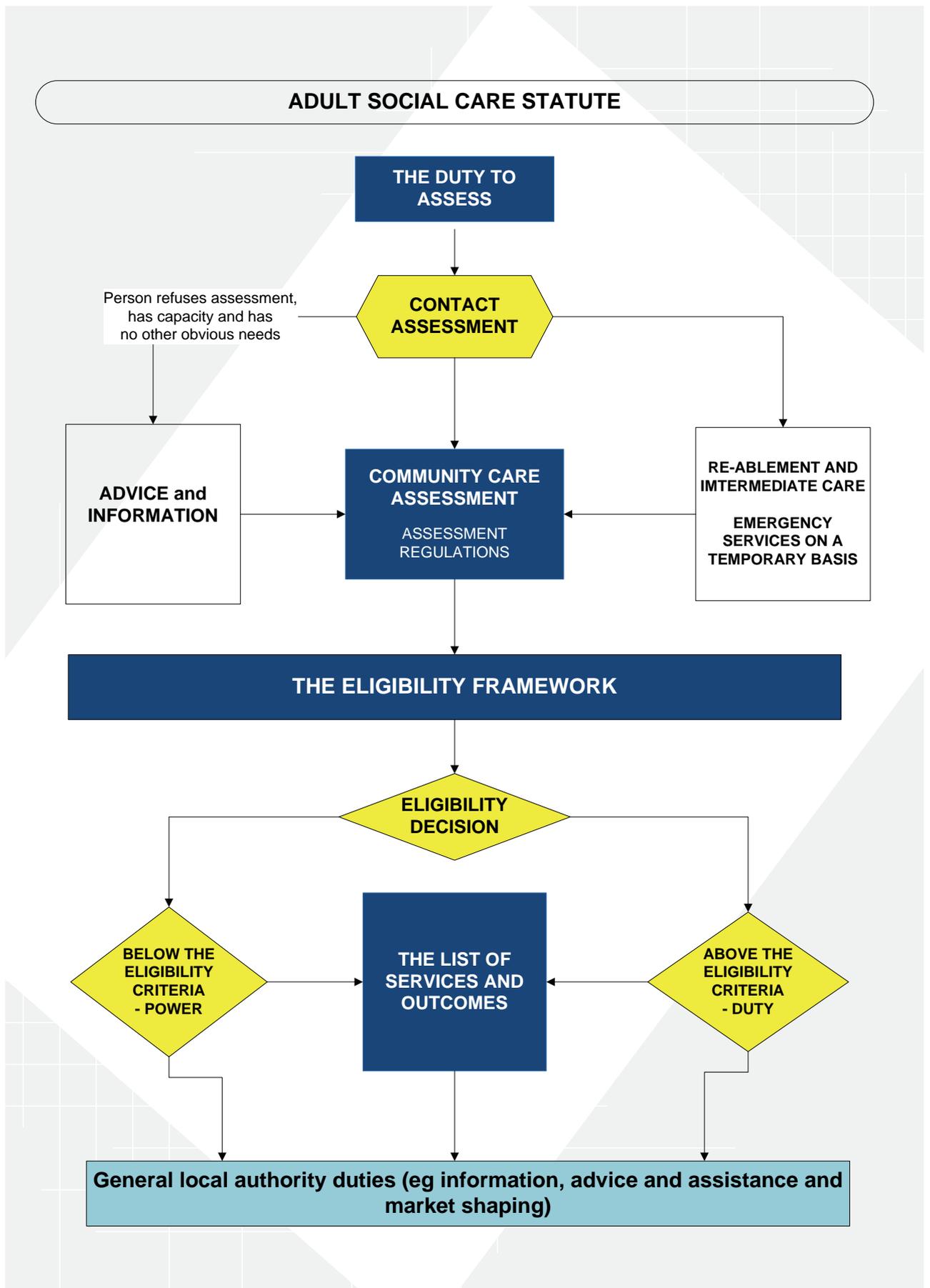
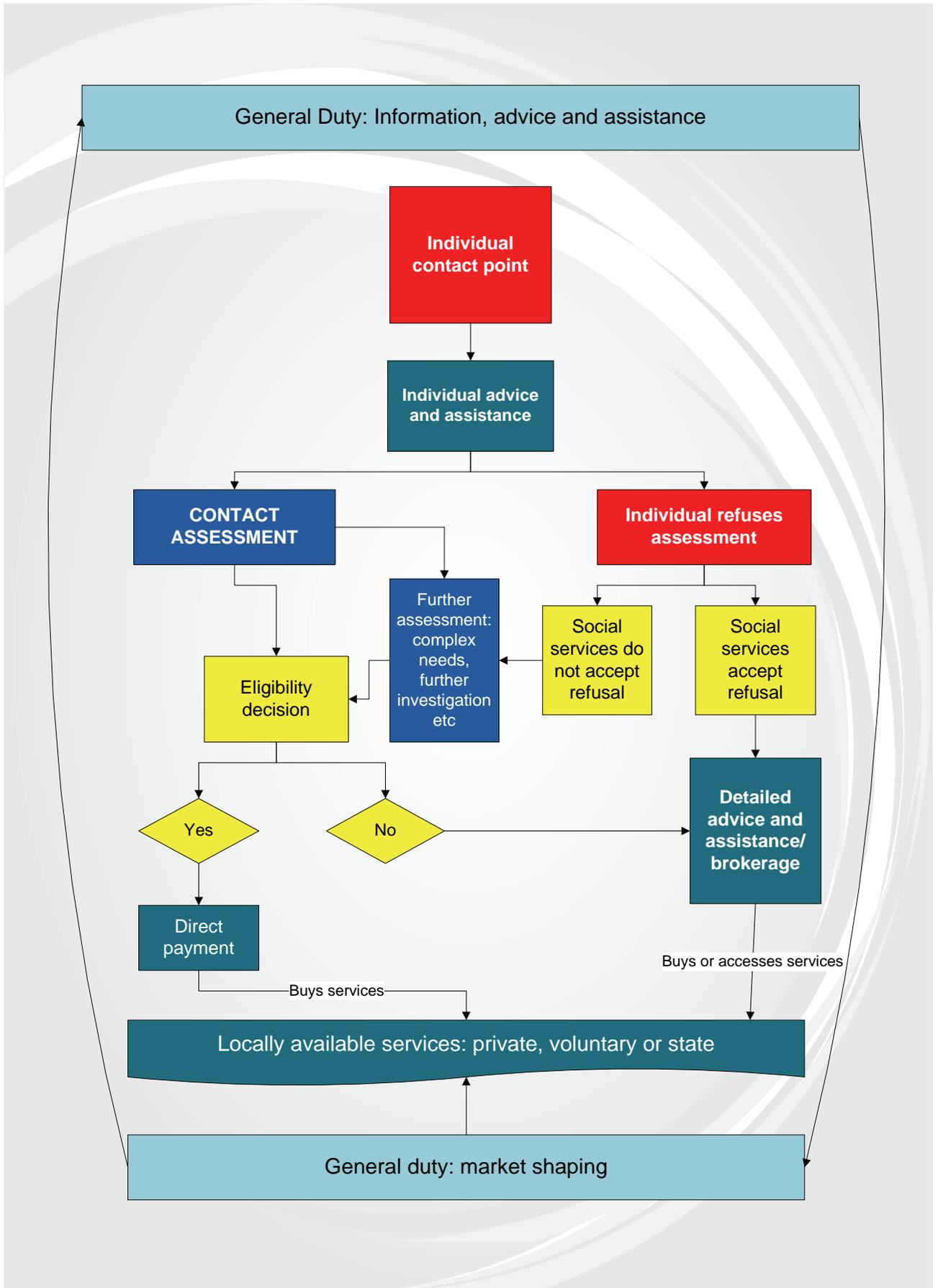


Diagram B: The personalisation approach



THE DUTY TO UNDERTAKE A COMMUNITY CARE ASSESSMENT

- 5.17 In this section, we consider how the duty to assess is triggered, the right to an assessment on request, and how the refusal of an assessment should be codified in statute.

Triggering the duty to assess

- 5.18 A community care assessment is the gateway to the provision of community care services. The primary duty to assess is section 47(1) of the NHS and Community Care Act 1990, which provides:

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

shall carry out an assessment of his needs for those services; and

having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services.

- 5.19 While this section is the primary assessment duty, it did not replace assessment duties in earlier legislation, such as section 2(1) of the Chronically Sick and Disabled Persons Act 1970. In addition, there are also two separate gateway duties to the assessment duty in the 1970 Act. These are:

(1) section 4 of the Disabled Person (Services, Consultation and Representation) Act 1986, which provides that when requested by a disabled person or their carer, a local authority must decide whether the needs of the disabled person call for the provision of any services in accordance with section 2(1) of the 1970 Act; and

(2) section 47(2) of the NHS and Community Care Act 1990, which provides that if at any time during a community care assessment, it appears to a local authority that the person being assessed is disabled, the authority must decide whether services are required as mentioned in section 4 of the Disabled Person (Services, Consultation and Representation) Act 1986 (which are services under section 2(1) of the 1970 Act).

- 5.20 The consultation paper concluded that a duty to assess is a crucial feature of adult social care law, but that the current legal framework for assessments is overlapping, complex and confusing and in urgent need of reform. We considered that the law should be reformed to provide a single assessment duty for the provision of community care services, which reflects the following key principles:

(1) there must be a clear and explicit requirement that an assessment must be carried out;

(2) there should be a low threshold for qualifying for an assessment which does not distinguish between user groups;

(3) the assessment duty should state clearly that a person must have needs *that can be met by* community care services, rather than a need *for*

community care services, to underline that assessments should be needs-led rather than services-led; and

- (4) the duty to assess should be triggered where a local authority has a legal power to provide or arrange for the provision of community care services.

5.21 We therefore proposed that there should be a duty to undertake a community care assessment in the statute, which is triggered where a person appears to the local authority to have social care needs that can be met by the provision of community care services and where the authority has a power to provide services to the person. We envisaged that as part of this proposal, the separate assessment processes and gateways in section 2(1) of the Chronically Sick and Disabled Children Act 1970, section 4 of the Disabled Person (Services, Consultation and Representation) Act 1986 and section 47(2) of the NHS and Community Care Act 1990 would be repealed.⁷

Consultation responses

5.22 The overwhelming majority of those who expressed a view agreed with this proposal, with many consultees pointing to the complexity of the existing system and the need for clarification and simplification.⁸ However, a small number of consultees expressed concern about the precise wording of the proposal and argued that if it were replicated in the statute it might establish a slightly higher threshold than section 47 of the NHS and Community Care Act 1990. The current wording of section 47 provides that the duty arises where it *appears* to the local authority that the person *may be in need* of services; whereas the consultation paper referred to *the appearance of needs*.

Discussion

5.23 As noted earlier in this Part, consultation has confirmed our view of the importance of having a single and clear assessment duty, which has a low qualifying threshold and applies to all service users. We also consider that the gateway duties into assessments should be repealed. Although we did not replicate its precise wording, the clear intention behind our proposal was to establish the same threshold for assessment as section 47 of the NHS and Community Care Act 1990. However, we also remain convinced that the trigger for the assessment should be amended to refer to *needs that can be met by services*, rather than *needs for services*. The formulation of the test itself is of course a matter for Parliamentary Counsel.

Recommendation 7: The duty to assess should be triggered where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may have social care needs that can be met by the provision of services.

⁷ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 4.2 to 4.23.

⁸ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 70.

Request

- 5.24 The consultation paper also considered whether service users should be given a right to an assessment on request. Technically, a local authority does not have to undertake an assessment under section 47 of the NHS and Community Care Act 1990 if a person requests one; the duty only arises if there is an appearance of need and a legal power to provide services. In practice, however, a request for an assessment is likely to trigger the local authority's duty since it will signify an *appearance of need*. Furthermore, a local authority must consider all requests for assessment in accordance with general public law principles.
- 5.25 In contrast to the 1990 Act, section 4 of the Disabled Person (Services, Consultation and Representation) Act 1986 provides that if requested to do so by a disabled person or their carer, the local authority must carry out an assessment and decide if services are necessary under section 2(1) of the Chronically Sick and Disabled Persons Act 1970. The consultation paper argued that a request mechanism would only be necessary if the current duty based on the appearance of need is not working – for example, if people generally, or particular user groups, are being excluded from assessments unlawfully. We therefore asked for further views on whether a request mechanism is needed.⁹

Consultation responses

- 5.26 A large majority of responses to this question argued that statute law should provide a right to an assessment on request.¹⁰ It was suggested that a request mechanism would be particularly beneficial for self-funders who are often excluded from assessment, unlawfully. A request mechanism was also seen as useful for those service users who had fluctuating or hidden disabilities and therefore may not come to the attention of local authorities. The right to an assessment on request was viewed as ensuring that potential service users could be brought into the system before their condition worsens.
- 5.27 On the other hand, several consultees expressed concerns that a request mechanism would have resource implications for local authorities since they would be obliged to undertake an assessment when it was not warranted. Furthermore, several consultees were concerned that a right to have an assessment on request might encourage unmeritorious or vexatious requests, which would place a burden on local authorities.
- 5.28 Several further concerns were raised about how a request mechanism would work in practice. First, there was the very real concern that introducing a right to have an assessment on request, alongside the duty triggered by the appearance of need, would mean that in practice local authorities would only undertake assessments when formally requested. Consultees referred to their experience of local authority practice and argued that in a climate of reduced resources, a formal request would become the default trigger for assessments, and local authorities would avoid undertaking assessments in other circumstances.

⁹ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 4.24 to 4.27.

¹⁰ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 74.

- 5.29 Second, a number of procedural issues were identified. For example, it was argued there would be considerable complexity in defining what constitutes a request; when it should be considered frivolous or unmeritorious; and how often an individual could request an assessment and in what time period (bearing in mind that people with fluctuating conditions may need to make requests more often). Another area of concern was who could make the request. For example, the duty in the Disabled Person (Services, Consultation and Representation) Act 1986 applies amongst others to a “disabled person” – should this continue and, if so, how would such a person be defined (given we do not recommend a definition of a disabled person for our scheme), or should it be extended to any service user or potential service user? Related issues arise such as whether the requester has to be resident in the local area, and whether carers, family members or others (such as advocates) could make a request on someone’s behalf, even where they were aware that the person did not want an assessment (and had not requested one themselves).

Discussion

- 5.30 Consultation has persuaded us both that there may be some individuals who are being unlawfully excluded from assessments (self-funders being the primary example), but also that a request mechanism may not be the most appropriate or effective way to address this, for several reasons.
- 5.31 First, consultation has suggested that there is a real danger in having a right to have an assessment on request alongside a duty to assess based on the appearance of needs. It can obscure the fact that individuals already have in effect a right to make a request to a local authority to be assessed. Anyone can request that a local authority exercise a function, and it would be unlawful for the local authority to, for instance, operate a policy of ignoring such requests. In the particular context of assessment, if a person brings him or herself to the attention of the local authority, then the authority must conduct an assessment, provided only that the low threshold of the appearance of need is met. It may also undermine the core duty to assess based on the appearance of need and lead to the situation where a local authority *only* undertakes an assessment when requested. As set out in Part 11 (Overlap Issues) in relation to children and young people, the situation is different where a local authority has a power rather than a duty to act; in these circumstances, a request mechanism can help to clarify the reasons why an authority decides in an individual case not to exercise its discretion.
- 5.32 Second, we acknowledge there are a number of procedural difficulties associated with a request mechanism. Arguably most of these issues are not insurmountable but it is clear that detailed requirements and prescription would be necessary to ensure that the request mechanism is operationally effective, and also allows for unmeritorious or vexatious requests to be refused. We are concerned that the end result of this would be an assessment process that was overly bureaucratic and procedurally difficult for local authorities to implement and service users and carers to understand.
- 5.33 Third, the examples given to us during the consultation period led us to conclude that in most of the instances where a request mechanism was seen as desirable, it was being used in a way that was more akin to a complaint or request for a re-

assessment – for example, where a person had been refused an assessment or where an assessment had not been to the person’s satisfaction. We think these situations are better categorised as the making of a complaint. Local authorities are required under the complaint regulations to investigate the complaint, give the complainant a timely response and ensure that, if necessary, action is taken.¹¹ In practice, the action taken in response to a justified complaint about a failure to assess (at all or properly) will be an assessment.

- 5.34 Finally, our recommendations, in clarifying local authority responsibilities and individual entitlements, should help ameliorate some of the problems identified in the existing legal framework and thus reduce the need for a request mechanism. For example, establishing one central duty and restating its low threshold, as well as establishing a general duty to provide information, advice and assistance (which would include information on the duty to assess) should reduce the risk of self-funders being refused assessments on the basis of resources. We, therefore, do not make any recommendation on this matter.
- 5.35 It is also important to note that we are not removing the right to make a request for an assessment. Individuals would still be entitled to make a request and in most cases local authorities would be required to undertake an assessment on this basis (subject to the low threshold for an assessment being satisfied). All we are removing is the requirement for local authorities to assess automatically on the basis of a request from a disabled person.

Refusal of assessment

- 5.36 As noted earlier in this Part, the duty to assess based on the appearance of need is a fundamental component of adult social care and should be maintained in the statute. However, we believe it would also be helpful to clarify and codify the law on when people can refuse to be assessed, to address some of the concerns of the advocates of personalisation.

The current law on assessment under the 1990 Act

- 5.37 The law on the effect of a refusal to be assessed, or a failure to co-operate with an assessment, is not satisfactory. The core duty in section 47 of the NHS and Community Care Act 1990 requires an assessment to be carried out when it appears to the local authority that a person to whom they may provide community care services may be in need of such services. The consent or agreement of the person assessed is not required, and lack of it does not, on the face of it, affect the mandatory nature of the duty.
- 5.38 There is limited case law which considers specifically the effect of refusal on the assessment duty in section 47 of the 1990 Act. There are, however, cases which touch on the issue in more detail in relation to two materially different contexts. The first is the duties under the Children Act 1989, Children (Leaving Care) Act 2000, and regulations made there under; and second in relation to the refusal of services by adults.

¹¹ Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, SI 2009 No 309 and Social Services Complaints Procedure (Wales) Regulations 2005, WSI 2005 No 3366.

- 5.39 In *R (J) v Caerphilly County Borough Council*, Lord Justice Munby, when he was a High Court judge, said:

The fact that a child is uncooperative and unwilling to engage, or even refuses to engage, is no reason for the local authority not to carry out its obligations under the Act and the Regulations. After all, a disturbed child's unwillingness to engage with those who are trying to help is often merely a part of the overall problems which justified the local authority's statutory intervention in the first place. The local authority must do its best.¹²

- 5.40 In *R (WG) v A Local Authority*, this approach was said to be useful in considering the duty under section 47, where a council had been willing to assess but the claimant had refused to co-operate.¹³

- 5.41 *R (J)* was approved by the Court of Appeal in *R (M) v Hammersmith and Fulham London Borough Council*, where Lord Justice Wall said:

Any system can deal with the compliant. Young people in the position of M, who have had wretched childhoods ... may well, like M, fail to co-operate with any investigation by the council into their circumstances. This fact does not, in my judgment, either of itself or as a matter of law, absolve local authorities of their duty to both investigate, and to put in place the services which children such as M require.¹⁴

- 5.42 While the assessment of a child is a very different situation to that of an adult, given that decisions about children are often based on the assumption that they lack competence, these cases suggest that where the refusal to engage with or consent to an assessment arose from or was part of the reason for social services involvement, then refusal should not be final.

- 5.43 On the other hand, in relation to service provision, it has been said that, even where a local authority is under a duty to provide the service (in this context, accommodation provided under section 21 of the National Assistance Act 1948):

The duty of the local authority is not absolute in the sense that it has a duty willy-nilly to provide such accommodation *regardless of the applicant's willingness to take advantage of it*.¹⁵

- 5.44 Such a refusal (in this case, implied by "a persistent and unequivocal refusal" to obey reasonable rules in connection with the occupation of the accommodation) means that:

¹² [2005] EWHC 586 (Admin), (2005) 8 CCLR 255 at [56].

¹³ [2010] EWHC 2608 (Admin) at [4].

¹⁴ [2006] EWCA Civ 917, (2006) 9 CCLR 418 at [74].

¹⁵ *R v Kensington and Chelsea Royal London Borough Council ex p Kujtim* (1999) 2 CCLR 340 at [30] (emphasis in original).

The local authority is entitled to treat its duty as discharged and to refuse to provide further accommodation. That will remain the position unless or until, upon some subsequent application, the applicant can satisfy the local authority that his needs remain such as to justify provision of ... accommodation and that there is no longer reason to think that he will persist in his refusal.¹⁶

- 5.45 It is widely recognised that, as a matter of practice, social workers often evade the requirement to undertake an assessment where it seems to them that there is no point in doing so, because no services or resources will subsequently be provided by the local authority. The law is often misunderstood not to require an assessment where the social worker believes that the potential service user's needs cannot reach the local authority's eligibility criteria, for instance.

Consultation responses

- 5.46 The issue of whether and if so when a person's refusal of an assessment can be taken to discharge a local authority's duty to assess was raised by a number of consultees.¹⁷ Some were concerned that the duty to assess can be triggered in circumstances where a person has not asked for and does not want an assessment. It was suggested that an answer to this may be to couch the duty in terms of a duty to *offer* a community care assessment. One consultee also suggested that the statute should specifically enshrine the right of an adult with capacity to refuse to be assessed, noting that social workers can find it difficult when an adult refuses help.

Discussion

- 5.47 In our view, the statute should state the extent to which a refusal of an assessment should discharge the local authority's duty to undertake the assessment. This has two advantages. In the first place, it will clarify an obscure issue in the law, in such a way as to promote desirable outcomes: that is, perseverance with an assessment where necessary and efficient avoidance of the task when it is not. Secondly, it will facilitate the more expansive vision of the local authority's role suggested by personalisation, without undermining important legal rights.
- 5.48 While the statutory language is a matter for Parliamentary Counsel, a local authority should be able to accept a person's refusal to have an assessment (or the refusal of someone else with appropriate authority for the person), unless the person lacks capacity in some respect relevant to the assessment or there are safeguarding concerns.
- 5.49 In the first situation, the statute should provide that if there is any doubt as to whether the person may lack capacity, then the person's refusal of an assessment would *not* discharge the local authority's duty to assess. The exception to the first situation is where it would be in the person's best interests *not* to have an assessment. So the local authority would be able to accept an

¹⁶ *R v Kensington and Chelsea Royal London Borough Council ex p Kujtim* (1999) 2 CCLR 340 at [32].

¹⁷ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) paras 4.13 to 4.15.

incapacitous refusal of assessment if it would not be in the person's best interests to have an assessment. Furthermore, the local authority would be able to refuse an incapacitous request for an assessment if it would not be in the person's best interests to have an assessment.

- 5.50 In relation to the second situation, the circumstances which would give rise to the duty to undertake an adult protection investigation are set out in Part 9 (Adult Protection). For current purposes, it is important to note that the duty will be triggered if there is a danger that the person is at risk of *harm*, which includes but is not limited to abuse by a third party, or self-neglect. It would therefore cover situations in which an initial refusal of an assessment might be covering some more deep-seated problem.
- 5.51 The refusal of assessment should not be final – there should be two mechanisms for re-triggering the duty to assess. The first is where it appeared to the local authority that either objective circumstance had changed, or more information had come to light, which raised concerns about capacity or safeguarding such as to override the refusal. Secondly, the person themselves should be allowed to abrogate their refusal by requesting an assessment. This would allow them to simply change their minds as to the desirability of an assessment, and for that change of mind to re-engage the statutory duty. In this instance, the person would have a formal right to an assessment on request (as noted above, there would be no general right to have an assessment on request set out in the statute).
- 5.52 We note that this recommendation would limit the *duty* to assess. The social services authority would still have a power to assess, should it appear to be desirable for some other reason.

Recommendation 8: The statute should provide that the local authority duty to assess will be discharged if the person to be assessed refuses the assessment (or if someone else with appropriate authority refuses on their behalf), unless the person lacks capacity in some respect relevant to the assessment, or there are safeguarding concerns. If the person subsequently makes a formal request for an assessment, then the authority must carry out the assessment.

THE FOCUS OF THE ASSESSMENT DUTY

- 5.53 Local authorities are currently required under section 47(1)(a) of the NHS and Community Care Act 1990 to carry out an assessment of “a person's needs”. This has been explained as requiring an assessment that is needs-led rather than services-led. That is, an assessment is concerned with evaluating those issues and problems that are identified when an individual approaches the authority and how they impose barriers to the person's independence or well-being; it should not focus only on the person's suitability for a particular existing service.¹⁸ Only

¹⁸ Caring for People: Community Care in the Next Decade and Beyond (1989) Cm 849, para 3.2.3.

once needs are identified should they be evaluated against the eligibility framework and then a decision made about services.¹⁹

- 5.54 The consultation paper noted three concerns about the current focus of assessments. First, the service-led model continued to influence practice, despite the intention of guidance to focus on needs alone. Second, an assessment of needs alone can be problematic in itself, as it focuses on a person's problems and difficulties, and can thereby be disabling for the person concerned and fail to support independence. Third, focusing on needs alone may mean that sufficient consideration is not given to the outcomes the person wants to achieve, contrary to Government policy and statutory guidance which increasingly emphasises the importance of considering outcomes. We therefore proposed that the focus of the assessment duty should be an assessment of a person's social care needs *and* the outcomes they wish to achieve, and should not focus on the person's suitability for a particular service.²⁰

Consultation responses

- 5.55 All of those who expressed a view on this proposal agreed that the focus of the assessment duty should be needs and outcomes.²¹ As well as preventing a service-led approach to assessments, consultees argued that the proposal would ensure that assessments are not focused on a person's perceived deficits and weaknesses, but rather towards their abilities, aspirations and preferences.
- 5.56 There were, however, some concerns about the proposal. Some consultees warned against focusing only on desired outcomes and not taking into account the things that are preventing the person from achieving those outcomes. It was also argued that a shift to an outcomes-based assessment may have resource implications. In addition, some consultees were concerned that the term "social care needs" is too narrow and does not reflect people's experience nor encourage innovative multi-agency responses.

Discussion

- 5.57 The way the assessment duty is currently phrased – to carry out an assessment of a person's needs for community care services – can be misunderstood as suggesting a service-led approach to assessment and may mean insufficient consideration is given to the outcomes a person wants to achieve. In our view, the assessment duty should focus on a person's social care needs and the outcomes they wish to achieve.
- 5.58 In relation to concerns expressed about resources, we note that the requirement to consider outcomes relates to the focus of assessment and not necessarily what a local authority will decide to do as a result of that assessment. Local authorities do not have a duty to meet all the public's presenting wants, wishes and preferred outcomes. Nonetheless, we believe it is right that the assessment

¹⁹ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 78. A similar point is made in NAFWC 09A/2002, *Health and Social Care for Adults*, paras 2.40 to 2.42.

²⁰ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 4.28 to 4.35.

²¹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 78.

should include expressly the outcomes a person wishes to achieve (as well as their needs) in order for local authorities to have sufficient information to make a fully informed decision as a result of that assessment.

Recommendation 9: The focus of the assessment duty should be an assessment of a person's care and support needs and the outcomes they wish to achieve.

THE PROCESS OF ASSESSMENTS

- 5.59 This section considers whether the assessment process should be prescribed in regulations and which areas the regulations should cover.

Should the assessment process be prescribed in regulations?

- 5.60 While the duty to assess a person is set out in statute law, the detail about how an assessment should be conducted is set out in directions and a multitude of guidance, as well as some specific statutory requirements contained mainly in the Disabled Persons (Services, Consultation and Recognition) Act 1986. While this approach can allow for flexibility and innovation, we suggested in the consultation paper that these advantages are only relevant if the process itself is clear and accessible. A particular characteristic of the current framework is that details of the assessment process are spread over multiple documents. Leaving detail mainly to guidance can also mean that it is treated as optional or best practice – even when it is statutory guidance – which means the practice and quality can vary considerably between different local authorities.
- 5.61 Given the centrality of the assessment process to adult social care and the importance of assessment as a service in its own right, we proposed that the statute should place a duty on the Secretary of State and Welsh Minister to make regulations which prescribe details of the assessment process, and should also specify the areas that the regulations must cover. While not making a proposal as to those areas, we suggested that they could include who is to be consulted; the way in which an assessment is to be carried out; who can carry out the assessment; recording of the results of an assessment; and the considerations to which the local authority must have regard in carrying out an assessment.²²

Consultation responses

- 5.62 The overwhelming majority of consultees who expressed a view agreed with this proposal, including several local authorities.²³ A number of consultees pointed to the complexity caused by the range of guidance issued on the assessment process for different service user groups, and suggested that this guidance should be replaced by regulations. Consultees suggested that introducing regulations would provide greater clarity, certainty and consistency. It was also suggested that putting the detail in regulations (rather than the statute) was more flexible and would help future-proof the legislation.

²² Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 4.48 to 4.57.

²³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 88.

5.63 However, a strong concern of many consultees – even those who supported the proposal – was that the regulations must not be overly prescriptive or constrain local authorities in adopting a proportionate and flexible approach to assessments. Several local authorities emphasised the need for the regulations to allow for different degrees of complexity in the assessment process.

5.64 A small number of consultees also disagreed with the proposal. It was argued that prescribing the assessment process in regulations could make the process overly bureaucratic and expensive as a result. Some suggested that a preferable approach would be to set out the process of assessment in the code of practice, rather than regulations. Conversely, a small number of consultees suggested that some details of the assessment process were of such enduring importance that they should be placed in the statute itself. The example given was the need to involve and consult the service user and carer in the assessment.

Discussion

5.65 Consultation has confirmed our view that the existing legal framework for conducting an assessment causes confusion and inconsistent practice. The assessment process is a vital aspect of community care law. It is crucial that the process for assessments is clear and enforceable. We therefore take the view that the key elements of how an assessment is carried out should be clarified in legislation. We generally consider that regulations, rather than the statute, provide the appropriate place to do this. It would be difficult to amend the primary legislation in order to keep up-to-date with changing practice.

5.66 We do not accept that regulations necessarily mean more complexity in the assessment process; as set out below, a key part of our recommendations is to ensure flexibility and proportionality in the assessment process.

5.67 Finally, our view is that there should be a duty to make regulations rather than a power. As we have said, the assessment process is a centrally important element in the delivery of adult social care, so we see it necessary that regulations are indeed made to ensure that it is carried out appropriately.

<p>Recommendation 10: The statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the assessment process.</p>
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The content of the regulations

5.68 Since there will be a duty to make assessment regulations, it is necessary to consider the content of those regulations and whether the statute should also require both Governments to cover certain topics or address certain issues in the regulations. It would be possible, for example, to have a bare duty; that is, one that is not subject to a further duty or power prescribing the areas that the regulations must or may cover. In effect, both Governments would be required to make regulations but would have complete discretion over their content. Alternatively, the statute could prescribe areas that the regulations must cover. The answer to this turns on whether some aspects of the assessment process are so important that they must be the subject of regulations. This is considered in the discussion below.

Who is to be consulted in an assessment

- 5.69 The consultation paper suggested that the regulations could specify who is to be consulted in an assessment. The legal framework already sets out some requirements. In particular, the Community Care Assessment Directions 2004 require that in assessing a person under section 47(1) of the NHS and Community Care Act 1990, a local authority must consult the person, consider whether the person has any carers and, where they think it appropriate, consult those carers. Although the Directions do not apply in Wales, statutory guidance on eligibility criteria in Wales recommends a similar approach.²⁴
- 5.70 Furthermore, if an assessment discloses a possible housing or medical need, then the NHS and Community Care Act 1990 requires a local authority to notify the relevant housing or health authority and invite them to assist in the making of the assessment.²⁵ This requirement is reinforced in statutory guidance.²⁶ Local authorities may also be required to consult with certain people or agencies under other legislation, such as deputies and attorneys appointed under the Mental Capacity Act 2005.

CONSULTATION RESPONSES

- 5.71 Several consultees argued that the regulations should require consultation with and involvement of the service user and carer in the assessment process, and it was also suggested that the regulations should require the provision of support and accessible information to enable this involvement. A few consultees suggested that the requirement to consult a service user and their carer is so important that it should be on the face of the statute. Some written responses suggested that other family members should also be consulted.
- 5.72 It was suggested that some assessments required the input of health professionals, such as doctors, nurses, occupational therapists, physiotherapists, and speech therapists to ensure all the needs of the person are identified. However, it was also argued that any list of consultees should be expressed broadly. Otherwise it could be interpreted as an exclusive list and groups or individuals not on the list would be excluded.

DISCUSSION

- 5.73 As noted above, local authorities are already required to consult service users and carers during an assessment. Consultation has confirmed the fundamental importance of this requirement. Therefore, while we generally consider that regulations provide an appropriate place to prescribe the detail of the assessment process, we agree that the exception to this should be the duty to consult service users and carers. Indeed, this would build on the statutory principle we recommend in Part 4 (Statutory Principles) that individuals should be given the opportunity to be involved, as far as is practicable in the circumstances, in assessments, planning and developing and reviewing their care and support.

²⁴ See, for example, NAFWC 09A/2002, *Health and Social Care for Adults*, paras 2.8 to 2.10, 2.49 and 6.10.

²⁵ NHS and Community Care Act 1990, s 47(3).

²⁶ See, for example, Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 86 and NAFWC 09A/2002, *Health and Social Care for Adults*, para 2.12.

- 5.74 The test for the consultation requirement would have to make some allowance for the very rare case where such consultation was realistically impossible. This might be because the service user implacably refuses engagement, or where such consultation would involve serious risk to anyone undertaking the assessment, or where consultation with a carer might cause the cared-for person considerable emotional distress, or visa versa. But the test should set a high threshold and make it clear that such cases would be rare and exceptional. We would expect a test of something higher than *reasonable practicability*. The code of practice should provide concrete examples of the kind of situation envisaged. Where consultation does take place, the nature of that consultation should be proportionate to the assessment undertaken; it could, for example, be a short conversation with the person. It could also include different forms of communication besides a face-to-face meeting (such as written correspondence).
- 5.75 In terms of consultation more generally, as noted above, the existing legal framework sets out requirements to consult with health, housing and other professionals where appropriate during an assessment. Other elements of our proposed scheme are relevant to these broader consultation requirements, including the duties to co-operate in Part 11 (Overlap Issues). We would expect there to be consultation with health and housing services and people with an interest in the person's welfare (such as other family members, advocates, voluntary organisations, professionals or service providers), where it is proportionate to do so. The Secretary of State and Welsh Ministers would have the option of setting out who should be consulted in the regulations. We do not think it is necessary to go further and require that the regulations cover such matters.

The way an assessment is to be carried out

- 5.76 The consultation paper suggested that the regulations could specify the way an assessment should be carried out. Existing statutory guidance provides some detail on this, including requirements that the assessment should include an initial screening process, and be proportionate to the needs presented by the individual. Statutory guidance also requires that information should be provided on what happens during the assessment; that a person-centred approach should be adopted; that those who can and wish to do so are encouraged to undertake a self-assessment prior to the local authority assessment; and that assessments are co-ordinated and integrated across relevant local agencies.²⁷

CONSULTATION RESPONSES

- 5.77 As noted earlier, a number of consultees emphasised that the assessment process needs to allow for different degrees of complexity and appropriate local flexibility. Consultees also put forward other suggestions about the way an assessment is carried out, including that any information provided should be

²⁷ See, for example, Department of Health, *Caring for People: Community Care in the Next Decade and Beyond: Policy Guidance* (1990) para 3.20; Department of Health, *Prioritising Need in the Context of Putting People First* (2010) paras 69, 76, 79, 83, 84 and 86; and NAFWC 09A/2002, *Health and Social Care for Adults*, paras 2.8, 2.9, 2.11, 2.12, 2.17 and 2.28.

accessible (taking into account the needs of the individual) and that assessments should be carried out face-to-face rather than over the phone.

DISCUSSION

- 5.78 A key part of our scheme is to encourage local authorities to undertake assessments that are proportionate to the needs presented by the individual. Statutory guidance has long encouraged local authorities to undertake proportionate assessments and this was an important theme raised at consultation.²⁸ In our view it is essential that proportionality is addressed in the assessment regulations and that therefore the Secretary of State and Welsh Ministers should be required to make regulations to require proportionate assessments.
- 5.79 It is important to note that proportionality does not automatically equate to minimalism: where a person has complex or multiple needs, a proportionate assessment may mean an in-depth and comprehensive exploration of their needs. Conversely, a proportionate assessment for other people may mean a brief conversation. On this basis, we would resist the suggestion that the regulations should require that all assessments are conducted face-to-face. In some instances, a telephone assessment may be sufficient and proportionate; for example, when people call social services with low-level needs and request a simple service, the initial contact may be sufficient to deal with this situation, whilst in other instances, a face-to-face assessment will be essential. To require a face-to-face assessment in all instances may be unduly onerous for both local authorities and the person concerned.
- 5.80 We agree that information should be provided about the assessment process. We envisage that the general duty to provide information, advice and assistance, as discussed earlier in this Part, would include the provision of information about the assessment and eligibility processes, as well as relevant information about the charging policy of the local authority. This would help ensure that people had sufficient information at the outset to make informed decisions about the assessment process. We do not, therefore, consider that it is necessary to put a further requirement in the regulations about providing information. However, the power to make regulations would be sufficiently broad to allow the Secretary of State and Welsh Ministers to make regulations on this matter in the future if, for example, it becomes clear that more specific requirements to provide information about assessments are necessary.
- 5.81 The issues of self-assessments and co-ordinated assessments are discussed separately later in this Part.

Who can carry out the assessment

- 5.82 The consultation paper suggested that the assessment regulations could specify who can carry out the assessment. In general, statutory guidance in England and

²⁸ See, for example, Department of Health Social Services Inspectorate and Scottish Office Social Work Services Group, *Care Management and Assessment: Practitioners' Guide* (1991) p 47; Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 69; and NAFWC 09A/2002, *Health and Social Care for Adults*, para 2.9.

Wales provides that local authorities should ensure that assessments are undertaken by suitably trained staff. For example, the statutory guidance on eligibility criteria in Wales provides that assessments for older people “should be undertaken by a trained and competent single assessor, qualified or not, in any of the care settings to which this guidance applies”.²⁹ Statutory guidance also requires specialist assessments for certain user groups; for example, in the case of a deafblind person the relevant guidance requires local authorities to ensure “a specialist assessment is arranged, to be carried out by a specifically trained experienced person/team equipped to assess the needs of a deafblind person”.³⁰

CONSULTATION RESPONSES

- 5.83 Views differed as to who should be charged with carrying out assessments. A number of consultees considered that assessments should always be carried out by a trained professional, such as a qualified social worker. Others, however, argued that assessments could be done by unqualified workers if they had adequate supervision. The issue of self-assessment is discussed separately in the section below.
- 5.84 Some consultees suggested that the statute needs to look at how to strengthen the legal duty to provide specialist assessments, such as to deafblind people, given that such assessments are essential in order to identify the particular needs and requirements of certain user groups.

DISCUSSION

- 5.85 We do not think it is necessary to require the making of regulations about who should carry out assessments generally. That will depend on the type of assessment undertaken and the circumstances of the case. The Secretary of State and Welsh Ministers will be able to deal with the issue in regulations if it appears to be necessary.
- 5.86 There is, however, one problem area where there should be such a requirement. That is specifying the circumstances in which a specialist assessment must be undertaken. While there would be some overlap with the assessment regulation on ensuring proportionate assessments (discussed above), in some cases a specialist assessment should *always* be required and indeed this is acknowledged in statutory guidance. At a minimum, we suggest that the existing requirement in statutory guidance for a specialist assessment for deafblind people should be elevated to the regulations. A specialist assessment may also be needed in other cases, such as for people with severe and enduring mental health problems, people with borderline mental capacity or those with dual diagnoses.
- 5.87 The related issue of self-assessment and delegation of the assessment process is discussed separately below.

²⁹ NAFWC 09A/2002, *Health and Social Care for Adults*, para 4.17. See also Department of Health, *Prioritising Need in the Context of Putting People First* (2010) paras 76 and 152.

³⁰ LAC(DH)(2009)6, *Social Care for Deafblind Children and Adults*, para 22 and NAFWC 10/2001, *Social Care for Deafblind Children and Adults*, para 21.

Timescales for assessments

- 5.88 The consultation paper suggested that the assessment regulations could specify timescales for when an assessment must be commenced following first contact with the local authority and when it should be completed. Currently the law does not prescribe a timeframe for assessments. However, the statutory guidance in both England and Wales provide that information should be provided to individuals on timescales for the assessment and care management process.³¹

CONSULTATION RESPONSES

- 5.89 A number of consultees requested that the regulations prescribe timescales for commencing and completing an assessment. Consultees gave examples of where people had had to wait significant periods of time for an assessment, and suggested that prescribing a timescale for assessments would be beneficial for both service providers and service users.
- 5.90 However, it also became clear during consultation that what an appropriate timescale was may depend on the circumstances. For example, following a diagnosis of sight loss, the individual concerned may need time to come to terms with their diagnosis before entering into the formal assessment process. In these circumstances, it was suggested that local authorities should provide any urgent services required and then carry out an assessment at an appropriate time and with an appropriate timescale. Other consultees noted that if a timescale was adopted, it was essential that it could accommodate specialist assessments (which may take more time) and cyclical needs (in which case the local authority may need to assess over a four to six month period).
- 5.91 Not all consultees considered that timescales should be prescribed in regulations. Some considered that there are already requirements about timeframes for assessments as part of the regulation and inspection process for local authorities, and as such it was unnecessary to put timeframes into regulations.

DISCUSSION

- 5.92 We recognise the concerns about delays by local authorities in commencing and finishing assessments. However, we do not consider that we should require the assessment regulations to set timeframes, nor do we make suggestions for what an appropriate timescale may be, for two reasons.
- 5.93 First, legislating timescales for assessments is a matter of practice to be determined by both Governments, rather than a matter of law reform. There are no existing timescales in law. Indeed, during the consultation, the importance of adopting an iterative approach to assessments was emphasised, where assessments are seen as an on-going process and not a one-off event. Prescribing timescales in regulations may limit the ability of local authorities and individuals to take this approach, and thereby conflict with the goal that assessments be proportionate and tailored to the circumstances. Second, consultation suggests that, in any event, appropriate timescales vary depending

³¹ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 80 and NAFWC 09A/2002, *Health and Social Care for Adults*, para 2.17.

on the circumstances of the case and so are not well-suited to being prescribed in regulations.

- 5.94 In our view, the demand for timescales may be better seen as a demand for clarity and certainty in the operation of the assessment process. We would expect the policy makers to address this need directly in designing assessment processes in the regulations. Against this, we acknowledge that in some non-emergency assessments, it may be appropriate and advantageous, in terms of clarity and consistency, to prescribe timescales for commencing or completing an assessment in the regulations, in the interests of clarity and certainty. The regulations-making power will be broad enough to allow for these matters to be specified in regulations, if either Government sees fit.

Considerations to which the local authority must have regard

- 5.95 The consultation paper suggested that regulations could specify the considerations to which the local authority must have regard in carrying out an assessment. Statutory guidance in England and Wales provides that the purpose of an assessment is to identify and evaluate an individual's needs and how these needs impose barriers or risks to that person's independence and/or well-being, both in the immediate and longer term.³² The risks to independence and well-being relate to all areas of life, and the guidance in England provides that with the exception of life-threatening circumstances or where there are serious safeguarding concerns, there is no hierarchy of needs. For example, needs relating to social inclusion and participation "should be seen as just as important as needs relating to personal care issues, where the need falls within the same band".³³
- 5.96 The law also requires local authorities to have regard to the contribution made by carers when undertaking an assessment. For example section 8 of the Disabled Person (Services, Consultation and Representation) Act 1986 requires that when a disabled person is living at home and receiving a substantial amount of care on a regular basis from another person and it falls to the local authority to decide whether the disabled person's needs call for the provision by them of any services, the local authority shall, in deciding that question, have regard to the ability of that other person to continue to provide such care on a regular basis. Furthermore, the Carers (Recognition and Services) Act 1995 provides that a local authority must take into account the results of a carer's assessment in making the decision as to whether the cared-for person's needs call for the provision of community care services. Under section 47(3) of the NHS and Community Care Act 1990 a local authority must also take into account, in making its decision as to the provision of services, any services which are likely to be made available to a person by a health or housing authority.

³² Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 78 and NAFWC 09A/2002, *Health and Social Care for Adults*, para 2.40.

³³ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 61. A similar statement is contained in NAFWC 09A/2002, *Health and Social Care for Adults*, para 5.11.

CONSULTATION RESPONSES

- 5.97 Consultees put forward several suggestions for what considerations a local authority should have regard to in undertaking an assessment. These included considering the whole family unit and what their needs are; looking at all aspects of life, including leisure, social interaction and exercise; and having regard to a person's personal, cultural or religious preferences.
- 5.98 Several consultees argued there needs to be greater clarity about how (if at all) an assessment should take into account needs that are being or could be met, other than by the provision of community care services. This concern was often raised in the context of carers, and the extent to which the role of the carer should be recognised during the assessment process. However, similar concern was also expressed about where a person's social care needs are being met through receipt of a financial grant or ordinary housing. Many consultees advocated that assessments should take into account wider needs and not just focus on social care needs.

DISCUSSION

- 5.99 The considerations to which a local authority should have regard in carrying out an assessment will depend on the circumstances of the case, such as the needs presented by the individual. It would be inconsistent with promoting proportionate assessments to specify a list of considerations which a local authority must in all cases have regard to in assessing a person. However, the scope of the regulation-making power should give the Secretary of State and Welsh Ministers the flexibility to introduce regulations to this effect, if they wish to do so.
- 5.100 However, one area that the regulations ought to cover specifically is how a local authority should deal with needs that are being or could be met by a third party. Consultation has persuaded us that there is confusion and a lack of clarity in the law about this issue. Case law provides currently that a need which is being met or could be met by a third party (such as a carer, a disabled facilities grant, or some other service) can nonetheless be an eligible need. Whether the local authority needs to provide services to meet the need, or whether that need could be met by a carer, third party or by other means, is properly a matter to be decided at the care planning stage and recorded in the care plan.³⁴
- 5.101 In practice, this means that a local authority should identify all presenting and eligible needs when undertaking an assessment, irrespective of whether or not they are being met. For example, just because a carer is currently meeting a person's needs does not mean that it should be discounted as an eligible need. Nor does it mean that the need should be considered in isolation without considering the carer's contribution to meeting that need. Rather, as part of the assessment of needs, the local authority should consider if and how the needs are being met and whether this is appropriate. The question of whether a carer (or other third party) is able and willing to meet an eligible need is relevant at the

³⁴ See, for example, *R (Spink) v Wandsworth London Borough Council* [2005] EWCA Civ 302, [2005] 1 WLR 2884 and *R v Sefton Metropolitan Borough Council ex parte Help the Aged* (1997-98) 1 CCLR 57, 68(E). This is also consistent with the approach set out in s 47(3) of the NHS and Community Care Act 1990.

care planning stage. This approach is reflected in the statutory guidance on eligibility criteria in England, *Prioritising Need*:

Whilst determination of an individual's need for assistance should take account of the support which carers, family members, friends and neighbours are willing and able to offer, the determination of presenting needs should identify all community care needs, regardless of whether and how they are being met. If, for example, an individual cannot perform several personal care tasks, but can do so without difficulty with the help of a carer, and the carer is happy to maintain their caring role in this way, both currently and in the longer term, then it is reasonable to record these as needs on the care plan, but that they are being fully met by the carer. Where an individual has needs and a carer is willing to meet some but not all of these, then the council should provide a response to address those eligible needs, which are those needs not being met by the carer.³⁵

- 5.102 Given the existing case law and statutory guidance, we take the view that in exercising their duty to make regulations on this issue, the Secretary of State and Welsh Ministers should make it clear that a local authority should consider all needs during an assessment, irrespective of whether they can or are being met by a third party. If a carer or third party is willing and able to meet a need, then this should be taken into account at the care planning stage; this would include, for example, taking into account any carer's (or young carer's) assessment that has been undertaken. The only exception to this position is the provision of National Asylum Support Service accommodation, which must be disregarded throughout the assessment and eligibility processes (as discussed further in Part 6 (Eligibility)).
- 5.103 Finally, we note the related concern about identifying non-social care needs in an assessment. As discussed above, the law currently requires that if a community care assessment discloses a possible housing or medical need, the local authority is required to notify the relevant housing or health authority and invite them to assist. The courts have also pointed out that local authorities should not be deterred from identifying needs which properly fall within the province of other services simply because they fear that they may ultimately have to meet them, if the other agency refuses.³⁶
- 5.104 We agree that a community care assessment should not be required or encouraged to identify only social care needs. As discussed above, the regulations must ensure that local authorities adopt a proportionate approach to an assessment, having regard to the needs presented by the individual. This approach would include taking into account any wider non-social care needs as appropriate. We suggest that the code of practice should clarify that where appropriate, community care assessments must consider a broad range of needs, including non-social care needs.

³⁵ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 94.

³⁶ *R (Wahid) v Tower Hamlets London Borough Council* [2002] EWCA Civ 287, (2002) 5 CCLR 239 at [35].

Other matters

- 5.105 A number of written responses considered that requirements about reviewing assessments should be included in the assessment regulations. We see reviews as part of the care planning process, and are discussed later in Part 8 (The Provision of Services). Other responses said that the regulations should set out the complaints and redress process for assessments. However, as a local authority is already required to make available information about its complaints processes, we do not consider that it is necessary or desirable to duplicate this requirement in the regulations.³⁷

Recommendation 11: The statute should require that in undertaking a community care assessment, a local authority must consult with the service user and carer, except if consultation is not realistically possible in the circumstances.

Recommendation 12: The community care assessment regulations must:

- (1) require a proportionate approach to assessment, having regard to the needs of the individual;**
- (2) specify the circumstances in which a specialist assessment must be arranged; and**
- (3) require assessors to consider all needs during an assessment, irrespective of whether they can or are being met by a third party and to take into account if a third party is willing and able to meet a need at the care planning stage.**

The community care assessment regulations may: require consultation with other persons or agencies; specify timescales; specify who can carry out an assessment; require the provision of information; specify the considerations to which the assessment should have regard; and specify a particular form of self-assessment,³⁸ if the Secretary of State or Welsh Ministers wish them to do so.

SELF-ASSESSMENT AND DELEGATION OF ASSESSMENT

Self-assessment

- 5.106 As noted above, the current duty to assess is placed on local authorities. The only power to delegate this function is under the NHS Act 2006 and NHS Act (Wales) 2006, which enable prescribed functions to be carried out by a health body.³⁹ Otherwise, there is no express power in the NHS and Community Care Act 1990 for a local authority to delegate to a third party its assessment duty. However, the statutory framework does require local authorities to invite other

³⁷ Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, SI 2009 No 309, reg 16 and Social Services Complaints Procedure (Wales) Regulations 2005, WSI 2005 No 3366, reg 7.

³⁸ Self-assessment is discussed separately below.

³⁹ See NHS Act 2006, s 75 and NHS (Wales) Act 2006, s 33.

agencies to assist in the assessment.⁴⁰ Furthermore, the Community Care Assessment Directions 2004 require that in assessing the needs of a person, a local authority must consult the person, consider whether the person has any carers and, where they think it appropriate, consult those carers. Although these Directions do not apply in Wales, similar requirements are contained in the statutory guidance on eligibility criteria in Wales.⁴¹ However, while a local authority might (and sometimes must) involve other persons or organisations in the assessment process, it must retain overall control of the process.

- 5.107 Notwithstanding this legal framework, the use of self-assessment has been developed through policy in England. The term *self-assessment* can indicate a range of options giving individuals a varying degree of control over their assessment. Self-assessments can be *co-produced* with the local authority, such as where a person is encouraged to self-assess as a stage in the assessment process, or they can be *pure*, in the sense that the entire assessment process is carried out by the individual without any involvement by the local authority.
- 5.108 The consultation paper suggested that a co-produced self-assessment is consistent with the legal requirement that a local authority retains overall control of the process and is, therefore, lawful. In contrast, a pure self-assessment would be a delegation of a local authority's statutory duty and is therefore unlawful. However, we asked for views on whether the statute should recognise co-produced self-assessment as a lawful form of assessment and whether it should allow for a pure self-assessment for certain people or groups of people.⁴²

Consultation responses

- 5.109 In relation to co-produced self-assessments, a large majority of responses to this question argued that the statute should recognise co-produced self-assessment as a lawful form of assessment.⁴³ Consultees suggested that co-produced self-assessments have a number of benefits: they are empowering and allow the individual to have a greater say over their needs and desired outcomes; the information collected is of high quality and validity compared to an assessment carried out by a local authority; and they reflect the goals of personalisation, including person-centred planning and choice and control.
- 5.110 However, several consultees were reluctant to put co-produced self-assessments on a statutory footing. One consultee highlighted the value of enabling service users to sit down with a social worker to discuss their needs and problems, and cautioned against replacing this with a process whereby a person completed a questionnaire that was considered independently by a social worker. It was argued that in a time of limited resources, promoting co-produced self-assessment would take away the incentive for local authorities to spend that time with the person, and would lead to this form of assessments becoming the default position. Another concern about including an element of self-assessment in the

⁴⁰ See NHS and Community Care Act 1990, s 47(3).

⁴¹ See, for example, NAFWC 09A/2002, *Health and Social Care for Adults*, paras 2.10, 2.49, 6.10.

⁴² Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 4.36 to 4.47.

⁴³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 81.

assessment process is that such a process may require the person to have considerable self-awareness and knowledge about how to express their needs. Lack of such knowledge could lead to an underestimation of needs or a tailoring of needs to available services. In a similar vein, consultees warned of self-assessment questionnaires becoming too standardised or formulaic over time, and argued that if legislation enabled greater use of self-assessment, it should also retain the requirement for local authorities to consider fully a person's needs.

- 5.111 Other consultees considered that it was not necessary to put co-produced self-assessment on a statutory footing, because it was simply one of the lawful ways, albeit a desirable one, of discharging the statutory duty to assess. Accordingly, some suggested that recognising co-produced self-assessments was a matter for guidance rather than statute. On the other hand, others argued that explicit statutory recognition of co-produced self-assessments may encourage more local authorities to take a partnership approach from the assessment stage through to care planning.
- 5.112 In relation to pure self-assessments, a small majority of responses to this question argued that the statute should not allow for a pure self-assessment for certain people or groups of people.⁴⁴ There were two main reasons given. The first was a concern about resources and accountability: a number of local authorities argued that they needed to be involved in assessments to ensure that eligibility and resources are applied consistently and to consider any risk factors. The second was the concern that pure self-assessment is not an effective or accurate form of assessment. People may underestimate their needs and thus persist with unidentified and unmet needs, or conversely may overestimate their needs. Furthermore, pure self-assessments can be too narrow in scope and perspective and do not take into consideration other people such as carers.
- 5.113 In addition to questioning the efficacy of pure self-assessments, a number of responses pointed to the difficulty (and also queried the appropriateness) of defining a cohort for whom a pure self-assessment would be suitable. It was suggested that distinguishing such a group could discriminate against those who were not given the right to self-assess and would create an inequitable two-tier system. It was also argued that defining a cohort for self-assessment may undermine the broad right to an assessment.
- 5.114 There was, however, some support expressed at consultation for pure self-assessment. For example, it was argued that some older people may be reluctant to allow the state to assess their needs because they fear judgements being made on how they choose to live their lives (for example, a flannel wash or using alcohol to alleviate pain); they fear the stigma of being helped by social services; and there is concern that the local authority will want to know all about their finances, which they would prefer to keep private. Against this, it was suggested that the answer to these kinds of problems is not to allow pure self-assessment, but rather to develop mechanisms for carrying out an assessment which are not too intrusive or stigmatising. It was also suggested that allowing pure self-assessment for low-level services may cause problems because it may mean that bigger issues, such as around safeguarding, may not be picked up.

⁴⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 84.

Discussion

- 5.115 Consultation has confirmed our view that the legal framework must ensure that people are involved as far as they want to be in the assessment process. The question is whether putting self-assessment on a statutory footing would add anything to the legal framework, and in particular, the statutory principles and the requirement to consult a service user and carer, which we recommend above should be brought across to the statute.
- 5.116 The overarching statutory principle in our scheme would require adult social care to promote or contribute to the well-being of the individual. In deciding how to give effect to this principle in relation to individuals, decision makers would have to, amongst other things, assume that the person is the best judge of their own well-being, except in cases where they lack capacity to make the relevant decision; follow the individual's views, wishes and feelings wherever practicable and appropriate; and give individuals the opportunity to be involved, as far as is practicable in the circumstances, in assessments, planning, developing and reviewing their care and support. As we recommend above, the statute would also require that in assessing the needs of a person, a local authority must consult the person and any carer, unless it was not realistically possible in the circumstances. These provisions would in effect build co-production into the statute and would ensure that people are involved so far as they want to be in the assessment process, including being able to self-assess.
- 5.117 However, while the effect of the well-being principle and the consultation requirement would be to require consultation in most cases, they do not prescribe the form or manner in which service users are to be consulted. A requirement to allow people to self-assess as part of the assessment process may provide this, depending on how self-assessment is defined or what form it takes. For example, the power to make assessment regulations could be used to prescribe a self-assessment form and requirements as to how self-assessments must be integrated into the assessment, eligibility and care planning processes. On the one hand, prescribing such an approach would give individuals the opportunity to lead the assessment process and should bring consistency in local authority practice, since not all local authorities may specifically allow for self-assessment. However, it may add an unnecessary layer into the assessment process, in circumstances where co-production of assessments should already be required by virtue of the statutory principles and the duty to consult.
- 5.118 We are persuaded that the crucial point is that assessments are person-centred and explore peoples' needs adequately. Including a requirement in the statute for self-assessments to be undertaken would not necessarily achieve this aim; paradoxically, it may lead to more formulaic assessments. On balance, therefore, we do not consider that self-assessments should be put on a statutory footing, but rather the code of practice should provide guidance on how they should be integrated into the assessment process where appropriate.⁴⁵

Recommendation 13: The code of practice should provide guidance on how self-assessment should be integrated in the assessment process.

⁴⁵ This issue is already addressed in Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 84.

Delegation of the assessment duty

- 5.119 As noted above, the only power to delegate the duty to assess is under the NHS Act 2006 and NHS (Wales) Act 2006, which enable prescribed functions to be carried out by a health body.⁴⁶ Aside from this power, however, the legal framework does require local authorities to involve other bodies in the assessment – in particular, if an assessment discloses a possible housing or medical need, the local authority is required to notify the relevant housing or health authority and invite them to assist.⁴⁷ However, while a local authority may involve other persons or organisations in the assessment process, and might contract with another body to carry out part of the assessment process on its behalf, it must retain overall control of the process.

Consultation responses

- 5.120 A number of consultees queried whether a local authority can or should be able to accept an assessment carried out by another body. Some consultees suggested that local authorities should be able to accept assessments made by appropriately skilled and qualified people, particularly health service staff, to avoid unnecessary duplication of assessments and to facilitate joint working. Others argued that local authorities should be able to delegate the information-gathering part of an assessment to third parties but the local authority should retain control of the eligibility decision based on that assessment.
- 5.121 Several consultees expressed concern about plans to encourage independent social work practices to carry out local authority functions, such as assessments, and argued this would undermine the quality of assessment and could lead to charges being introduced.

Discussion

- 5.122 In our view, local authorities currently have the ability in law to co-produce assessments or, where appropriate, authorise others (such as service users, carers, health professionals, and advocates) to undertake the assessment or aspects of the assessment, subject to the local authority retaining ultimate control of the process and ensuring that certain minimum requirements are satisfied.
- 5.123 This position would be maintained in our scheme. However, we appreciate that the extent to which a local authority can properly involve others in discharging their assessment duty can be a matter of confusion. In our view, the code of practice should provide guidance on when it would be appropriate to authorise other individuals or organisations to undertake the assessment or aspects of the assessment, and what degree of oversight must be provided by the local authority. This would include, for example, sufficient control for the local authority to be able to satisfy itself that the assessment complies with the legal requirements, including the well-being principle, assessment regulations and requirement to consult the service user and carer, and which allows them to

⁴⁶ See NHS Act 2006, s 75 and NHS (Wales) Act 2006, s 33.

⁴⁷ NHS and Community Care Act 1990, s 47(3).

properly take the decision on eligibility and service provision.⁴⁸ This would include rectifying any inadequacies in the assessment of need and ensuring that considerations such as the role of carers, and any safeguarding concerns, have been properly taken into account.

- 5.124 We note that whatever arrangements are made by local authorities for the assessment, the existing rules must be retained which prevent charges being made on those assessed for the provision of assessments. Our recommendations on charging and prohibitions on charging are set out in Part 8 (The Provision of Services).

Recommendation 14: The code of practice should provide guidance on when it would be appropriate for a local authority to authorise other individuals or bodies to carry out an assessment, or aspects of an assessment, and what degree of oversight should be provided by the local authority.

LINKS WITH OTHER ASSESSMENTS

- 5.125 There has been considerable commentary on the multiple assessment regimes for different service users. In the White Paper, *Our Health, Our Care, Our Say*, the previous Government acknowledged the desire for greater integration between different services.⁴⁹ At consultation we received a clear message that service users, carers and professionals were concerned by the proliferation of multiple assessment regimes for service users. Service users and carers expressed frustration at the number of assessments they had to endure, the duplication of information that arises and being asked the same questions and giving the same information time and time again. 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. Other consultees were confused by the relationship between a community care assessment and other assessments, such as the Care Programme Approach for people with mental health problems and the Single Assessment Process for older people.

Different types of assessment

- 5.126 There are several different types of assessments which relate to adult social care. Some are aimed at encouraging integrated health and social care assessments for specific client groups and can incorporate, where appropriate, a community care assessment. Often they will specify their own assessment domains and care plans. For example, the Care Programme Approach is a system for assessing the health and social needs of people who need specialist mental health services.⁵⁰ The assessment is to determine whether a person requires support from secondary mental health services. This decision is based on locally determined criteria (separate to the local authority eligibility criteria).

⁴⁸ Although as noted in Part 8 (The Provision of Services), the local authority could also authorise others to produce the care and support plan with an appropriate level of oversight by the authority.

⁴⁹ *Our Health, Our Care, Our Say* (2006) Cm 6367, para 5.26.

⁵⁰ See HC(90)23/LASSL(90)11, *The Care Programme Approach for People with a Mental Illness, Referred to Specialist Psychiatric Service* and Department of Health, *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance* (2008).

There is also the Single Assessment Process, which is the primary method for the assessment of all older people. The guidance requires health and social services bodies to have fully integrated commissioning arrangements and integrated provision of services. In Wales, the guidance on the Single Assessment Process is combined with the statutory guidance on eligibility criteria.⁵¹

- 5.127 Other assessments are aimed primarily at establishing eligibility for non-social care services, but the community care assessment will be relevant. For example, assessments for NHS continuing healthcare need to consider which health services it is lawful for a local authority to provide under the National Assistance Act 1948. Furthermore, the *NHS Continuing Healthcare (Responsibilities) Directions 2009* require the NHS to consult, so far as is reasonably practicable, with the relevant social services authority before making a decision on a person's eligibility for NHS continuing healthcare. The guidance also suggests that any existing community care assessment should be used to help inform the assessor about a person's eligibility for NHS continuing healthcare.⁵²
- 5.128 Finally, some assessments are aimed at specific client groups but essentially have no clear legal basis. For example, person-centred planning was developed originally for assessing people with learning disabilities and although the resulting plans are referred to as a *person centred plan*, it is not a separate form of care planning. As the guidance explains, person-centred planning is not the same as a community care assessment but is an approach to how such an assessment can be carried out. In practice, therefore this approach can be used more widely.⁵³
- 5.129 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 London Borough of Islington*, where a person had been assessed and rejected for support from specialist mental health services using the Care Programme Approach guidance, and was found to be ineligible for community care services on the basis of that decision, the court held that a proper community care assessment had not been carried out.⁵⁴

Discussion

- 5.130 It is important that the statute should allow for and encourage joined-up assessments wherever possible. First, we recommend that the statute should include a clear statement to the effect that a local authority can carry out a community care assessment at the same time as any other assessment is carried out for the purposes of, for example, the Care Programme Approach, the Single

⁵¹ Department of Health, *Single Assessment Process: Guidance for Local Implementation* (2002) and NAFWC 09A/2002, *Health and Social Care for Adults*.

⁵² Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care: July 2009 Revised* (2009) para 73. These provisions are discussed in detail in Part 11 (Overlap Issues).

⁵³ Department of Health, *Planning With People Towards Person Centred Approaches* (2001) p 4.

⁵⁴ [2004] EWHC 7 (Admin), (2005) 82 BMLR 113.

Assessment Process, eligibility for NHS Continuing Healthcare and any other enactment. This power would also allow for the production of a single care and support plan across the different legal assessment regimes (see Part 8 (The Provision of Services)).

- 5.131 Second, we note earlier in this Part that local authorities can already authorise other individuals or bodies to undertake an assessment or aspects of an assessment, subject to it retaining overall control of the assessment process – and that this would continue under our scheme. This could include, for example, allowing for joint health and social care assessments to be carried out by the same assessor. For example, it may be more appropriate for a local authority to allow a Community Psychiatric Nurse to carry out a community care assessment of a person with mental health problems whose case they manage and who has no social worker involved in their care. We also recommend above that the code of practice should provide guidance on the circumstances in which authorisation could be given.
- 5.132 Finally, we recommend in Part 11 (Overlap Issues) that the statute would include an enhanced duty to co-operate. This would provide that where a local authority is undertaking a community care assessment and it appears there may be a need for housing, health or other services, the relevant authority can be notified and invited to assist in the assessment. If it refuses to co-operate, the requested authority would be required to give written reasons.

Recommendation 15: The statute should include a clear statement to the effect that a local authority can carry out a community care assessment at the same time as any other assessment is carried out.

PART 6

ELIGIBILITY

INTRODUCTION

- 6.1 This Part considers the legal framework for determining whether or not a person is eligible for community care services, and the duty to provide residential accommodation under section 21 of the National Assistance Act 1948.

DETERMINING ELIGIBILITY FOR SERVICES

- 6.2 After a local authority has carried out a community care assessment, section 47(1)(b) of the NHS and Community Care Act 1990 provides that it must decide, having regard to the results of the assessment, whether the person's needs call for the provision by them of any services. This section does not, however, provide any further detail on how this decision should be made. Instead, statutory guidance in England and Wales has been issued to help local authorities make this decision. The statutory guidance sets out an *eligibility framework* which local authorities must use to specify their *eligibility criteria*. If a person's needs fall within the local authority's eligibility criteria, then the statutory guidance provides that the local authority must meet those needs.¹

- 6.3 Underpinning the statutory guidance, however, is a number of different statutes. The relationship between the statutory guidance in England and Wales and the underlying community care legislation is complex: some statutes only set out a power to provide a service, whereas others set out their own internal criteria which, if met, give rise to a duty to provide the service. In the consultation paper, we concluded that the significance of the statutory guidance on eligibility criteria varies according to the precise nature of the statutory provision in question. The correct legal interpretation of the legal duty to meet eligible needs is as follows:

- (1) where there is a strong individual duty which provides limited scope to take into account availability of resources (such as section 21 of the National Assistance Act 1948), the statutory guidance is irrelevant and section 47(1)(b) acts as a signpost to the criteria in the legislation;²
- (2) where there is an individual duty to provide services which gives local authorities a greater ability to have regard to resources or other factors (such as section 2(1) of the Chronically Sick and Disabled Persons Act 1970 and section 117 of the Mental Health Act 1983), the statutory guidance is relevant and in effect is the tool that must be used to interpret the statutory duty;
- (3) where there is a general duty to provide services (such as section 29 of the National Assistance Act 1948), the statutory guidance on eligibility

¹ In England, Department of Health, *Prioritising Need in the Context of Putting People First* (2010) and in Wales, NAFWC 09A/2002, *Health and Social Care for Adults*.

² *R (N) v London Borough of Lambeth* [2006] EWHC 3427 (Admin).

criteria can be very relevant as the means through which the duty is crystallised into an individually enforceable duty;³ and

- (4) where there is a discretionary power (such as section 45 of the Health Services and Public Health Act 1968), the statutory guidance is central and local authorities must use it to decide whether to exercise their discretion and in what circumstances. If eligible needs are identified that call for the provision of services, then the statutory guidance effectively will turn that discretionary power into a duty, unless the local authority can establish good reason to depart from the guidance.
- 6.4 Given this complexity, the consultation paper argued that it would be clearer and more effective to make an assessment of need and the application of eligibility criteria the sole means by which a person's eligibility for community care services (including residential care) is determined. We therefore proposed that the statute should place a duty on local authorities to determine whether a person's social care needs are eligible needs, using eligibility criteria; and to provide community care services to meet all eligible needs. We also suggested that this is likely to reflect the approach used currently by local authorities.⁴
- 6.5 The effect of this proposal would be to repeal almost all existing powers to provide community care services (including residential care, which is discussed separately below).
- 6.6 The consultation paper considered separately the position of section 2(1) of the Chronically Sick and Disabled Persons Act 1970, which is an enforceable individual duty to provide "necessary" services to disabled people. It was argued that the removal of section 2(1) would not undermine existing rights to services because deciding whether it is "necessary" to provide section 2(1) services is effectively the same as our proposed approach that a local authority must assess and apply eligibility criteria to determine eligibility for services.⁵

Consultation responses

- 6.7 An overwhelming majority of those who expressed a view agreed with our proposed approach to determining eligibility, with consultees pointing to the complexity of the existing system and the benefits of our proposed reform.⁶ At several consultation events, local authority staff confirmed our assertion that the proposal reflected existing practice. However, some consultees raised the issue of resources. The Welsh Assembly Government, for example, said it wanted to give further consideration to the resource implications of consolidating the duties on local authorities to provide or arrange services. A number of local authorities argued that sometimes eligible needs can be met by signposting to other services (such as an adaptation provided through a Disabled Facilities Grant), and only after such alternative methods of provision have been exhausted should social services be responsible for meeting those needs. It was also suggested that local

³ *R (Hughes) v Liverpool City Council* [2005] EWHC 428 (Admin), (2005) 8 CCLR 243.

⁴ *Adult Social Care* (2010) Law Commission Consultation Paper No 192, paras 6.2 to 6.18.

⁵ *R v Gloucestershire County Council ex p Barry* [1997] AC 584.

⁶ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 117.

authorities need a level of discretion about *how* eligible needs are met given the limited resources available. Finally, some consultees argued there should remain a separate power or target duty to provide community care services to those who do not have eligible needs.

- 6.8 In relation to section 2(1) of the 1970 Act, a majority of responses to the proposal agreed that this section should be removed.⁷ Some did so subject to our proposed eligibility framework achieving the same level of services and outcomes for disabled people, and others emphasised the importance of ensuring that disabled children should retain their existing rights to services. Several consultees expressed concern about the removal of the list of services contained in section 2(1). A small minority opposed our proposal outright, arguing that section 2(1) should be retained in our scheme.

Discussion

- 6.9 Consultation has confirmed our view that the current legal framework for determining eligibility is inadequate and needs to be consolidated into a single duty to meet all eligible needs. We do not agree with the suggestion that resource implications may arise from the consolidation of the duties to meet eligible needs. Consultation has confirmed that the proposal reflects the existing practice of local authorities. Indeed, it would be surprising if it did not: we remain of the view that our proposal reflects the correct legal position. With the exception of residential care (which is discussed separately below), local authorities are already, in effect, under a duty to meet all eligible needs as defined by their eligibility criteria, arising out of the relationship between the statutory guidance and the underlying community care legislation. Furthermore, the statute would continue to allow, where appropriate, for signposting to other services to meet eligible needs and would allow for eligible needs to be met by non-community care services. This is discussed in more detail in Part 5 (Assessments) in relation to the assessment regulations and joined-up assessments.
- 6.10 We are also aware of the importance of retaining existing entitlements to services. As noted previously, in most cases, the underlying community care legislation and the eligibility criteria will establish a strong individually enforceable duty to provide services. While the final wording of the duty will be a matter for Parliamentary Counsel, our recommendation is made on the basis that the new duty to provide services in the statute is an individually enforceable duty.
- 6.11 We note the concern that local authorities need to have discretion about *how* eligible needs are met given the limited resources available. Nothing in our proposals would prejudice this. The current law is clear that in taking the decision on how to meet eligible needs, local authorities can in certain cases have regard to resources.⁸ This position would be retained in our scheme. Furthermore, local authorities would continue to have a power to meet needs that fall below their eligibility criteria.

⁷ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 147.

⁸ *R v Sefton Metropolitan Borough Council ex p Help the Aged* (1997-98) 1 CCLR 57.

- 6.12 In relation to section 2(1) of the 1970 Act, it would be incongruous for us to maintain a separate assessment and eligibility system in our scheme for *disabled people* alongside our recommended eligibility scheme. Most importantly, people who are or would be entitled to services under the 1970 Act would remain entitled to services under our recommended assessment and eligibility system. We agree that it is important to maintain the effect of section 2(1) as an enforceable individual duty; this is reflected in our final recommendations below. Furthermore, we also recommend in Part 11 (Overlap Issues) that children’s existing rights to services under the 1970 Act should be retained. We accept that many consultees wished to see the current list of services in section 2(1) retained. Our approach to the definition of services is set out in Part 8 (The Provision of Services) where we recommend that a list of outcomes and services should be introduced. As argued in that Part, this list would cover the existing section 2(1) list while also remaining flexible enough to evolve and remain up-to-date.

Recommendation 16: The statute should place a duty on local authorities to:

- (1) determine whether a person’s social care needs are eligible needs, using eligibility criteria; and**
- (2) provide or arrange community care services to meet all eligible needs.**

The wording of the duty must make it clear that the duty is an individual duty enforceable through judicial review.

THE ELIGIBILITY FRAMEWORK

- 6.13 Under the above proposal, eligibility criteria would become the key means of establishing eligibility for community care services. We therefore proposed that the statute should impose a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the eligibility framework and in particular the risks to independence that may call for the provision of services (for example, the four bands of risks currently used in the statutory guidance on eligibility criteria); and the objectives that are to be achieved by the provision of services. The details of how the eligibility framework would operate, including how eligibility criteria are set by individual local authorities, would remain in statutory guidance.⁹

Consultation responses

- 6.14 An overwhelming majority of those who expressed a view agreed with this proposal.¹⁰ A clear theme in the responses was the benefits in terms of consistency and clarity that the proposal would bring. A small number of consultees suggested, however, that the eligibility framework was of such importance that it should be on the face of the statute. On the other hand, the Welsh Assembly Government wished to consider whether there should be a power rather than a duty to make regulations.

⁹ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 6.19 to 6.22.

¹⁰ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 121.

Discussion

- 6.15 The existence of *an* eligibility framework is fundamental to the system we propose. The system cannot work without it. Local authorities will be required to use the eligibility framework prescribed by the Secretary of State and Welsh Ministers to set their eligibility criteria; they will be required to use the criteria to determine whether a person's needs are eligible; and they will be required to meet all eligible needs. Therefore, unless the regulations are made, local authorities will not be able to exercise their statutory functions. There is, therefore, a strong case for a mandatory duty for the Secretary of State and Welsh Ministers to make these regulations.
- 6.16 At the time of writing, there are reports of councils considering so-called *super-critical thresholds* by setting eligibility criteria higher than the four bands set out in the statutory guidance. While the statutory guidance on eligibility criteria is clear that local authorities should take account of their resources, expectations and local costs in setting their eligibility criteria,¹¹ we are concerned that it fails to specify clearly which band a local authority must, as a minimum, provide services to meet, or indeed whether local authorities can set their criteria higher than the critical band. It is not up to us to say what eligibility framework should be prescribed. But in our view it is essential that the law is clear about basic minimum entitlements to services, such as in the code of practice.

Recommendation 17: The statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the eligibility framework for the provision of community care services. The code of practice should specify clearly how local authorities should set their eligibility criteria, including the needs that a local authority must, as a minimum, provide services to meet.

National eligibility criteria

- 6.17 At the time the consultation paper was published, both Governments were considering the introduction of national eligibility criteria, whereby the Secretary of State and the Welsh Ministers would prescribe the threshold of eligibility which would apply in each local authority.¹² We proposed that if national eligibility criteria were to be introduced, then they should be prescribed in regulations issued by the Secretary of State and Welsh Ministers respectively. Although posed in the form of a provisional proposal, in reality, this is merely an illustration of the ability of our regulations to implement alternative policies. In their written submissions, both the Government and Welsh Assembly Government agreed that if national eligibility criteria were introduced, then these should be prescribed in regulations. The majority of consultees also agreed with this proposal.¹³ A

¹¹ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 44; NAFWC 09A/2002, *Health and Social Care for Adults*, para 5.19.

¹² Building the National Care Service (2010) Cm 7854, p 14 and Welsh Assembly Government, *Paying for Care in Wales* (2009) pp 44 to 46. The Welsh Assembly Government appears to have confirmed this policy in Welsh Assembly Government, *Sustainable Social Services for Wales* (2011) para 3.47.

¹³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 126.

formal recommendation is not necessary; it is sufficient to note that our system could be used to implement such a policy.

SECTION 21 OF THE NATIONAL ASSISTANCE ACT 1948

6.18 Section 21 of the 1948 Act, and the relevant directions,¹⁴ place a duty on local authorities to provide residential accommodation for adults “who by reason of age, illness, disability or any other circumstance are in need of care and attention which is not otherwise available to them”. As noted above, the consultation paper proposed that almost all of the existing community care statutory provisions, including section 21, should be repealed and replaced by a single assessment and eligibility framework. However, in Part 7 of the consultation paper we acknowledged the possibility that some groups may lose their current entitlement to residential care if section 21 is repealed. There are two categories of people who are currently eligible for section 21 accommodation:

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

6.19 Where a person is in the first category, we argued that their entitlement to residential care would remain unaffected by the proposal. In relation to the second category we argued that, while most people would continue to be entitled to accommodation, a small number might lose their entitlement. The categories of people most at risk are some asylum seekers and those people ineligible under housing legislation. Accordingly, we proposed that section 21 should be repealed and that both Governments should ensure a proper scheme for the provision of residential accommodation to those people who may lose entitlement. But if such a scheme is not introduced, then section 21 should be retained but only in relation to those people who would otherwise lose their entitlement.¹⁶

Consultation responses

6.20 A majority of consultees who expressed a view agreed with the proposals.¹⁷ Most responses agreed with our conclusion that in relation to the first category of people, because their eligibility for section 21 accommodation is only triggered if the *care and attention* they require is *not otherwise available to them* in their own homes, a need for residential accommodation would be likely to translate into a *critical need* and therefore satisfy the eligibility criteria.

6.21 In relation to the second category of people, some consultees argued that we had underestimated the risk that certain groups would lose their entitlement to residential care. The consultation paper questioned whether a person in need of *care and attention* (even a relatively low-level need) but who does not have

¹⁴ LAC(93)10, appendix 1.

¹⁵ *R (M) v Slough Borough Council* [2008] UKHL 52, [2008] 1 WLR 1808 at [30].

¹⁶ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 7.4 to 7.30.

¹⁷ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) pp 138 to 146.

access to accommodation in which that need can be met, would be assessed as falling below the eligibility criteria. In other words, the lack of accommodation would transform that need into an eligible need.

- 6.22 Consultees argued that whereas for the first category of people the need must be linked clearly to the need for residential care (as opposed to needs that can be met by home-based care), for the second category the need for *care and attention* stands alone and does not necessarily have to be connected directly to a need for accommodation. In effect, the need could remain at a relatively low-level (and not trigger the eligibility criteria) even if the person were homeless. Furthermore, it was argued that a section 21 decision differs from an eligibility criteria decision because under the former the local authority must disregard the theoretical availability of National Asylum Support Service (NASS) accommodation.¹⁸ In contrast, when making an eligibility criteria decision, a local authority can take into account support which is or may be provided elsewhere (such as a Disabled Facilities Grant or support from a carer).¹⁹ Therefore, consultees contended that section 21 provides a lower threshold for some groups compared to eligibility criteria decisions.
- 6.23 Finally, it was argued that section 21 is easier to enforce than a local authority eligibility criteria decision. The section 21 criteria are set out on the face of the statute and there is extensive authority on how this should be interpreted. Once the criteria are satisfied, an enforceable duty arises; compared to other community care statutes, section 21 provides less elasticity in meaning and a more limited ability for local authorities to plead lack of resources.²⁰

Discussion

- 6.24 As noted in the consultation paper, the aim of our review is not to remove any existing entitlements to services. As a result of consultation, we cannot be sure that this will not occur if section 21 is repealed. It is therefore necessary to consider how *existing rights* to residential care can be retained in our scheme.
- 6.25 The consultation paper proposed that section 21 should be repealed and that both Governments should ensure a proper scheme for the provision of residential accommodation to those people who might otherwise lose their entitlement. This was premised on the view that the defining characteristic of the category of those who may lose entitlement is *not* that their social care needs are sufficiently acute to justify the provision of services, but that, due to a lack of appropriate accommodation, their social care needs cannot be met.
- 6.26 However, many consultees were sceptical of the idea that either Government would be willing or able to ensure a proper scheme for the provision of accommodation for these groups. Furthermore, were there to be such a scheme,

¹⁸ *R (Westminster City Council) v National Asylum Support Service* [2002] UKHL 38, [2002] 1 WLR 2956.

¹⁹ *R (Spink) v Wandsworth London Borough Council* [2005] EWCA Civ 302, [2005] 1 WLR 2884.

²⁰ *R v Sefton Metropolitan Borough Council ex p Help the Aged* (1997-98) 1 CCLR 57, 67(E) to 67(I).

it was not likely to provide better accommodation than NASS,²¹ the shortcomings of which made the delivery of social care problematic. The Government's response did not suggest that any proper housing scheme was likely to be introduced. The Welsh Assembly Government confirmed that they have no plans for legislative reform in Wales in this regard. On this basis we conclude that section 21 should be retained.

- 6.27 The retention of section 21 raises some awkward technical decisions about the drafting of the provision for Parliamentary Counsel. The first relates to where the section 21 duty should be located. It could be retained in our scheme as a separate standalone provision contained in the 1948 Act, or a provision included in the new adult social care statute. We would prefer the latter. One of the advantages of our scheme is that it allows for all adult social care legislation to be located in one place.
- 6.28 However, the provision would undeniably be out of kilter with the rest of the statute. First, section 21 is a power, subject to approvals and directions. It is the exercise of directions, which we would generally abolish, which renders it into a duty.²² Second, section 21(1)(a) and (aa) refers to a list of service user groups, something we have rejected elsewhere in our scheme.²³
- 6.29 On consultation, it was argued that the long history of case law on section 21 is now largely settled, and its current wording must therefore be preserved to avoid re-opening settled issues. There is clearly force in this argument; the regulations in respect of the provision of NASS accommodation, for instance, are written around the availability of "any other support available" (including under section 21).²⁴ We consider that section 21 should be retained with only such amendment as will have no consequences on its effect (subject to confirming its residual status). The extent to which this can be done must be a matter for Counsel. If it were thought that the effect of the 1993 directions and approvals could be acceptably introduced onto the face of the statute, then in our view that would be preferable to maintaining one remaining approvals and directions power.
- 6.30 More importantly, there is a need to clarify the relationship between the residual section 21 and our scheme. We considered and rejected two options. The first was to retain section 21 specifically for those groups we had identified as potentially losing the right to accommodation if we abolished section 21. Under this option, the section would apply only to a defined group, consisting of, for example, asylum seekers and the intentionally homeless. We rejected this because it depended on us accurately predicting, and specifying, all groups who could possibly rely on section 21. This we are not confident we can do. The second rejected option was to maintain section 21 as a standalone residential care provision, which would operate alongside our duty to meet eligible need. In

²¹ NASS accommodation is provided by the Home Secretary pursuant to section 95 or section 4 of the Immigration and Asylum Act 1999.

²² The relevant directions turn the power into a duty for those ordinarily resident in the local authority's area and those in urgent need of accommodation, see LAC(93)10, appendix 1.

²³ See discussion in Part 12 (Other Issues) on the definition of disability for example.

²⁴ Asylum Support Regulations 2000, SI 2000 No 704, reg 6.4. See also *R (Westminster City Council) v National Asylum Support Service* [2002] UKHL 38, [2002] 1 WLR 2956.

effect, there would be two parallel eligibility schemes: section 21 for residential accommodation and the eligibility framework for non-residential services. This we rejected as building-in the very duplication and complexity we aim to eliminate. It would also retain what we consider to be the artificial distinction between residential care and all other forms of social care.

- 6.31 We, therefore, conclude that the better option is to confine section 21 to anyone who would not be eligible under our duty to meet eligible need. In effect, section 21 would operate as a long-stop legal duty for those with a need for *care and attention* who fall below the local authority eligibility criteria. The potential difficulty with this approach is that it could increase the likelihood of asylum seekers being assessed under the eligibility framework as eligible for community services with NASS accommodation, and thus being excluded from the section 21 duty. This would mean that fewer people with a need for care and support would be eligible for social services accommodation. However, this could be addressed by making it clear that the provision of NASS accommodation is residual, and a community care assessment should operate on the basis that it is not available.
- 6.32 It is also important that our scheme should not alter the current position in interim relief cases, particularly where the claimant is seeking accommodation. Some consultees argued that section 21 provides a strong backdrop to challenge local authorities who refuse to exercise their discretion to carry out an emergency community care assessment and accommodate the person pending the outcome of that assessment. There may be fears that by establishing section 21 as a residual duty, a claimant's ability to rely on a substantive duty to accommodate would be undermined or there will be confusion as to whether to use eligibility criteria or section 21 to challenge the local authority. We do not consider that this would be the case. Under our scheme, claimants would be able to rely on two substantive duties when seeking the provision of accommodation. The relationship between the two duties would be clearly stated in our scheme: if a person falls below the local authority eligibility criteria, the residual section 21 may still be used. The courts would have the power to grant interim relief in urgent cases while the local authority decides whether the person is eligible for accommodation under the eligibility criteria *or* the residual section 21 duty.

Recommendation 18: Section 21 of the National Assistance Act 1948 should be retained in our scheme and, if it is possible to do so, be located in the adult social care statute and not as a separate standalone provision in the 1948 Act. Moreover, it should be retained with only such amendment that will have no consequences on its effect.

The residual section 21 duty should be retained as a long-stop legal duty, available only to those who fall below the local authority eligibility criteria.

PART 7

CARERS' ASSESSMENTS AND ELIGIBILITY

INTRODUCTION

- 7.1 This Part sets out our recommendations for reform of the legal framework for carers' assessments and eligibility for carers' services.¹

CARERS' ASSESSMENTS

The carers' assessment duty

- 7.2 The current legal framework for carers' assessments is fragmented and multi-layered. The Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000 both create duties to undertake carers' assessments but in different circumstances and with different purposes. The 1995 Act requires a local authority to take the results of a carer's assessment into account when deciding whether to provide services to the cared-for person. In contrast, the purpose of assessment under the 2000 Act is to decide whether to provide services to the carer. Both of these Acts were amended by the Carers (Equal Opportunities) Act 2004, which introduced a requirement for local authorities to inform carers of their right to request a carer's assessment where the local authority believes the carer may be entitled to an assessment under either the 1995 or 2000 Act. It also required that the assessment must include consideration of whether the carer works or wishes to work, and is undertaking, or wishes to undertake, education, training or any leisure activity.² In addition to these specific statutes on carers' assessments, section 8 of the Disabled Person (Services, Consultation and Representation) Act 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.
- 7.3 The consultation paper proposed that the duties to assess a carer in the 1995 Act and the 2000 Act – including the amendments made to each by the Carers (Equal Opportunities) Act 2004 – should be consolidated into a single duty to undertake a carer's assessment.³ We proposed that the duty should not depend on the cared-for person receiving a community care assessment, as required under the 1995 Act. Instead, following the approach of the 2000 Act, it would require that 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.
- 7.4 We note that because the two assessment duties under the 1995 and 2000 Acts have different purposes, consolidating these requirements into one provision would change the legal position. A local authority could not, for example, carry out a separate carer's assessment which *only* considered whether to provide

¹ Young carers and parent carers are discussed separately in Part 11 (Overlap Issues).

² See Carers (Recognition and Services) Act 1995, ss 1(2B) and 1(2C) and Carers and Disabled Children Act 2000, ss 1(3A), 6(2A) and 6A.

³ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 5.2 to 5.10.

services to the cared-for person (as provided for under the 1995 Act); it would have to use the carer's assessment both to decide whether to provide services to the cared-for person and to decide whether to provide services to the carer. However, we doubt that local authorities make this distinction in practice and therefore, consolidating the two duties would not have resource implications.

- 7.5 The consultation paper made no specific proposals in relation to section 8 of the Disabled Person (Services, Consultation and Representation) Act 1986. However, we envisaged that the requirement to have regard to the care being provided by a carer – which applies even where the carer declines an assessment – would be provided for in other aspects of our proposals. This provision is discussed in more detail in Part 5 (Assessments).

Consultation responses

- 7.6 The overwhelming majority of responses to this proposal agreed that there should be a consolidated duty to undertake a carer's assessment in the statute.⁴ No consultee disagreed and only one held an equivocal position. Several consultees, including carers' organisations and individual carers, emphasised the importance of ensuring that the carers' assessment duty remained standalone to ensure that carers continued to be entitled to an assessment even if the person being cared-for refuses an assessment or is not receiving or is not eligible for community care services.
- 7.7 Some consultees raised concerns that carers who are caring for someone with medical needs only are not eligible for an assessment because the person they are caring for is not someone for whom the local authority is providing or has a power to provide community care services.

Discussion

- 7.8 Consultation has confirmed our view that the current legal framework for carers' assessments is fragmented, overlapping and confusing for local authorities and carers alike. We therefore consider that the existing duties to assess a carer should be consolidated into a single duty. The duty should not depend on the cared-for person simultaneously receiving a community care assessment, but rather should only require that the cared-for person is someone for whom the local authority has a power to provide services. This ensures that a local authority's duty to assess will arise even if the cared-for person has refused a community care assessment, or does not qualify for services.
- 7.9 We note the concern that carers who are caring for people with medical needs only may be excluded from carers' assessments, both under the existing law and our recommendation. If significant numbers of carers were being excluded on this basis, extending the duty would have significant resource implications, and would therefore be a matter of policy rather than law reform. However, we doubt whether in reality this is a significant issue. If the cared-for person has *some* social care needs in addition to their health needs then under our system, as under the current law, a carer's assessment should be undertaken. Moreover, even if there were a caring role in connection with solely medical needs, if that

⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 94.

role was affecting the carer's own health or well-being, the carer themselves would appear to be in need of community care services, and so the local authority's duty to undertake a community care assessment would be triggered.

Recommendation 19: There should be a single duty to undertake a carer's assessment in the statute, which is triggered where the local authority is satisfied that the cared-for person is someone for whom the local authority has a power to provide services (subject to the other criteria for an assessment being satisfied).

The substantial and regular test

- 7.10 Under the current legal framework, only carers providing a substantial amount of care on a regular basis are entitled to a carer's assessment. The consultation paper proposed that the *substantial and regular test* be removed because it lacked clarity, was overly complex, and was apparently being applied inconsistently between different local authorities. Instead, we proposed that all carers providing care to another person should be entitled to a carer's assessment (subject to the *appearance of need* criterion – see below).⁵
- 7.11 The consultation paper acknowledged that this proposal may appear to widen the potential recipients of a carer's assessment but argued that the proposal reflects current best practice guidance issued by the Department of Health. This guidance recommends that local authorities “may wish to have a policy of offering carers an initial assessment in circumstances where the carer is providing support to a community care service user” to determine the degree of impact of the caring role and whether a full carer's assessment is needed.⁶

Consultation responses

- 7.12 A large majority of responses to this proposal agreed that the *substantial and regular test* should be removed.⁷ Consultees argued that the test was unclear, confusing and complex. It was also suggested that in practice the test is used to exclude certain categories of carers from an assessment, due to its disproportionate emphasis on the amount of time spent in a caring role; these categories include those who provide care for someone with fluctuating or unpredictable needs, even though this role has a significant impact on the carer's life. Finally, some consultees considered that removing the test would enable a greater focus on prevention services, consistent with Government policy.
- 7.13 The Government argued that our proposal would extend local authorities' existing responsibilities and therefore wanted to consider any resource implications. However, it did acknowledge that the proposal may be a better reflection “of what [the Government is] trying to achieve as it addresses the impact, or potential impact, of caring, rather than setting specific criteria to be met”. Similarly, the

⁵ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 5.12 to 5.21.

⁶ Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) paras 49 and 54. See also National Assembly for Wales, *Practitioners Guide to Carers' Assessment: Carers and Disabled Children Act 2000* (2001) para 4.1.3.

⁷ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 96.

Welsh Assembly Government supported the principle behind this amendment, recognising that “in some instances the only way to ascertain whether a carer is providing regular and substantial care is to undertake an assessment”. However, it also considered that any “increase in the number of assessments would have resource implications whether or not a service was provided as a consequence”, and wished to explore further the resource implications of the proposal.

- 7.14 Some local authorities in their written responses, as well social workers at consultation events, supported our contention that the proposal would not have resource implications because it reflected existing practice and would simplify the carers’ assessment process. However, the majority of local authorities who provided written response – even some of those that agreed with the proposal – argued that removing the *substantial and regular test* would lead potentially to an increase in their workload. Several authorities argued that any assessment undertaken should be proportionate to the needs presented by the carer.

Discussion

- 7.15 We accept that the removal of the *substantial and regular test* would in law broaden the criteria for a carer’s assessment and theoretically could have some resource implications. But we do not consider it right to retain this test. While it is true that this would have the advantage of being resource neutral, it arguably creates inefficiency by requiring local authorities to undertake pre-assessments to decide whether a carer satisfies the *substantial and regular* requirement. Retaining this requirement also leaves a confusing and complex test in place, which does not provide a clear and consistent gateway to carers’ assessments. One middle way would be to define the *substantial and regular test*, in the legislation, the assessment regulations or the code of practice. We do not think this would bring the desired clarity and consistency. Statutory guidance on this test has been in place in England for five years⁸ and the evidence from our pre-consultation paper web-based research indicated significant variation in the ways in which local authorities state their interpretation of the definition of *regular* and *substantial* (some of which is in clear contradiction to the guidance).⁹ It is also relevant to consider that while our proposal would mean a carer’s assessment is not restricted to *substantial and regular* carers, the duty to assess would only be triggered where the carer *appears to be in need*.
- 7.16 We therefore prefer to maintain our proposal. Minimising the resource impact requires that carers’ assessments should be proportionate. We already recommend in Part 5 (Assessments) that proportionality should be a requirement of the assessment process, and should be enforced by means of the assessment regulations.
- 7.17 Given our view that this recommendation will have minimal effect on resources, we cannot claim for the recommendation many of the benefits that those supporting it did, such as that it would bring more carers into the system.

⁸ Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005). In Wales, practice guidance has been in place since 2001 – National Assembly for Wales, *Practitioners Guide to Carers’ Assessment: Carers and Disabled Children Act 2000* (2001) para 2.4.

⁹ Adult Social Care (2010) Law Commission Consultation Paper No 192, para 5.13.

However, we consider that this recommendation would bring clarity, consistency and efficiency to the gateway for carers' assessments.

Recommendation 20: The duty to assess a carer should apply to any carer who is providing care to another person and not be restricted to those carers who are providing a substantial amount of care on a regular basis. Any such assessment undertaken should be proportionate to the needs presented by the carer.

The request mechanism

- 7.18 Currently, a carer's assessment can be undertaken only if it is requested by the carer. We proposed in the consultation paper that the requirement for a carer to request an assessment should be removed, on the basis that it may deter many carers from accessing an assessment and was overly bureaucratic. Instead, we proposed that the duty to assess should be triggered where a carer appears to have, or will have upon commencing the caring role, needs that could be met either by the provision of carers' services or by the provision of services to the cared-for person.¹⁰
- 7.19 The consultation paper did not discuss expressly the potential resource implications of this proposal. However, we did suggest that the existing request mechanism wastes time and resources by requiring local authorities to inform carers of their right to request an assessment (having satisfied itself that the carer is providing *substantial and regular care*), and then requires the carer to make the request for an assessment, before the assessment can commence. Consultation was seen as an opportunity to assess whether in practice the request mechanism is ignored by local authorities.

Consultation responses

- 7.20 A large majority of responses to this proposal agreed with removing the request mechanism.¹¹ Consultees suggested that an inherent difficulty of the request mechanism is that it requires the carer to see themselves as a carer. Many individual carers at different consultation events told us that they did not identify as carers, but rather saw themselves as parents, spouses, siblings or children of the cared-for person; one consequence being that carers will not see themselves as requiring support and do not request an assessment.
- 7.21 Some consultees, however, expressed concerns about the proposal. First, it was argued that triggering the duty to assess by the appearance of needs may mean that carers would have assessments imposed on them. Several consultees argued that carers should have the right to refuse an assessment unless there are concerns about their mental capacity or the safety of the carer or cared-for person. Second, a small number of consultees were concerned that an assessment trigger that linked needs to available services (the appearance of needs *that could be met by the provision of services*) may lead to a poor take-up of assessments. Finally, some consultees argued that the right to request an

¹⁰ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 5.22 to 5.29.

¹¹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 101.

assessment should be retained alongside our proposed *appearance of needs* trigger. This was seen as an important safeguard for hidden carers who are not identified as eligible for a carer's assessment.

- 7.22 Only a few consultees commented on the potential resource implications of the proposal to remove the request mechanism. The Welsh Assembly Government, for example, supported the principle behind this proposal, but expressed concerns about the resource implications as it "has the potential to widen the recipients of a carer's assessment".

Discussion

- 7.23 We disagree with the suggestion that our proposal to remove the request mechanism would widen the recipients of a carer's assessment, including by imposing assessments on carers who did not want them. In our view, the cohort of carers that would be eligible for an assessment under our proposal would be very similar to those who are entitled to an assessment under the current framework. In particular, any carer who appears to have needs that could be met by services would, as a matter of practice, already satisfy the current test of providing *substantial and regular care*. Indeed, statutory guidance requires that the *substantial and regular* test should focus on evaluating the impact of caring on the individual carer.¹²
- 7.24 We understand that one difference between the existing system and our proposal is that currently local authorities only have a duty to inform such carers of their right to request an assessment and are only required to undertake an assessment when requested. In contrast, under our system a local authority's duty to assess could arise even if the carer did not request an assessment – for example, in circumstances where the carer is at risk of harm but does not want an assessment. However, we consider that in practice most authorities would already assess in these cases or at least find another way to address the risks; for example, by carrying out a community care assessment or dealing with it as a safeguarding investigation.
- 7.25 It is also relevant to consider that in practice, the duty to assess is still overwhelmingly likely to be triggered by a request by the carer, either directly or where the request is channelled through another source, such as a doctor. This is, after all, the case now for those who receive community care services and enjoy a right to an assessment on the basis of the appearance of need. This means there is still likely to be the same strong element of self-selection in triggering the assessment as there is now. In addition, our recommendation about when a local authority can accept a refusal of an assessment as discharging its duty to assess – set out in Part 5 (Assessments) – would also apply to carers. This means unless there are concerns about capacity or safeguarding, the local authority would be able to accept a refusal of an assessment. Therefore, we do not consider that the cohort of carers that would be eligible for an assessment would widen as a result of this proposal.

¹² Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) paras 48 to 49. See also National Assembly for Wales, *Practitioners Guide to Carers' Assessment: Carers and Disabled Children Act 2000* (2001) para 2.4.

- 7.26 We are also not convinced that our proposal would lead to an increase in workload. Either local authorities do what they are supposed to do under the current law – make an initial decision as to whether the carer is providing *substantial and regular care*; if so, to inform the carer of their right to request an assessment; and then finally, undertake the assessment if the carer so requests – in which case our proposal would remove an unnecessary and unhelpful bureaucratic process. Or they simply undertake appropriate assessments of carers when they can find them, in which case our proposals would not adversely affect workload. It is only if local authorities are routinely and deliberately refusing to assess on request that there would be significant impact, and we found no evidence of that during consultation. It is worth noting that our impression, particularly from consultation meetings, was that most local authorities undertook appropriate assessments of carers when they found them – they do now what the law would require them to do if our scheme was adopted.
- 7.27 We also note that our proposals would remove the duty to inform carers of their right to request an assessment. However, this would be in the context of the general duty to provide information, advice and assistance that we discuss in Part 5 (Assessments), so it should be resource neutral.
- 7.28 Consultation has confirmed our view that there are problems with relying on a request from carers to trigger a carer’s assessment. In our view, the better approach is to provide that a carer’s assessment is triggered where a carer appears to have, or will have upon commencing the caring role, needs that could be met by the provision of carers’ services or services to the cared-for person. On balance, we think it unlikely that this will have a significant effect, positive or negative, on the ability of the system to find *hidden* carers. We doubt that the requirement to inform a carer of their right to an assessment is better at bringing them out of hiding (that is, to recognise and embrace their caring role) than the direct offer of an assessment on the basis of the *appearance of need*. The practice issue of finding carers is much more important than the legal characterisation of what will amount to much the same action. It is also relevant to note that carers will continue to be able to request an assessment, in the sense of bringing themselves to the attention of the local authority, and the local authority would have to consider that request. Consistent with the approach we recommend for service users in Part 5 (Assessments), we do not consider that a parallel request mechanism is necessary.

Recommendation 21: The carers’ assessment duty should no longer require a carer to request the assessment in order to trigger the duty. Instead, the duty should be triggered where it appears to the local authority that the carer may have, or will have upon commencing the caring role, needs that could be met by the provision of carers’ services or services to the cared-for person.

The focus and process of carers’ assessments

- 7.29 The consultation paper did not put forward a proposal on the focus of the carers’ assessment duty. However, our intention was that our proposed duty would consolidate the existing requirements of the Carers (Recognition and Services) Act 1995 and Carers and Disabled Children Act 2000 (as amended). The effect is that the assessment must:

- (1) be of the carer's ability to provide and to continue to provide care for the person cared for; and
- (2) take into consideration whether the carer works or wishes to work, or is undertaking, or wishes to undertake, education, training or any leisure activity.

7.30 The broader issue is the extent to which the process and content of carers' assessments should be prescribed in law. There are currently many different pieces of statutory and practice guidance on carers' assessments in England and Wales, which provide detail about how a carer's assessment should be undertaken.¹³ In the consultation paper, we proposed that the process of undertaking a community care assessment should be prescribed in regulations. A further issue raised at consultation was whether the process of undertaking a carer's assessment should similarly be prescribed in regulations.

Consultation responses

7.31 A number of consultees commented on the focus of carers' assessments.¹⁴ Some consultees suggested areas which they argued should be central to an assessment, including the question of whether the carer is willing to continue to provide care; whether he or she would wish to undertake education, learning, training, or any leisure, social or community activity; and also the impact of caring on the health and emotional well-being of the carer. Several consultees expressed the view that carers' assessments should be proportionate to the needs presented by the carer.

Discussion

7.32 In our view, the current focus of a carer's assessment is appropriate and should be retained. This focus necessarily includes consideration of the carer's willingness to provide, or continue to provide, care; accordingly, we do not consider it necessary to specify this point in the statute.¹⁵ However, the code of practice should state clearly that the focus of a carer's assessment includes consideration of whether the carer is willing to provide, or continue to provide, care.

¹³ See, for example, Department of Health Social Services Inspectorate, *Carers (Recognition and Services) Act 1995: Policy Guidance* (1996), <http://www.carersnet.org.uk/documents/documents.html> (last visited 7 April 2011); Department of Health Social Services Inspectorate, *Carers (Recognition and Services) Act 1995: Practice Guide* (1996), <http://www.carersnet.org.uk/documents/documents.html> (last visited 7 April 2011); Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001); Department of Health, *A Practitioner's Guide to Carers' Assessments under the Carers and Disabled Children Act 2000* (2001); Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) and National Assembly for Wales, *Practitioners Guide to Carers' Assessment: Carers and Disabled Children Act 2000* (2001).

¹⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) paras 5.9 to 5.10.

¹⁵ See, for example, Department of Health, *Carers and Disabled Children Act 2000 and Carers (Equal Opportunities) Act 2004: Combined Policy Guidance* (2005) para 43; and National Assembly for Wales, *Practitioners Guide to Carers' Assessment: Carers and Disabled Children Act 2000* (2001) para 3.1.2 and Appendix A.

7.33 In Part 5 (Assessments), we set out our view that the existing legal structure for community care assessments – whereby the detail on how an assessment should be carried out is spread amongst directions and numerous editions of statutory and practice guidance – causes confusion and an inconsistent approach to assessment. These same problems extend to carers' assessments. We therefore take the view that, consistent with the approach taken for community care assessments, the statute should place a duty on the Secretary of State and Welsh Ministers to prescribe the process for carers' assessments in regulations. In our view, the recommendations we have put forward as to what must be covered in the community care assessment regulations, and also the areas that the regulations may cover, would be suitable for the carers' assessment regulations. However, later in this Part we also make two further recommendations for the regulations as they apply to carers.

Recommendation 22: The statute should provide that a carer's assessment must:

- (1) be of the carer's ability to provide and to continue to provide care for the person cared for; and**
- (2) take into consideration whether the carer works or wishes to work, or is undertaking, or wishes to undertake, education, training or any leisure activity.**

Recommendation 23: The statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the process for carers' assessments.

Exemptions from the definition of a carer

7.34 The Carers (Recognition and Services) Act 1995 and Carers and Disabled Children Act 2000 exclude from the definition of a carer – and thus eligibility for a carer's assessment – someone who provides or will provide the care in question by virtue of a contract of employment or other contract with any person, or as a volunteer for a voluntary organisation.¹⁶ Section 8 of the Disabled Person (Services, Consultation and Representation) Act 1986 excludes persons employed to provide care by any body in the exercise of its functions under any enactment.

7.35 Under our proposals these exclusions would be maintained. However, we also proposed that certain categories of carers who receive payment for the care they provide should not be excluded from the definition of a carer. These were:

- (1) a previously unpaid carer who now receives payment for their services through direct payments received by the cared-for person;
- (2) a carer who is paid for some but not all of the care they provide; and

¹⁶ Carers (Recognition and Services) Act 1995, s 1(3) and Carers and Disabled Children Act 2000, s 1(3).

- (3) a carer where the local authority believes the caring relationship is not principally a commercial one.
- 7.36 We argued that carers in these situations are often in a different position – with different relationships and personal dynamics at play – than an ordinary paid or volunteer care worker, and so should not be automatically excluded from accessing a carer’s assessment. The standard, but not only, situation we envisaged was where someone had been an unpaid family carer, and was now receiving some payment from the cared-for person’s direct payment.¹⁷

Consultation responses

- 7.37 This proposal generated a mixed response at consultation. While a majority of those who expressed a view agreed with the proposal, there was significant dissent and a number of concerns were raised.¹⁸
- 7.38 Some local authorities and other consultees argued that our proposal may have resource implications because it could mean that authorities are paying twice for carers: once for a direct payment to the cared-for person to pay the carer for care and secondly for a carer’s assessment – with the potential for a third, if a carer is found to have eligible needs for services. In addition to resource issues, consultees raised concerns that the proposal would erode the distinction between an informal carer and employee, and would compromise the employer/employee relationship which a person who receives a payment has entered into. In relation to the third limb, some consultees suggested that judging whether a relationship was principally a commercial one would lead to major practice difficulties and also seemed to extend the right to an assessment to volunteers.
- 7.39 On the other hand, however, many consultees agreed with our argument that there is a distinction between a previously unpaid informal carer and a paid or volunteer care worker, and that receipt of money will not necessarily professionalise a carer such that they are akin to a paid or volunteer care worker. The Government agreed with the intention of the proposal but argued that a “simpler test as represented by [the third limb] alone would be sufficient”.

Discussion

- 7.40 We are persuaded that retaining the first two limbs in the form proposed could, indeed, have resource implications, and could be accused of causing the duplication of effort by the local authority referred to in some responses.
- 7.41 In contrast, something based on the third limb would be useful. However, this proposal should be adapted in two ways. First, the reference to *commercial* should be expanded to include an equivalent relationship between an external volunteer and the cared-for person. Second, it should be recast as a discretion for the local authority to decide whether or not to assess a carer where they believe the caring relationship is not principally a commercial/normal volunteering one. This would enable the local authority to control any significant adverse resource implications.

¹⁷ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 5.30 to 5.36.

¹⁸ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 105.

Recommendation 24: A local authority should have discretion to assess a carer who receives payment for the care they provide or is a volunteer worker, where the authority believes the relationship is not principally a commercial or ordinary volunteering one.

Relationship with community care assessments

- 7.42 The effect of our proposals in the consultation paper is that our scheme would set out two assessment duties – one for service users, and one for carers. Although these duties will be separate, the consultation paper asked whether the statute should encourage, where appropriate, a more unified approach to community care assessments and carers’ assessments.
- 7.43 It was recognised that the law already requires a degree of integration between the assessments. For example, under the Carers (Recognition and Services) Act 1995, a local authority must take into account the results of a carer’s assessment in making the decision as to whether the cared-for person’s needs call for the provision of community care services. There is a similar requirement to have regard to the ability of a carer to continue to provide care on a regular basis, under section 8 of the Disabled Person (Services, Consultation and Representation) Act 1986. We had envisaged that this would continue in our scheme.
- 7.44 Furthermore, practice guidance issued by the Department of Health provides that carers’ assessments:
- should be seen as part of a holistic assessment of the needs for support of the cared-for person and the carer, identifying the outcomes desired by both and it should be reflected in the care plan (where it is appropriate for cared-for person and carer’s issues to be dealt with together) or in a separately held carer’s plan (where there is a need for confidentiality).¹⁹
- 7.45 The consultation paper therefore suggested that the assessment regulations could help encourage a more unified approach, for instance, by requiring, where appropriate, that the same assessor or team undertake the community care and carer’s assessment, and possibly also a common form for the assessments.²⁰
- 7.46 The consultation paper also raised the option of merging the community care assessment duty with the carers’ assessment duty, so that the statute focused simply on people with social care needs.²¹ For the reasons set out in the paper,

¹⁹ Department of Health, *A Practitioner’s Guide to Carers’ Assessments under the Carers and Disabled Children Act 2000* (2001) para 30. See also National Assembly for Wales, *Practitioners Guide to Carers’ Assessment: Carers and Disabled Children Act 2000* (2001) para 3.3.2.

²⁰ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 5.38 to 5.43.

²¹ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 5.44 to 5.52.

we do not consider that this is a practicable alternative, nor was it supported during consultation.²² We have therefore dismissed this option for reform.

Consultation responses

- 7.47 A majority of responses who expressed a view argued that our scheme should encourage a more unified assessment process for carers and cared-for people.²³ Some consultees suggested that a more unified assessment process would increase efficiency. On the other hand, a small number of consultees expressed concern over increased workload and resource implications.
- 7.48 Amongst those consultees who supported a unified assessment process, the main reason given was that it would encourage more holistic assessments and more joined-up services and support after assessment. However, a number of consultees argued that it was important to retain the ability to have separate assessments for carers and cared-for people, as the interests and concerns of both may differ. Individual carers at consultation events argued that it was important not only for carers to have separate assessments, but also for them to have different assessors. For example, one carer suggested that without a different assessor they can feel as if their ability as a carer is being judged and the assessment process can become counterproductive because they want to show they are coping well for fear of being seen as a bad parent, or having a child taken away or put into care.
- 7.49 A number of consultees supported a more joined-up or co-ordinated (rather than unified) process. For example, it was suggested that when one type of assessment is carried out (such as a community care assessment) this should act as a trigger for the other type of assessment (a carer's assessment). Finally, some consultees considered that it would be preferable to encourage a unified assessment process in the guidance rather than set out in the statute.

Discussion

- 7.50 Encouraging a more unified process in legislation is unlikely to have significant resource implications; if anything it may allow for more efficient and effective assessments, leading to better and more effective care planning. Our scheme should encourage this approach in the following ways.
- 7.51 First, the assessment regulations must provide that the results of the carer's and cared-for person's assessments should inform each other. These two requirements should work together in practice to ensure that there is a degree of joint care planning between the carer and the cared-for person, even in cases where the assessments may be entirely separate and conducted by separate assessors. The equivalent requirement for a community care assessment to take into account a carer's assessment at the care planning stage is set out in Part 5 (Assessments).
- 7.52 Second, the regulation-making power should be broad enough to enable the Secretary of State and Welsh Ministers to require that the family's situation as a

²² See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 113.

²³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 109.

whole should be considered. This is already encouraged by the *Prioritising Need* statutory guidance²⁴ and the importance of having regard to the family situation as a whole was emphasised in consultation. However, we do not consider it necessary at this stage to require both Governments to make regulations on this point, as having regard to the family's situation would be facilitated through other recommendations in our scheme. These include our statutory principle to achieve a balance with the well-being of others, such as carers, and the requirement to have regard to any carers and young carers set out in Parts 5 (Assessments) and 11 (Overlap Issues). The Secretary of State and Welsh Ministers should, however, have the ability to make regulations on this point if it becomes clear that the provisions in the statute are not working effectively to ensure that a family's situation as a whole is considered in an assessment.

- 7.53 Third, we suggested in the consultation paper that the regulations could require that the same assessor or team should undertake the community care and carer's assessment, where appropriate. At consultation it was clear that not all carers believed this would be appropriate in all cases. We accept this and do not make a recommendation.
- 7.54 Fourth, we suggested in the consultation paper that the regulations could prescribe a common form for carers' assessments, which directed those undertaking the assessment to consider whether the carer also has needs for community care services. We now doubt that a form is necessary or desirable. In practice a carer's assessment should identify whether a person has needs for community care services. It would be descending to an unnecessary degree of detail to require a particular form (the regulations could, however, be used to prescribe such a form if either Government wished).
- 7.55 Fifth, at consultation it was suggested that a carer's assessment should be triggered automatically whenever a community care assessment identifies a carer. In our view this is already the case in practice and this position would be maintained. As set out above, we recommend the adoption of a low threshold to trigger a carer's assessment, namely the appearance of needs, which is likely to be satisfied when a community care assessment identifies a carer who is going to be involved in providing part of the care package. Furthermore, the statute would require consultation with the carer as part of the community care assessment process. A carer's assessment may, in practice, be the mechanism by which local authorities carry out this consultation. Thus we do not consider that further prescription is necessary on this point.
- 7.56 Finally, a unified approach may be needed where a carer and cared-for person live in different local authority areas. We discuss this issue in detail in Parts 10 (Ordinary Residence and Portability) and 11 (Overlap Issues).

Recommendation 25: The carers' assessment regulations must make provision to require local authorities to take into account the results of the cared-for person's community care assessment in determining whether to provide services to a carer.

²⁴ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 25. See also para 26.

The carers' assessment regulations may require local authorities to have regard to the family's needs as a whole when undertaking a community care assessment or carer's assessment and in determining whether to provide services, if the Secretary of State or Welsh Ministers wish them to do so.

CARERS' ELIGIBILITY FOR SERVICES

- 7.57 Local authorities currently have a power to provide services to carers but not an express duty. In exercising this power, authorities can, but are not required to, apply an eligibility framework and criteria. Practice guidance in England advises that local authorities should implement an eligibility framework based on the extent of the risk to the sustainability of the caring role.²⁵ This advice is cross referenced in the *Prioritising Need* statutory guidance – and the eligibility framework for carers is reproduced – but the guidance does not comment on whether this should be adopted by local authorities in England.²⁶
- 7.58 The research carried out for the purposes of the consultation paper found, however, that many local authorities are using an eligibility framework to decide whether to provide services to carers.²⁷ However, the eligibility framework used differs between local authorities, with practice ranging from applying the same eligibility framework that is used for service users, adding in further indicia to the service user eligibility framework, or using the eligibility framework for carers set out in practice guidance.²⁸
- 7.59 Given the inconsistency in how carers' eligibility for services are being determined, the consultation paper proposed that there should be a mandatory national eligibility framework which local authorities must use to decide whether or not to provide services to individual carers, and a duty to meet the eligible needs of carers. The eligibility *criteria*, which sets the level at which services to carers are provided, would remain at the discretion of local authorities and they would be entitled to take resources into account when setting their criteria. We argued that these proposals would remove the current ambiguity about how decisions are made regarding the provision of services to carers, and would mean that a carer's eligibility for support is assessed against the same overall framework throughout England and throughout Wales.
- 7.60 The consultation paper argued that the proposal should have negligible resource implications because it would not change the existing legal position. Furthermore, it would not represent a change in practice given our web-based research suggested that many local authorities were already using an eligibility framework for carers and providing services to carers to meet their eligible needs. We recognised, however, that this was an area at the interface between policy and

²⁵ Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) para 70.

²⁶ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) paras 97 to 103.

²⁷ The research is available on the Adult Social Care project page on: <http://www.lawcom.gov.uk>

²⁸ See Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) para 70.

law reform, and we asked for feedback on both the proposal itself and on the judgement as to whether this was properly a matter for law reform.²⁹

Consultation responses

- 7.61 The overwhelming majority of responses to this proposal agreed that there should be a mandatory national eligibility framework for carers' services, and a duty to meet the eligible needs of carers.³⁰ A number of consultees pointed to the difficulties and inconsistencies in the current system, and suggested that a more transparent system was needed to determine carers' eligibility for services.
- 7.62 However, a number of local authorities and other consultees – even those supporting the proposal – argued that it would have resource implications. The Welsh Assembly Government argued that the proposal constituted a “significant shift in policy” and the “resource and delivery implications would need to be assessed fully and carefully considered” before it could support this approach. On the other side, it was suggested that rationalising the decision-making process for eligibility may be a preventative measure that would reduce costs in terms of crisis management and emergency care, and that the proposed duty reflected common practice already.
- 7.63 While expressing support for an eligibility framework for carers, several consultees called for greater clarity on what carers' services are, and whether meeting the eligible need of carers would be through carers' services to the carer, or whether it could be through services to the cared-for person. It was also suggested that there needs to be a working relationship between the eligibility frameworks for carers and cared-for people.

Discussion

- 7.64 We recognise there is concern that this proposal would have cost implications for local authorities because it would mean that they have a new duty to meet a carer's eligible needs. However, this argument is flawed for a number of reasons.
- 7.65 First, local authorities already have to respond to certain needs of carers in some circumstances. An authority could not adopt a policy never to exercise the power to provide services, since this would amount to fettering its discretion.³¹ In practice, local authorities do provide services to carers. The aim of our proposal is to provide greater clarity on how a local authority exercises this power and what level of needs it will provide services to meet.
- 7.66 Second, local authorities are already required in law to provide *some* services to meet the needs of *some* carers. In particular, if a carer's needs gave rise to a *critical risk* to the sustainability of the caring role, then it is likely that existing community care legislation would require a response. The practice guidance in England provides that a critical risk to the sustainability of the caring role arises when the carer's life may be threatened; major health problems have developed

²⁹ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 6.48 to 6.65.

³⁰ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 134.

³¹ See, for example, *R v London County Council ex p Corrie* [1918] 1 KB 68. See also P Craig, *Administrative Law* (6th ed 2008) para 16-013.

or will develop; there is, or will be, an extensive loss of autonomy for the carer in decisions about the nature of tasks they will perform and how much time they will give to their caring role; there is, or will be, an inability to look after their own domestic needs and other daily routines while sustaining their caring role; involvement in employment or other responsibilities is, or will be, at risk; or many significant social support systems and relationships are, or will be, at risk.³²

7.67 Under both the Disabled Person (Services, Consultation and Representation) Act 1986 and Carers (Recognition and Services) Act 1995, local authorities have to take into account the ability of a carer to continue to provide care in deciding upon services to the cared-for person. Consequently, a local authority is required to take into account a critical risk to the sustainability of the caring role in deciding whether to provide services to the cared-for person.

7.68 Furthermore, as set out in Part 6 (Eligibility), local authorities are required to apply eligibility criteria to decide whether to provide services to the cared-for person. If a carer has needs which trigger any of the critical risks to the sustainability of the caring role set out in the carer's eligibility framework, this should satisfy the critical indicator of "vital social support systems and relationships cannot or will not be sustained" which is used to denote a *critical need* in the eligibility framework for service users.³³ If such a critical need was identified in the cared-for person's assessment, then it would require (in practice if not in law) the provision of services to meet the need, since all local authorities must meet the eligible needs of the cared-for person.³⁴ In addition, although the services must be provided to the cared-for person, they must address the eligible need, which is the inability to sustain the support and relationship systems. Therefore, any services provided would need to benefit the carer.

7.69 Third, a carer's critical needs may require the provision of services either to the cared-for person or the carer themselves, in order to prevent a breach of the cared-for person's human rights. In *R (Hughes) v Liverpool City Council*, the court expressed the view that the shortcomings of the local authority in failing to provide services to meet a severely disabled man's eligible needs would have amounted to a breach of his right to private and family life under Article 8, but for the substantial amount of care provided by the service user's mother.³⁵ In his general observations, Mr Justice Mitting said a potential breach of human rights would arise if "for example, his mother is unable to continue to provide the care that she does owing to her own difficulties, and her efforts are not adequately substituted by Liverpool".³⁶

³² Department of Health, *Carers and Disabled Children Act 2000: Carers and People with Parental Responsibility for Disabled Children: Practice Guidance* (2001) para 70.

³³ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 54 and NAFWC 09A/2002, *Health and Social Care for Adults*, para 5.16.

³⁴ At the time of writing, there are reports of councils considering so-called "super-critical" thresholds by setting eligibility criteria higher than the four bands set out in the statutory guidance. See Part 6 (Eligibility).

³⁵ *R (Hughes) v Liverpool City Council* [2005] EWHC 428 (Admin), (2005) 8 CCLR 243, [37] to [38].

³⁶ As above.

- 7.70 We note that this interpretation of the existing obligations of local authorities has been accepted by the Government in the statutory guidance on eligibility criteria in England, which was reissued after our consultation paper was published.³⁷
- 7.71 Finally, it would not be the case that the eligibility framework for carers that was ultimately introduced would necessarily alter existing legal responsibilities. Under the proposed system, the Secretary of State and Welsh Ministers would have discretion in how the eligibility framework is drawn up in the regulations, including the type of needs and risks that are covered. They could draw the framework so that it mirrored the existing legal obligations described above. Furthermore, it is important to be clear that we are not proposing that both Governments prescribe national eligibility *criteria*, which all local authorities must adopt and meet eligible needs. In contrast, we are proposing that the eligibility *framework* is prescribed in regulations, and local authorities would then use this framework to specify their eligibility criteria. Where local authorities draw the line for eligibility would depend on the same factors that they must consider when setting the eligibility criteria for service users, namely resources, local expectations and local costs.³⁸ We also note that under the existing law, a carer's needs could be met by the provision of services to the cared-for person or the carer; this position would be maintained in our system. We are not proposing that local authorities would have to provide particular services to a carer to meet their needs.
- 7.72 We recognise that clarifying the existing law may have the effect of making local authorities more aware of their existing obligations and the situations in which they should be meeting a carer's needs. This may have an impact on resources, although it is difficult to quantify this effect, if it arises at all. However, even if our proposal did have this consequence, it does not necessarily mean more resources have to be provided. Rather, the reform can be made within the same level of funding, but may require adjustment in how the needs are being met. For example in order to meet the needs of carers, a local authority may divert services they were providing to service users to support the carer directly. Whether this readjustment is made or whether the Government and Welsh Assembly Government decides to provide more funding to meet carers' needs without having to divert services from service users, is a political decision for both Governments to make.
- 7.73 For these reasons, we disagree that our proposal has significant cost implications. It allows the Secretary of State and the Welsh Ministers, and local authorities themselves, to determine the resources to be devoted to carers' services. All the proposal would do is to require that such determinations are made in a particular, and consistent, way.
- 7.74 While our system would not extend local authority obligations, it would have the strong benefits of making the process of determining the obligations more transparent, obvious and understandable. Consultation has persuaded us that there are real concerns about the inconsistency and lack of transparency in relation to how local authorities decide whether carers receive services. We

³⁷ See Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 100.

³⁸ As above, para 44.

therefore recommend that there should be such a prescribed eligibility framework. In accordance with the approach set out in Part 3 (Structure of Reform), this should be a duty rather than a power, as the legal framework we recommend depends on the regulations being made.

- 7.75 As a final point, we recognise concerns that this proposal may shift the focus of local authorities to meeting critical needs only, rather than taking a more preventative approach. We recommend in Part 5 (Assessments) a general duty on local authorities to provide information, advice and assistance to those who have or may develop social care needs, including carers. This duty would operate alongside the duties to assess and meet eligible needs and could be used by local authorities to undertake, for example, preventative work.

Recommendation 26: The statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the eligibility framework for the provision of carers' services.

Recommendation 27: Local authorities should be required to:

- (1) determine whether a carer's needs are eligible needs using eligibility criteria; and**
- (2) provide or arrange services to meet all eligible needs of carers.**

PART 8

THE PROVISION OF SERVICES

INTRODUCTION

- 8.1 If a local authority determines that a person has eligible needs, having undertaken an assessment and applied eligibility criteria, it must then decide what services should be provided to meet those needs. This Part examines service provision. Specifically, it covers the definition of community care services and carers' services; care and support plans; personal budgets; direct payments; the choice of accommodation directions; charging for services; and services that must be provided free of charge.

THE DEFINITION OF COMMUNITY CARE SERVICES

- 8.2 *Community care services* is the generic legal term used to describe the range of care and support that can be provided to service users.¹ Once a local authority has undertaken an assessment and concluded that a person has needs that call for the provision of community care services, then the authority must make arrangements for those services to be provided. This Part considers how the statute should define those services.
- 8.3 At consultation, our use of the phrase *community care services* was criticised by some consultees as outdated and out of kilter with the policy of personalisation. As noted in Part 5 (Assessments) in relation to the phrase *community care assessments*, we recognise that the language in legislation should be updated, where appropriate, to reflect the modern approach and goals of adult social care. However, we have continued to use the phrase *community care services* in this report in order to reference the services defined in section 46(3) of the NHS and Community Care Act 1990. We do so without prejudice to the renaming of *community care services* in any legislation following our report.
- 8.4 Community care services are defined by reference to various lists of services which appear in different statutes and/or in approvals and directions. The consultation paper proposed that these lists should be consolidated into a short and broad list of community care services which would be set out on the face of the statute; arguing that this would allow the definition of community care services to evolve and remain up-to-date, whilst also maintaining some degree of clarity and certainty. The consultation paper put forward the following list:
- (1) residential accommodation;
 - (2) assistance and facilities in the home;
 - (3) social work service and support and advice;

¹ The NHS and Community Care Act 1990, s 46 (3) defines "community care services" as services provided or arranged by a local authority under the National Assistance Act 1948, part 3; Health Services and Public Health Act 1968, s 45; NHS Act 2006, s 254 and sch 20; the NHS (Wales) Act 2006, s 192 and sch 15; and Mental Health Act 1983, s 117.

- (4) centres or other facilities in the community; and
- (5) social, leisure, communication, education and training activities.²

Consultation responses

- 8.5 The definition of community care services produced a range of views at consultation.³ A majority of responses to this proposal not only agreed that setting out a short and broad list in statute law was the correct approach, but also supported the list proposed. It was argued this provides clarity, while also allowing some degree of flexibility in the provision of services. Some consultees – while agreeing with the proposal – emphasised that the list must be indicative rather than exhaustive so as not to hinder innovation. Others suggested specific amendments to the list, such as the inclusion of advocacy and transport services.
- 8.6 However, support for a short and broad list of community care services was not universal. Some consultees criticised our proposal on the basis that it perpetuates a service-led rather than outcome-led approach to care and support, and may restrict creative support planning. They also suggested that it would be difficult to future-proof any list of services.
- 8.7 Several consultees put forward an alternative approach, based on outcomes rather than services. Under this approach, the appropriate services that can be provided would be those that most effectively and efficiently achieve the desired outcomes listed in the statute. This approach is intended to encourage greater flexibility on the part of commissioners and providers to meet need and it was argued, would result in a more effective and efficient use of public resources.
- 8.8 A small number of consultees argued that community care services should be left undefined in statute law.⁴ It was suggested, for example, that any list could too easily become outdated and that leaving services undefined would be more consistent with personalisation and the increasing allocation of personal budgets. However, other consultees argued this approach would produce confusion and increased litigation over what constitutes a community care service.

Discussion

- 8.9 Consultation has persuaded us to reconsider our approach to defining community care services, both in terms of our approach to the definition (whether it be through a list of services or outcomes, for example) and the content.

Our approach to the definition

- 8.10 We have considered and rejected the option of leaving community care services undefined. In our view there are advantages to having some form of list (whether of services or outcomes) in the statute because it does at least give some indication about the range of services that can be provided. This leaves the broad and general list of services and the list of outcomes.

² Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 9.2 to 9.24.

³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) pp 165 and 173.

⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 175.

- 8.11 A strong argument in favour of the list of services is that it would provide clarity and certainty. Furthermore, this was the option favoured at consultation; in particular, many disability groups viewed the existing statutory lists of services as a valued aspect of community care law, particularly the list in section 2(1) of the Chronically Sick and Disabled Persons Act 1970.
- 8.12 Opponents of the list of services argued this would restrict unnecessarily the range of services that can be provided, thereby undermining the policy of personalisation. However, this criticism is not entirely valid. The proposed list contains general and broad categories of services that can be used to justify the provision of a wide range of services, including *non-traditional* social care services. Furthermore, these categories are capable of reflecting current and future developments in the types of services that can be provided and so are less likely to become outdated. Arguably, a more valid criticism of our proposal is that it fails to serve any useful legal purpose and, in particular, it fails to delineate effectively the types of services that can be provided. But the general point still stands that outcomes as opposed to listed services are more in keeping with the policy of personalisation and self-directed support.
- 8.13 There are two main difficulties with an outcome-based approach. First, outcomes are often insufficiently precise to be capable of operating effectively in legislation. Indeed, this was apparent with many of the outcomes proposed at consultation such as personal identity, autonomy, self-determination and dignity. Second, there would be a difficult relationship between a list of outcomes and the eligibility framework. The current eligibility framework helps to clarify, to some extent, the outcomes that must be achieved by the provision of services. For example, if a person has eligible needs that are categorised under the *Prioritising Need* statutory guidance as preventing them from carrying out “the majority of personal care or domestic routines”, the purpose of the services provided must be to ensure that the person is able to carry out these routines.⁵ Thus, the framework has already identified the outcome that the service should achieve and it is not clear what is added to this process by referring to a separate list of outcomes.
- 8.14 However, the same criticism could also be directed at the proposed list of services. For example, if a person has eligible needs that are categorised under the eligibility framework as preventing them from carrying out *the majority of personal care or domestic routines*, then the list of services merely confirms that assistance in the home can be provided. In effect, the framework has already identified the general category of service that must be provided and it is not clear what is added to this process by referring to a separate list of services.
- 8.15 In our view, both the list of services and an outcomes-based approach have their advantages and disadvantages, and neither stands out clearly from the other. Therefore, we have considered an alternative option of a hybrid definition which incorporates elements of both approaches. This is the approach taken in the Government of Wales Act 2006. Although used for a very different purpose, we have found the definition helpful. It defines “social care services” as:

⁵ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) p 21.

Any of the following provided in connection with the well-being of any person: residential or non-residential care services; information, advice, counselling or advocacy services; financial or any other assistance.

8.16 The term “well-being” is then defined, in relation to individuals, as meaning well-being so far as relating to any of the following:

- (1) health and emotional well-being;
- (2) protection from harm and neglect;
- (3) education, training and recreation;
- (4) the contribution made by them to society;
- (5) social and economic well-being; and
- (6) securing their rights.⁶

8.17 In our view, this approach has clear advantages. It retains the relative clarity of a list of services, allows for future developments in service provision and is in keeping with the policy of personalisation. This approach is also less open to the criticism of being *service-led*, since it establishes a balance between services *and* outcomes.

8.18 Moreover, a list of outcomes based on the concept of well-being does have advantages for our overall scheme. In Part 4 (Statutory Principles), we recommend the introduction of a single overarching principle that adult social care must promote or contribute to the well-being of the individual. Therefore, the inclusion of a list of outcomes to which the well-being principle must be directed would help assist decision makers in applying this principle.

8.19 We have, therefore, concluded that the statute should include a hybrid definition of community care services. This raises the more important question of which services and outcomes should be included in the definition.

The content of the definition

8.20 Consultation has persuaded us that the list of services in our hybrid definition must be as clear and straightforward as possible and include the minimum number of categories. Given the range of services that can be provided by social services authorities, including personalised services and self-directed support, we also consider that our list should be illustrative and non-exhaustive through the inclusion of the catch-all category *any other form of assistance*.

8.21 It is important that the list of services should include a separate category for residential accommodation. Not only is residential care still a major aspect of

⁶ Government of Wales Act 2006, sch 5, part 1, field 15, matter 15.9.

adult social care,⁷ but in law some distinction is necessary between residential and non-residential services because different rules apply on this basis; for example, for the purposes of ordinary residence, charging for services, direct payments and the division between social care and other areas of law. Most of these rules would continue under our scheme. We agree that the law must be clear that residential care includes ordinary housing, as well as registered care homes and other forms of supported living; however, we consider this should be clarified in the code of practice, rather than in statute law.

8.22 In the consultation paper, we proposed that the list of services should include *social, leisure, communication, education and training activities*. In our view, it is vital that this category should be maintained in our scheme. Amongst other matters, it emphasises the Article 8 rights of disabled people to participate in the life of the community and to have “access to essential economic and social activities and to an appropriate range of recreational and cultural activities”.⁸ In strict terms, however, *social, leisure, communication, education and training activities* describe outcomes that services must achieve, rather than types of services. In the context of a hybrid definition, this category would be more appropriately provided for in the list of outcomes and not the list of services.

8.23 The consultation paper also proposed that the list of services should include *assistance and facilities in the home, social work service and support and advice, and centres or other facilities in the community*. On consultation, it was argued that these fail to describe adequately the range of services that can be provided in the community. We have also considered the categories of community services set out in the Government of Wales Act 2006: non-residential care services; advice, counselling or advocacy services; financial or any other assistance. These categories have the advantage of being relatively clear and straightforward and incorporating a broad range of services. However, we are concerned that the key concept of *non-residential care services* fails to emphasise sufficiently the vital importance of access to the community and to community services and activities for service users. Furthermore, any definition of social care services must include reference to social work services. Our recommended list below has been formulated to reflect these points.

8.24 The list of outcomes in the Government of Wales Act 2006 provides a useful starting point in considering how the purpose of well-being should be identified in our scheme. First, we agree that well-being must include health and emotional well-being. It is important that service provision should aim to secure both physical health (for example, through gym membership or a commode) and mental health (for example, through counselling). Second, it is vital that adult social care services can be provided where necessary in order to protect people from harm and neglect. For example, local authorities may need to apply for appointeeship under social security legislation or deputyship under the Mental Capacity Act 2005 where a service user is being financially abused. Third, as

⁷ In 2009-10, there were 225,600 people in residential and nursing care in England. See Information Centre, *Community Care Statistics: Social Services Activity, England 2009-10 (Initial Release)* (2011).

⁸ *R (A) v East Sussex County Council* [2003] EWHC 167 (Admin), (2003) 6 CCLR 194 at [99] by Munby LJ (when he was a High Court judge).

noted above, adult social care services have an important role to play in addressing peoples' *education, training and recreation needs*, for example by providing a day centre or funding to attend evening courses or football matches. Fourth, it is important that adult social care services should help service users to take part in society, for example through the provision of communicator guides for deafblind people and providing assistance with transport. Fifth, we agree that well-being should include securing a person's rights and entitlements. Relevant services might include, for example, welfare benefit advice, advocacy or securing legal advice. Finally, we are not persuaded it is necessary to include a specific outcome in the list based on social and economic well-being. This outcome, in our view, is not sufficiently precise and adds little to the other outcomes.

Recommendation 28: *Community care services* (however named) should be defined in the statute as any of the following provided in accordance with the well-being principle:

- (1) residential accommodation;**
- (2) community and home-based services;**
- (3) advice, social work, counselling and advocacy services; or**
- (4) financial or any other assistance.**

The statute should set out the following list of outcomes to which the well-being principle must be directed:

- (1) health and emotional well-being;**
- (2) protection from harm;**
- (3) education, training and recreation;**
- (4) the contribution made to society; and**
- (5) securing rights and entitlements.**

THE DEFINITION OF CARERS' SERVICES

8.25 Adult social care legislation does not define the types of services that can be provided to carers. Instead, local authorities are given discretion to provide any services that it "sees fit to provide" and that will "in the local authority's view help the carer care for the person cared for".⁹ However, the legislation does include a strong emphasis on services that would assist a carer to take part in employment, education, training or leisure activities, as a result of the amendments to the Carers and Disabled Children Act 2000 made by the Carers (Equal

⁹ Carers and Disabled Children Act 2000, s 2(2).

Opportunities) Act 2004.¹⁰ The consultation paper proposed that carers' services should continue to be undefined in legislation.¹¹

Consultation responses

- 8.26 A majority of those who expressed a view agreed with this proposal.¹² Most consultees argued that leaving carers' services undefined would give local authorities the necessary flexibility to meet a wide range of needs and would encourage a creative approach to service provision. However, others argued that there should be consistency between our approach to defining carers' services and our approach to defining community care services. In effect, a broad definition of carers' services should be set out on the face of the statute.

Discussion

- 8.27 Adult social care law adopts an inconsistent approach to the definition of carers' services and community care services; whereas carers' services are undefined, community care services are defined through lists of services. It is not entirely clear why the law has developed in this way, and we have considered whether our scheme should maintain this approach or impose consistency.
- 8.28 At consultation, it was argued that carers' services should be defined in a different way to community care services because the focus of a carer's assessment is primarily on the sustainability of the caring role and often the outcome of the assessment will be the provision of services to the cared-for person. In effect, carers' services must be undefined to allow for a greater degree of flexibility and enable services to be provided to the cared-for person. However, it would still be possible to retain this flexibility if there were a list of carers' services and outcomes; it would be relatively easy to build into the list categories of services or outcomes that are relevant to the cared-for person or to cross refer to the definition of community care services.
- 8.29 Others argued that in contrast to service users, there is no duty to provide carers' services and therefore no need for a statutory definition. However, it does not follow automatically that a duty to provide a service means that the service must be defined; for example, the enforceable duty under section 117 of the Mental Health Act 1983 to provide after-care services is not accompanied by a list of services or further definition. Moreover, under our scheme there would be a mandatory eligibility framework for carers' services which, according to this argument, would strengthen the case for a definition of carers' services.¹³
- 8.30 In our view, there are compelling arguments for a consistent approach to the definition of carers' services and the definition of community care services. Not only would this ensure clarity and certainty but the use of such a list would

¹⁰ Carers and Disabled Children Act 2000, s 1 (3A). This section provides that assessments must consider whether the carer works or wishes to work, and is undertaking, or wishes to undertake, education, training or any leisure activity.

¹¹ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 9.52 to 9.53.

¹² See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 184.

¹³ The eligibility framework for carers' services is discussed in Part 7 (Carers' Assessments and Eligibility).

encourage a broader assessment of carers' needs than is currently the case. In effect, it would underline the fact that, as well as considering the caring role, support can be provided to meet a broad range of needs and outcomes. Furthermore, there are no strong reasons for maintaining a different approach.

- 8.31 We therefore consider that in our scheme, carers' services should be defined by reference to a list of services and outcomes similar to the list recommended for service users, or the same list of services and outcomes could be used for service users and carers. In our view, the list that we recommend for service users would not need to be adjusted to apply to carers. In particular, it includes reference to *employment, training and recreation*, which replicates the amendments to carers' legislation introduced by the Carers (Equal Opportunities) Act 2004.

Recommendation 29: Carers' services should be defined in the statute through reference to the same list of services and outcomes that we recommend for service users.

CARE AND SUPPORT PLANS

- 8.32 Care and support plans are produced at the end of the assessment process for the purpose of recording a person's assessed and eligible needs and detailing how a local authority plans to meet those needs.
- 8.33 During consultation, our use of the phrase *care plans* in the consultation paper was criticised by some consultees as outdated and out of kilter with the policy of personalisation. As noted above, we recognise that the language in legislation should be updated, where appropriate, to reflect the modern approach and goals of adult social care. In this Part of the report, for convenience we use *care and support plans* and *plans*. We do so without prejudice to the renaming of these plans in any legislation following our report.

The duty to provide a care and support plan

- 8.34 The consultation paper proposed that the statute should place a duty on local authorities to produce a plan for people who have been assessed as having eligible needs. This, it was argued, would improve the clarity of law since there is currently no statutory reference to care and support plans and the requirement to produce one must be discerned through reference to a range of statutory and practice guidance. Furthermore, it would underline the importance of such a plan within the community care process.
- 8.35 The consultation paper also proposed that the duty to produce a plan should be supported by a duty on the Secretary of State and Welsh Ministers to make regulations concerning the form and content that the plan must take.¹⁴

¹⁴ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 10.2 to 10.5.

Consultation responses

- 8.36 The overwhelming majority of responses to the proposal supported a statutory duty to produce a care and support plan.¹⁵ Some reported that currently plans are often inadequate or there is a failure to produce one at all, and welcomed a statutory duty on the basis that it would ensure a more consistent approach. Some participants at consultation events argued that our proposal should go further and require local authorities to produce a plan for self-funders and people assessed as falling below the eligibility criteria.
- 8.37 Some consultees argued that our proposal failed to recognise sufficiently the importance of co-production between local authorities and service users in developing the care and support plan, and service users should have the right to produce their own plan, should they so wish. A number of carers' organisations queried whether the duty to produce a plan would be extended to carers.
- 8.38 The majority of responses to this proposal also agreed that regulations should prescribe the form and content that the plan must take. Many consultees pointed to the widespread confusion over the current requirements for plans due to the myriad of guidance and argued that our proposal would bring greater clarity and certainty. It was also argued that the various pieces of guidance overlap each other and can give the impression that the form and content of plans is a matter on which local authorities have much flexibility, which leads to varying standards. Regulations specifying the form and content of care and support plans would, it was argued, enable service users to be more certain about what they are entitled to. Several consultees argued that our recommendation should go further and ensure that the *primary legislation* sets out the form and content of plans.

Discussion

- 8.39 Consultation has confirmed our view that statute law should place a duty on local authorities to provide a care and support plan for those individuals with assessed eligible needs. The care and support plan is just as central a feature as the assessment process. The making of regulations would promote legal clarity, encourage a consistent approach to the production of care and support plans and would underline the importance of such plans within the community care process. Moreover, this duty would not place any additional or onerous demands on local authorities since statutory guidance already requires them to produce such a plan.¹⁶
- 8.40 Some consultees argued that this duty should be extended to self-funders. In our view, the law already requires most self-funders with assessed eligible needs to be provided with a plan; the duty to assess arises irrespective of resources and as a general rule an individual's financial circumstances are only relevant following the eligibility decision and to the extent that they must contribute to the

¹⁵ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 203.

¹⁶ For example, see Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 121; NAFWC 09A/2002, *Health and Social Care for Adults*, para 6.22; and Department of Health, *Caring for People: Community Care in the Next Decade and Beyond: Policy Guidance* (1990) para 3.24.

cost of services.¹⁷ Our recommendation will not alter this position; that is, local authorities will continue to be required to produce a plan for self-funders where they have eligible needs. This position should be clarified in the code of practice.

- 8.41 Some consultees argued that our proposed duty should be extended to people who fall below the eligibility criteria. Local authorities currently have a power but not a duty to produce a care and support plan for such people. This position would also be maintained in our scheme. In addition, statutory guidance in England and in Wales provides that if a person is assessed as falling below the eligibility criteria, the council should put the reasons in writing and make a written record of the assessment available to the individual.¹⁸ The extent of the reasons should be proportionate to the extent and depth of the assessment undertaken; it may, for example, be sufficient and adequate to record a contact assessment in brief notes. In other instances, the written record may include a copy of the assessment notes and decision, or a short summary of the reasons. This is an important legal requirement that should be reflected in the statute.
- 8.42 In our view, local authorities currently have the ability in law to co-produce care and support plans or where appropriate to authorise others (for example, service users, carers, health professionals and advocates) to produce the plan, subject to the local authority retaining overall control of the process and ensuring that certain minimum requirements are satisfied, which are discussed below. This position would be retained in our scheme. The code of practice should provide guidance on when it would be appropriate to authorise other individuals or organisations to produce the care and support plan, and what degree of oversight should be provided by the local authority.
- 8.43 This duty would apply to carers who have assessed eligible needs under the eligibility framework that we recommend in Part 7 (Carers' Assessments and Eligibility).
- 8.44 Strong arguments were made at consultation for placing the form and detail of the care and support plans in regulations. In particular, it would improve legal clarity and consistency and enable service users to be more certain about what they can expect their plan to contain. Consistent with the approach set out in Part 3 (Structure of Reform), we consider that statute law should require the Secretary of State and Welsh Ministers to make regulations prescribing the form and content of care and support plans, because the effective operation our scheme depends on such regulations being issued.

¹⁷ However, there are exceptions, for example the provision of residential care (*R v Sefton Metropolitan Borough Council ex p Help the Aged* (1997-98) 1 CCLR 57) and where the person is in receipt of a disabled facilities grant (*R (Spink) v Wandsworth London Borough Council* [2005] EWCA Civ 302, [2005] 1 WLR 2884).

¹⁸ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 106; NAFWC 09A/2002, *Health and Social Care for Adults*, paras 5.38 and 2.57.

Recommendation 30: The statute should place a duty on a local authority to ensure the production of a care and support plan for people with assessed eligible needs (including carers). If a person falls below the eligibility criteria, then the authority should be required to put the reasons for that decision in writing and make a written record of the assessment available to the individual.

The code of practice should provide guidance on when it would be appropriate for local authorities to authorise others to produce the plan and what degree of oversight should be provided by the local authority, and clarify that self-funders with assessed eligible needs have a right to a care and support plan.

Recommendation 31: The statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the form and content of care and support plans.

The content of the care and support plan

- 8.45 The consultation paper made no proposals on the content or form of care and support plans but asked whether statutory plans in other areas of law – such as pathways plans in the Children Act 1989 and statements of special educational needs in the Education Act 1996 – provide a useful model for adult social care legislation.

Consultation responses

- 8.46 Few written responses expressed views about the content of care and support plans.¹⁹ Participants at consultation events suggested that it was important to include certain factual details such as a list of assessed needs and the name of the key worker. Others argued that the prescribed form of plans should be flexible to accommodate different situations; for example, where direct payments are being provided it will be important for the plan to set out agreed expectations on what may or may not be purchased. It was also suggested that there should be a defined review time and some explanation of how a person's personal budget and/or direct payment has been calculated.
- 8.47 Several responses focused on the way care and support plans should be produced. For many consultees, co-production was seen as central to developing plans which are tailored to the individual. Multi-agency working was also seen as essentially an extension of co-production to include all relevant agencies which may have an impact on a service user's care.

Discussion

- 8.48 On consultation, there was widespread confusion about the existing legal requirements for care and support plans. Part of the difficulty is that the form and content that plans must take are set out across a range of guidance and policy

¹⁹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) paras 10.24 to 10.26.

documents and in case law. In our view, it is established in law that the plan must be in writing, and should include:

- (1) a summary of assessed needs;
- (2) the identification of eligible needs and supporting reasons for the decision;
- (3) any unmet needs;
- (4) a clear explanation of how any personal budget has been calculated;
- (5) the care and support that is being provided or arranged to meet the eligible needs;
- (6) (in the case of a service user's care and support plan) any support which carers and others are willing and able to provide;
- (7) (in the case of a service user's care and support plan) support to be provided to address needs identified through the carer's assessment, where appropriate;
- (8) any financial contributions the individual is assessed to pay;
- (9) contingency plans and emergency contact details;
- (10) monitoring arrangements and review date;
- (11) a note indicating if the person has agreed its content and in instances where this is not possible, a record of the reason why;
- (12) a note on whether or not the service user has consented for the plan to be shared among relevant agencies and a reason where this was not possible;
- (13) the name of the person responsible for co-ordinating the plan and details of other professionals involved;
- (14) a list of people who have a copy of the plan;
- (15) copies of any other separate assessments such as a nursing plan, manual handling assessment and risk assessment;
- (16) any restrictions or deprivations of liberty imposed by the plan; and

- (17) an assessment of the person's capacity to consent to the actions covered by the plan, and confirmation that those actions are agreed to be in the person's best interests.²⁰
- 8.49 Furthermore, the Welfare Reform Act 2009 has established pilot schemes in England – known as the *Right to Control* – whereby a disabled person can draw together different funding streams (including community care funding) to establish a single care and support plan for all the resources for which they qualify.²¹ The regulations impose various duties upon the responsible authorities including developing a support plan and providing services in accordance with that plan.²²
- 8.50 While it is important to ensure that the care and support plan regulations in our scheme place clear requirements on professionals, in order to be workable the regulations should not be overly prescriptive and must ensure flexibility and proportionality in the care planning process. Moreover, it is important that our recommendations do not undermine the development of policy in this area such as the *Right to Control*. In our view, the current minimum legal requirements for the contents of a care and support plan can be distilled into a smaller number of *key* elements which must form the basis of the regulations. We set out our recommended list below.
- 8.51 We also suggest that the Government and Welsh Assembly Government consider making regulations on some of the other legal requirements, listed above. As a minimum, the code of practice should provide concrete examples of these requirements.
- 8.52 On consultation, there was widespread concern about the proliferation of multiple care and support plan regimes for different service user groups. In our view, it is important that the law should not require professionals to produce multiple plans for the same individual under different regimes (for example, community care law, the Care Programme Approach and the Single Assessment Process). We, therefore, recommend that our scheme should enable the production of a single plan across the different regimes. The need to link the various different assessment regimes is discussed in more detail in Part 5 (Assessments).
- 8.53 We recognise the particular concern that service users are involved and, as far as possible, are able to take ownership of the care and support plan. In our view, this involvement would be encouraged in a number of ways. We recommend in Part 4 (Statutory Principles) the introduction of statutory principles which would

²⁰ See Department of Health, *Prioritising Need in the Context of Putting People First* (2010) paras 119 to 126; NAFWC 09A/2002, *Health and Social Care for Adults*, para 6.22; Department of Health, *Caring for People: Community Care in the Next Decade and Beyond: Policy Guidance* (1990) para 3.24 to 3.26; *R (Savva) v Royal Borough of Kensington and Chelsea* [2010] EWCA Civ 1209; Community Care Assessment Directions 2004; Department of Health, *Single Assessment Process: Guidance for Local Implementation* (2002) annex E; Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 21.4; and Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (2007) para 6.25.

²¹ The other funding streams are the Independent Living Fund, Disabled Facilities Grants, Right to Control for Work Choice, Access to Work and Supporting People.

²² The Disabled People's Right to Control (Pilot Scheme) (England) Regulations 2010, SI 2010 No 2862.

apply to the provision of a care and support plan and would require, amongst other matters, that service users should be fully involved wherever appropriate and possible. Second, we recommend above that the code of practice should provide further guidance on when it would be appropriate to authorise other individuals or organisations to produce the care and support plan. On this basis we do not consider that any additional legal provisions are necessary.

Recommendation 32: The care and support plan regulations must:

- (1) require that plans be set out in writing and signed on behalf of the local authority;**
- (2) require that plans include a summary of assessed needs, eligible needs, and outcomes to be achieved;**
- (3) specify where appropriate that plans must include the amount of the personal budget and how this sum has been calculated;**
- (4) require that plans must include a summary of the services that will be provided, whether a direct payment will be provided and any financial contributions;**
- (5) require that plans are reviewed regularly; and**
- (6) specify that a copy of the plan should always be made available to the service user.**

The care and support plan regulations may specify other requirements for the plan, if the Secretary of State or Welsh Ministers wish them to do so.

The code of practice should provide concrete examples of the form and content of care and support plans, addressing both the requirements in the regulations and other legal requirements.

PERSONAL BUDGETS

8.54 A personal budget gives individuals who are eligible for social care services a “single transparent sum allocated to them in their name and held on their behalf, rather like a bank account”. The individual can then choose to take this money out “either in the form of a direct payment in cash, as provision of services, or as a mixture of both cash and services, up to the value of their total budget”.²³

8.55 In England, the previous Government stated that it would introduce personal budgets “for everyone eligible for publicly funded adult social care support other than in circumstances where people require emergency access to provision”.²⁴ The consultation paper raised concerns that despite this policy intention, no changes had been made to the legislative framework in order to accommodate personal budgets, and in some instances, they do not sit easily with the underlying community care legislation.

²³ Our Health, Our Care, Our Say (2006) Cm 6737, para 4.32.

²⁴ HM Government and others, *Putting People First* (2007) p 3.

- 8.56 We argued that the law and personal budgets should be more closely aligned and the existing ambiguity and confusion over how and where personal budgets fit into the current law should be clarified. However, in order to accommodate the different policy position in Wales, where personal budgets have not been introduced, we proposed that the statute should give the Secretary of State and Welsh Ministers powers to make regulations requiring local authorities to allocate personal budgets for people who are eligible for services. This would allow for different policies and approaches in each country.²⁵
- 8.57 Since the publication of the consultation paper, the Coalition Government in England has confirmed its policy intention that local authorities should provide everyone who is eligible (including carers) with a personal budget, preferably as a direct payment, by April 2013.²⁶

Consultation responses

- 8.58 The majority of consultees who expressed a view agreed with the proposal.²⁷ However, some consultees argued that personal budgets are not appropriate for all service users, and had not been sufficiently tested to be put on a statutory footing at this stage. Others raised concerns about the resource allocation systems used to calculate a personal budget, and suggested there is a lack of clarity on whether personal budgets will be allocated to all service users as a matter of course, or whether individuals will be able to choose whether to receive a personal budget, or if some other selection criterion will be used.
- 8.59 The Government supported the proposal but stated that in aiming for an enduring statute it wished to consider further whether “to specify the particular mechanism of a personal budget, or take a broader approach”. The Welsh Assembly Government noted that although it has not adopted the approach to personal budgets that is being introduced in England, “it may be prudent to include these enabling provisions so that Welsh Ministers have such regulation-making powers should they be required in the future”.

Discussion

- 8.60 Consultation has confirmed our view that the legal framework and the policy of personal budgets must be more closely aligned. Although consultees had general concerns about personal budgets and how they work in practice, it is clear that, in England, the Government intends to increase the number of people using personal budgets to purchase their care. On this basis it is essential that personal budgets are recognised in our scheme. To leave this significant policy development without a statutory basis would leave local authorities uncertain of their legal obligations and individuals uncertain of their entitlements.
- 8.61 We remain convinced that the Secretary of State and Welsh Ministers should have a *power* and not a *duty* to make regulations on personal budgets. This would give, for example, the Welsh Assembly Government flexibility to alter its

²⁵ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 6.31 to 6.47.

²⁶ Department of Health, *A Vision for Adult Social Care* (2010) para 4.9 and HM Government, *Recognised, Valued and Supported: Next Steps for the Carers Strategy* (2010) p 24.

²⁷ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 129.

approach to personal budgets in the future, if it wished to do so. We accept that it is important to allow each Government to develop, if they wish to do so, new forms of personal budgets in the future; examples might include joint health and social care personal budgets. Therefore, we make no recommendations on the precise form that personal budgets should take. However, if regulations are made, then we would expect that they should, as a minimum, provide clarity about who is eligible for a personal budget, whether individuals can refuse a personal budget and any other situations where personal budgets should not be allocated.

Recommendation 33: A regulation-making power should be introduced to enable the Secretary of State and Welsh Ministers to require local authorities to allocate a personal budget to service users and carers. The regulations, if made, must prescribe who is eligible for a personal budget and the circumstances in which budgets should not be allocated.

DIRECT PAYMENTS

- 8.62 Direct payments are monetary payments made by local authorities directly to service users and carers, so that they can purchase the assistance or services that the authority would otherwise provide. They are described in statutory guidance as:

fundamental to achieving the Government's aim of increasing people's independence, choice and control by providing personalised alternatives to the social care services offered by a council with social services responsibilities.²⁸

The legal framework for direct payments

- 8.63 Section 57 of the Health and Social Care Act 2001 gives the Secretary of State and Welsh Ministers a power to make regulations requiring or authorising local authorities to make direct payments to a person, with his or her consent, who has been assessed under section 47 of the NHS and Community Care Act 1990 as being eligible for a service. Where such a person lacks mental capacity to consent to the making of direct payments, then under section 57(1)(1A), the payments can be made to a "suitable person". Carers are also eligible for direct payments where the local authority decides that a service under section 2(2) of the Carers and Disabled Children Act 2000 should be provided.
- 8.64 In England, the regulations require local authorities to make a direct payment if:
- (1) the person appears to be capable of managing a direct payment alone or with assistance;
 - (2) the person is not subject to certain court orders;
 - (3) the direct payment is provided to secure the provision of a community care service within the meaning of section 46(3) of the NHS and

²⁸ Department of Health, *Guidance on Direct Payments* (2009) p 1.

Community Care Act 1990 or a carer's service under section 2 of the Carers and Disabled Children Act 2000; and

- (4) the authority is satisfied that the person's need for the service can be met by securing the provision of it by means of direct payment.²⁹
- 8.65 Under these regulations, the duty to make direct payments extends to most people who are subject to compulsory measures under the Mental Health Act 1983 and there is a power to make direct payments in respect of services which the person is under an obligation to accept as a result of the 1983 Act or certain criminal justice legislation. The equivalent regulations in Wales continue to exclude these groups.³⁰
- 8.66 There are various restrictions placed on the provision of direct payments. For example, direct payments cannot be used to purchase services from any close family members or partners who live with the person, except if the local authority is satisfied that securing the service from such a person is necessary to meet satisfactorily the person's need for that service.³¹ Direct payments also cannot be used to purchase long-term residential accommodation but can be used to purchase short-term stays of not more than a period of four continuous weeks in any period of 12 months.³² Statutory guidance in Wales states that direct payments cannot be used to purchase a service from a local authority.³³ Although the equivalent statutory guidance in England does not cover this point expressly, the guide to receiving direct payments states that direct payments cannot be used to purchase local authority services.³⁴
- 8.67 The consultation paper proposed that our scheme would retain the existing content of the direct payment provisions and would not alter the balance between statute and regulations. In effect, statute law would set out the duty to provide direct payments, but most of the detail would be set out in regulations.³⁵

Consultation responses

- 8.68 The majority of consultees who expressed a view agreed with the proposal.³⁶ However, some argued that our recommendations should go further by establishing a stronger duty to provide direct payments. Others wished to see aspects of the direct payment regulations clarified; for example, that a direct

²⁹ Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009, SI 2009 No 1887.

³⁰ Community Care, Services for Carers and Children's Services (Direct Payments) (Wales) Regulations 2004, WSI 2004 No 1748.

³¹ As above, reg 11 (England) and reg 7 (Wales).

³² As above, reg 13 (England) and reg 8 (Wales).

³³ Welsh Assembly Government, *Direct Payments Guidance: Community Care, Services for Carers and Children's Services (Direct Payments) Guidance Wales* (2004) para 95.

³⁴ Department of Health, *A Guide to Receiving Direct Payments From Your Local Council: A Route to Independent Living* (2009) p 16.

³⁵ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 10.15 to 10.18.

³⁶ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 215.

payment must be sufficient to meet the individual's assessed needs. Finally, a number of consultees argued that the statute should recognise expressly that direct payments may not always be appropriate, either because the service user does not want one or because the provision of a direct payment may put the service user at risk of harm or abuse.

Discussion

- 8.69 We recognise that many consultees argued that our recommendations should go further in altering the content of the regulations. However, our view is that the original provisional proposal was right. The statute should be capable of expressing whatever policy choices are made in respect of direct payments.

Recommendation 34: The direct payments provisions should be retained in their existing form in our scheme.

Should direct payments be extended to cover residential accommodation?

- 8.70 As noted above, direct payments cannot be used to purchase long-term residential accommodation. However, the *choice of accommodation directions* require local authorities to accommodate the person at the place of his or her choice in certain situations (discussed below). The consultation paper argued that the most effective way of securing the policy of choice and control would be to extend direct payments to cover residential accommodation. However, it also recognised that Government policy was opposed to this. We, therefore, asked for further views on the question of whether direct payments should be extended to cover residential accommodation.³⁷

Consultation responses

- 8.71 At consultation events, there were mixed views on whether direct payments should be extended to cover residential accommodation. Most written responses to this question argued that direct payments should be extended in this way and agreed that it would promote choice and control.³⁸ However, a significant number of consultees – including those who agreed – expressed concern that allowing direct payments to be used to purchase residential accommodation would lead to service users using direct payments to be charged higher rates for their accommodation. Some consultees argued that moving into residential care is an option of last resort and direct payments would not be appropriate in such circumstances. Finally, the Government – which had previously been opposed to the extension of direct payments – expressed a more open approach. The Welsh Assembly Government, however, stated that it was opposed to the extension of direct payments to residential accommodation.

Discussion

- 8.72 In our view, there are sound reasons in principle for extending direct payments to cover residential accommodation. It would give some service users greater

³⁷ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 10.6 to 10.12.

³⁸ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 209.

choice and control over the provision of accommodation and would mean they no longer have to rely on their preference being acknowledged and implemented by local authority staff. Although direct payments would not be suitable for all people moving into residential care, in many cases the option of direct payments will be appropriate and we see no reason in principle for excluding people merely on the basis of the type of service being provided.

8.73 Nonetheless, we accept that there are practical questions concerning the economics of care home provision. First, extending direct payments to residential care will alter the current situation in residential care purchasing, because instead of one local authority purchasing residential care, there will be many individuals using their direct payment to purchase their own care. However, we do not consider that this change will have a significant effect in practice. The local authority would still be exercising a high degree of market power in the local market for residential care. It would merely be doing so by different means. Rather than a centrally negotiated contract with the supplier (or a series of spot contracts), it would be setting a cap on the basis of the residential care direct payments it authorised. Indeed, it is arguable that, as a mechanism to control price, a cap on payments to individuals may be more efficient, in that it could remove the considerable transaction costs on both local authority and supplier in negotiating and supervising block contracts.

8.74 Second, there may be a risk that the price of residential accommodation may go up if there is a greater risk of default in the direct payment system. This risk may arise if people routinely use their direct payment for an unauthorised purpose rather than using it to pay their residential care costs. We take the view that there is a very low risk of this happening. Direct payments have been in place for non-residential care services for over 15 years, and we are not aware of mis-spending being a significant problem in practice. Furthermore, there are several ways in which local authorities can control the use, and rectify the misuse, of direct payments; including suspending direct payments, recovering payments made and reverting to directly provided services. Therefore, the danger is not likely to be a significant one, but cannot be wholly discounted.

8.75 We have discussed this issue with residential care providers and have taken advice from economists. Based on the information and advice we have received, we are satisfied that it is likely that the extension of direct payments would have neutral or positive resource implications (that is, not allowing prices for residential care to rise). However, further safeguards could be provided if necessary, such as allowing local authorities to provide a list of approved providers of residential care which could be brought to the attention of the service user (although they would not be obliged only to contract with providers from this list) which may in practice limit the use of direct payments to a list of providers, thus providing some further level of control on prices.³⁹

Recommendation 35: Direct payments should be extended to cover residential accommodation.

³⁹ See Department of Health, *Guidance on Direct Payments* (2009) pp 32 and 33 and Welsh Assembly Government, *Direct Payments Guidance: Community Care, Services for Carers and Children's Services (Direct Payments) Guidance Wales* (2004) paras 65 and 66.

CHOICE OF ACCOMMODATION DIRECTIONS

8.76 As noted above, when a local authority has decided that residential accommodation should be provided under section 21(1) of the National Assistance Act 1948, the *choice of accommodation directions* require the authority to accommodate that person at the place of their choice within England and Wales.⁴⁰ This duty applies provided that:

- (1) the accommodation is suitable in relation to the person's assessed needs;
- (2) to do so would not cost the authority more than what it would usually expect to pay for accommodation for someone with the individual's assessed needs;
- (3) the accommodation is available; and
- (4) the person in charge of the accommodation is willing to provide accommodation, subject to the council's usual terms and conditions.⁴¹

8.77 Where a resident chooses accommodation that is more expensive than the local authority would usually expect to pay, the *additional payments regulations* allow for the resident to be placed in the more expensive accommodation, provided that a third party, such as a relative or friend, is able and willing to top-up the difference.⁴² Residents who are subject to the 12 week property disregard⁴³ or have entered into a deferred payments agreement⁴⁴ may make top-ups from specified resources on their own behalf.⁴⁵

8.78 The consultation paper proposed that the *choice of accommodation directions* should be placed in primary legislation. It was argued this would reflect the importance of the directions within community care law and be consistent with the

⁴⁰ National Assistance Act 1948 (Choice of Accommodation) Directions 1992 and in Wales, the National Assistance Act 1948 (Choice of Accommodation) Directions 1993.

⁴¹ As above, para 3 (England) and para 3 (Wales).

⁴² National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Amendment) (England) Regulations 2001, SI 2001 No 3441 and the National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Wales) Regulations 2003, WSI 2003 No 931. See also LAC(2004)20, *Guidance on National Assistance Act (Choice of Accommodation) Directions 1992*, para 3.2 and NAFWC 46/2004 *Guidance on the National Assistance Act 1948 (Choice of Accommodation) Directions 1993*, para 4.2.

⁴³ The value of a resident's home is disregarded for the first 12 weeks of a permanent admission to a care home.

⁴⁴ 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.

⁴⁵ LAC(2004)20, *Guidance on National Assistance Act (Choice of Accommodation) Directions 1992*, para 3.2 and NAFWC 46/2004 *Guidance on the National Assistance Act 1948 (Choice of Accommodation) Directions 1993*, para 4.2.

approach that has been adopted for direct payments. We also proposed that the *additional payments regulations* should be retained in secondary legislation.⁴⁶

Consultation responses

- 8.79 An overwhelming majority of consultees who expressed a view agreed with the proposal.⁴⁷ It was argued there is widespread uncertainty over the existence and status of the directions, and that placing them in statute would give them additional prominence and ensure they are not ignored by local authorities. On the other hand some consultees, including the Government and Welsh Assembly Government, disagreed on the basis that placing the directions in statute law might make them too inflexible and restrict the ability to amend them.
- 8.80 Several consultees raised concerns about the requirement in the directions that preferred accommodation can only be provided if to do so would not cost the local authority more than what it would usually expect to pay for accommodation for someone with the individual's assessed needs. It was suggested this allows local authorities to use blanket cost figures that are not referable to the person's individual needs or real market costs. Others argued that it should be clarified that the provisions apply to non-registered housing. Few consultees made specific reference to the *additional payments regulations* but those who did were positive.

Discussion

- 8.81 Consultation has confirmed our view that the choice of accommodation provisions are an important aspect of community care law and should be given a statutory basis. As we argue in Part 3 (Structure of Reform), the use of directions adds to the complexity of the law by establishing parallel systems of legal entitlement and we recommend that they should not be used in our scheme. We accept, however, that the choice of accommodation provisions should not become too inflexible. This would be avoided by setting out in regulations the detail of when this duty would apply and the additional payments provisions. In effect, the statute would give the Secretary of State and Welsh Ministers a power to make regulations requiring or authorising local authorities to accommodate a person at the place of his or her choice, and the circumstances in which this applies, as well as the existing provisions on additional payments. As noted above, this is the same approach that is taken to the direct payments provisions.
- 8.82 Two specific concerns about the choice of accommodation directions were raised by consultees. First, it was argued that the directions should be amended to clarify the meaning of *usual cost*. We note that detailed guidance for local authorities is already provided on how to interpret this term and we would expect this to be included in the code of practice issued in our scheme.⁴⁸ Second, there was some confusion over the coverage of the directions. In our view, the directions apply to the provision of registered and unregistered housing, and this

⁴⁶ Adult Social Care (2010) Law Commission Consultation Paper No 192, para 10.14.

⁴⁷ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 212.

⁴⁸ LAC(2004)20, *Guidance on National Assistance Act (Choice of Accommodation) Directions 1992*, paras 2.5.4 to 2.5.8 and NAFWC 46/2004 *Guidance on the National Assistance Act 1948 (Choice of Accommodation) Directions 1993*, paras 4.1 to 4.14.

position would be maintained under our scheme. Part of the confusion may arise from the fact that the detail of the accompanying guidance applies to registered care homes only.⁴⁹ We suggest that the coverage of the choice of accommodation provisions should be explained clearly in the code of practice.

Recommendation 36: A regulation-making power should be introduced to enable the Secretary of State and Welsh Ministers to require or authorise local authorities to accommodate a person at the place of their choice within England and Wales and to allow for the making of additional payments.

CHARGING FOR SERVICES

- 8.83 Section 22 of the National Assistance Act 1948 places a duty on local authorities to recover payments from a person provided with residential accommodation under the 1948 Act. It also provides that, if a person is unable to pay the full cost, the authority must assess the resident's ability to pay and determine what lower rate should be paid, and that every resident must be allowed to retain a weekly allowance. If temporary accommodation is being provided for less than eight weeks the local authority has the discretion to limit such charges.
- 8.84 Unlike with residential accommodation, local authorities are not under a duty to charge for non-residential services (including carers' services). Section 17 of the Health Services and Social Security Adjudications Act 1983 provides that a local authority in England providing such services "may recover such charge (if any) for it as they consider reasonable". Furthermore, regulations establish that direct payments can be paid as a gross or net payment. When the local authority makes a gross payment it can subsequently seek reimbursement of the assessed charge. Any charge must be an amount that is reasonably practicable for the service user to pay (subject to a means test).⁵⁰ Statutory guidance published by the Department of Health sets out how to calculate a service user's contribution to their personal budget.⁵¹ In Wales, the Social Care Charges (Wales) Measure 2010 provides that local authorities may charge for non-residential services "any such amount as it considers reasonable".⁵² However, it also sets out provisions governing maximum charges, about persons and services in respect of which charges must not be imposed and determinations as to ability to pay.
- 8.85 The consultation paper recognised that the remit of our review does not extend to altering the rules on charging for services and that the vast majority of the detail on charging would continue to be set out in regulations and guidance. We proposed that, in order to cater for any future changes in policy and policy divergence between England and Wales, a regulation-making power should be

⁴⁹ LAC(2004)20, *Guidance on National Assistance Act (Choice of Accommodation) Directions 1992*, para 1.1.

⁵⁰ Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009, SI 2009 No 1887, reg 9(2) and the Community Care, Services for Carers and Children's Services (Direct Payments) (Wales) Regulations 2004, WSI 2004 No 1748, reg 6(2).

⁵¹ Department of Health, *Fairer Contributions Guidance: Calculating an Individual's Contribution to their Personal Budget* (2010).

⁵² Social Care Charges (Wales) Measure 2010, s 1(2).

introduced to enable the Secretary of State and the Welsh Ministers to require or authorise local authorities to charge for residential and non-residential services.⁵³

Consultation responses

- 8.86 A majority of consultees who expressed a view agreed with the proposal.⁵⁴ Many argued, for example, that a regulation-making power would give greater flexibility and avoid the need for primary legislation if both Governments wish to change the charging rules in the future. However, some consultees expressed a concern that this proposal could *require* local authorities to charge for non-residential services, which would amount to altering the charging rules.

Discussion

- 8.87 In our view, a regulation-making power should be included in the statute to enable the Secretary of State and the Welsh Ministers to require or authorise local authorities to charge for residential and non-residential services. It is also important that this power is sufficiently flexible to enable the introduction of a charging framework for services, such as that established currently in Wales.
- 8.88 We recognise that many consultees are opposed to the introduction of any requirement to charge for non-residential services. Our recommendation is made on the basis that the existing legal position would continue to apply and that any change would be subject to full public consultation and Parliamentary scrutiny. However, the decision to alter the charging rules would be, as it is now, a matter for the Government and the Welsh Assembly Government.

Recommendation 37: A regulation-making power should be introduced to enable the Secretary of State and the Welsh Ministers to require or authorise local authorities to charge for residential and non-residential services, or to establish a charging framework for services.

SERVICES THAT MUST BE PROVIDED FREE OF CHARGE

- 8.89 Section 15 of the Community Care (Delayed Discharge) Act 2003 gives the Secretary of State the power to make regulations to require that certain services must be provided free of charge.⁵⁵ The regulations in England provide that “intermediate care” and “community equipment (aids and minor adaptations) services” must be provided free of charge.⁵⁶ Elsewhere, the law provides that local authorities in England and Wales cannot charge for non-residential services

⁵³ Adult Social Care (2010) Law Commission Consultation Paper No 192, para 10.19 to 10.23.

⁵⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 218.

⁵⁵ This Act has not been implemented in Wales, although s 16 provides for similar regulation-making powers for the National Assembly for Wales.

⁵⁶ Community Care (Delayed Discharge etc) Act (Qualifying Services) (England) Regulations 2003, SI 2003 No 1196.

to people with Creutzfeldt Jacob Disease;⁵⁷ advice about services or an assessment,⁵⁸ and after-care under section 117 of the Mental Health Act 1983.⁵⁹

- 8.90 While recognising that it is beyond our remit to extend the current services that can be provided free of charge, the consultation paper stated that as a minimum our scheme would not remove any of the current exemptions that apply to charging. We, therefore, proposed that the existing regulation-making power, which enables services to be provided free of charge, should be maintained in our scheme. We also proposed that, in order to promote legal clarity, all free services should be included in the regulations.⁶⁰

Consultation responses

- 8.91 The overwhelming majority of those who expressed a view agreed with this proposal.⁶¹ However, some consultees expressed concern that this proposal could lead to local authorities adopting an overly cautious approach whereby they charged for everything that was not specified in the regulations. It was therefore suggested that our scheme should specify that local authorities do not necessarily have to charge for all other services.

Discussion

- 8.92 The existing regulation-making power, which enables services to be provided free of charge, should be maintained in our scheme. Furthermore, all free services should be included in the regulations. In our view, it is not necessary to specify that local authorities can provide other services free of charge, where they have discretion to make this decision. This would be clear in the wording of the charging provision, whereby local authorities would be given a power – rather than a duty – to charge for certain services.

Recommendation 38: The existing regulation-making power, which enables services to be provided free of charge, should be maintained in our scheme. As a minimum the current services that must be provided free of charge should be included in the regulations.

⁵⁷ Department of Health, *Fairer Charging Policies for Home Care and Other Non-Residential Social Services* (2003) para 75 and Welsh Assembly Government, *Fairer Charging Policies for Home Care and Other Non-Residential Social Services* (2002) para 63.

⁵⁸ As above, para 8 (England) and para 10 (Wales).

⁵⁹ *R (Stennett) v Manchester City Council* [2002] UKHL 34, [2002] 2 AC 1127.

⁶⁰ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 10.24 to 10.25.

⁶¹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 221.

PART 9

ADULT PROTECTION

INTRODUCTION

- 9.1 The existing legal framework for adult protection is “neither systematic nor co-ordinated, reflecting the sporadic development of safeguarding policy over the last 25 years”.¹ Unlike in Scotland, there is no single or coherent statutory framework for adult protection in England and Wales. Instead, it must be discerned through reference to a wide range of law including general community care legislation and guidance, the Mental Health Act 1983, the Mental Capacity Act 2005, the Safeguarding Vulnerable Groups Act 2006, the inherent jurisdiction of the High Court, and the civil and criminal justice systems.² Whilst the remit of our review does not extend to all of this legislation, it does include local authority safeguarding powers and duties.
- 9.2 Several consultees made an important distinction between *safeguarding* and *adult protection*. Whilst *safeguarding* relates to the prevention of abuse and has a broad focus that extends to all aspects of a person’s general welfare, *adult protection* refers to investigation and intervention where it is suspected that abuse may have occurred. Safeguarding, considered in this context, is properly part of the general approach to be taken to assessment and the delivery of services. In this Part, however, we consider the legal framework for adult protection, rather than safeguarding. Specifically it considers the duty to investigate; the definition of an adult at risk; compulsory and emergency powers; section 47 of the National Assistance Act 1948; the duty to protect property; adult safeguarding boards; duties to co-operate; the legal basis of *No Secrets* and *In Safe Hands*; and other issues raised at consultation.

A DUTY TO INVESTIGATE ADULT PROTECTION CASES

- 9.3 There is currently no express statutory duty on local authorities to investigate cases where service users or others are at risk of harm. The consultation paper argued that, nonetheless, in certain circumstances local authorities are placed under a legal duty to investigate actual or potential adult protection cases and that this duty arises from four primary sources:
- (1) the duty to assess under section 47 of the NHS and Community Care Act 1990 and provide services under community care legislation;
 - (2) local authority statutory powers to take or initiate compulsory action under section 47 of the National Assistance Act 1948, the Mental Health Act 1983 and the Mental Capacity Act 2005;

¹ Commission for Social Care Inspection, *Raising Voices: Views on Safeguarding Adults* (2008) para 2.1.

² See Law Commission, *Adult Social Care: Scoping Report* (2008) paras 4.270 to 4.275 and Appendix B for a more detailed overview.

- (3) the statutory guidance *No Secrets* and *In Safe Hands* which establish social services as the lead co-ordinating agency for safeguarding; and
- (4) public law requirements, including those imposed by the European Convention on Human Rights (ECHR).

9.4 However, we argued that the community care assessment duty, which is the main legal vehicle for investigations, was not framed primarily with adult protection cases in mind, and is often an unsatisfactory mechanism for dealing with them. Therefore, we proposed that the statute should clarify the existing legal position and establish a duty on local authorities to make enquiries and take appropriate action in adult protection cases. Appropriate action could include service provision, monitoring or the use of existing compulsory powers.³

Consultation responses

9.5 A large majority of responses to this proposal agreed with the introduction of an express duty to investigate.⁴ Many argued this would give legitimacy to safeguarding enquiries, encourage a consistent approach nationally, raise the status and profile of adult protection work and most importantly, help to improve outcomes. However, there were some queries and some disagreement about certain aspects of the proposal.

9.6 Many consultees, including those agreeing with the proposal, argued that the proposed duty needed to emphasise more the importance of multi-agency working. In effect, the proposed duty established safeguarding investigations as a local authority function, rather than developing joint safeguarding duties with other statutory bodies. Several adult safeguarding teams pointed out that in their particular region the local authority safeguarding functions had been delegated or were being carried out in partnership with health services under section 75 of the NHS Act 2006 or section 33 of the NHS (Wales) Act 2006. Some consultees developed this point and argued for a separate safeguarding statute which should place joint duties on local authorities, health services and the police to investigate allegations of abuse and neglect and take appropriate action.

9.7 Several consultees commented on the terminology used in the duty to investigate. For example, there was some disagreement whether the term *investigate* or *enquiry* should be used. Others argued that the statute should establish clear timescales for both investigation and intervention.

9.8 A small number of consultees did, however, disagree with the proposal. Some argued that the existing duty to carry out a community care assessment was sufficiently flexible to cover adult protection cases, as well as individuals who are not at risk of harm. Furthermore, the addition of an express duty of investigation might encourage local authorities to approach adult protection as a separate and isolated activity, rather than viewing it as a consequence of a failure to provide services at an early stage. The end result would be resources shunted to adult protection work and away from so-called lower priority cases.

³ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 12.5 to 12.22.

⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 283.

Discussion

- 9.9 There was almost universal agreement at consultation with our view that the existing law places a duty on local authorities to investigate cases of abuse and neglect in certain circumstances. This view was reinforced by the judgment in *A Local Authority v A*, handed down during our consultation, which stated that:

Where the state – here, a local authority – knows or ought to know that a vulnerable child or adult is subject to restrictions on their liberty by a private individual that arguably give rise to a deprivation of liberty, then its positive obligations under Article 5 will be triggered. These will include the duty to investigate, so as to determine whether there is, in fact, a deprivation of liberty.⁵

- 9.10 Some consultees, however, disagreed that the duty to investigate should be expressed as a separate statutory provision, arguing that it was already incorporated adequately within the general duty to assess. In effect, this view suggests that our review should look more towards an expansion in the conception of assessment, for example by including a reference to abuse and neglect in the statement of the duty to assess.
- 9.11 Whilst we recognise that investigation shares much with an assessment, we consider that it is important to maintain it as a separate function. A general assessment duty is not designed to meet the specific demands of some adult protection cases; a view supported by several local authorities and adult safeguarding teams. Enquiries into abuse and neglect often amount to a more formal process than a community care assessment, and may need to focus less on the need for services and more on establishing the facts and validity of the allegations, especially if police inquiries are also taking place. The most common outcome of a safeguarding investigation is not the provision of care and support services but increased monitoring.⁶ Furthermore, an adult protection investigation may need to consider compulsory forms of intervention.
- 9.12 We do, however, recognise the danger that adult protection could become separated from the mainstream provision of care and support and it is, therefore, important to build links between them in the statute. We envisage that the code of practice would set out how the general assessment is integrated with adult protection enquiries. Similar to the *Assessment Framework* guidance under the Children Act 1989, the code of practice should clarify, for example, that a person undergoing a general assessment could become the subject of adult protection enquiries if evidence came to light that they were at risk of abuse or neglect. Conversely an adult protection investigation could easily revert to a general assessment if such allegations are discounted.⁷ Furthermore, as we recommend in Part 4 (Statutory Principles), the well-being principle would require decision-makers to always consider the need to safeguard adults from abuse and neglect

⁵ [2010] EWHC 978 (Fam), (2010) 13 CCLR 404 at [95] by Munby LJ.

⁶ The NHS Information Centre for Health and Social Care, *Abuse of Vulnerable adults in England: October 2009 – March 2010* (2011) and Care and Social Services Inspectorate Wales, *Protection of Vulnerable Adults Monitoring Report 2007-2008* (2009).

⁷ Department of Health, *Framework for the Assessment of Children in Need and their Families* (2000) paras 3.15 to 3.19.

when making any decision or undertaking any action under the statute, including in non-adult protection cases. In our view, this will underline the importance of acting to prevent abuse, as well as the need to investigate and intervene in cases of abuse or neglect.

- 9.13 Consultees put forward strong arguments in favour of a multi-agency approach to safeguarding. We agree that our proposals should not undermine this approach and indeed should go further and promote it. However, the need for a separate multi-agency safeguarding statute, which places new and substantive joint duties on a range of agencies (including local authorities, health services, probation and the police), is beyond the remit of our review. Moreover, we are not persuaded that the introduction of separate legislation would necessarily address all the concerns raised by consultees. In our view, it is important for the law to establish clear responsibilities for adult protection and we are concerned that the introduction of joint multi-agency duties to investigate and take action could lead to blurred accountability for taking action in individual cases.
- 9.14 This is not to argue that our scheme should not encourage a multi-disciplinary approach, but this should be balanced against the need to establish clear responsibilities on each of the main actors concerned. Nonetheless, we do accept the criticisms made of our approach at consultation and agree that many of our proposals need to be revised in order to reflect the importance of a multi-agency approach to adult protection.
- 9.15 First, the statute should provide clearly that local social services authorities have the lead co-ordinating responsibility for safeguarding. This would place strategic responsibility on authorities to ensure that local policies and procedures are in place so that the roles and responsibilities are clear between and within local agencies at different levels – including operational, supervisory line management, senior management, corporate and Chief Officer and Chief Executive. It would also involve ensuring that appropriate multi-agency arrangements are established and maintained, and that a safeguarding strategy is produced in consultation with all relevant organisations. This duty would, therefore, replicate and reinforce the existing social services role set out in *No Secrets* and *In Safe Hands*.⁸ As is currently the case under the NHS Acts 2006 and NHS (Wales) Act 2006, this role could be delegated to health services.⁹
- 9.16 Second, the statute will place a specific duty on social services authorities to investigate, or cause an investigation to take place, in individual cases. This should be worded to ensure that this duty can be discharged through a range of *pathways* or different routes through safeguarding. For example, the social services authority could undertake enquiries themselves, refer the matter to the appropriate agency or initiate a multi-agency investigation. The duty to investigate could also be delegated to the NHS, as is currently the case, under the NHS Act 2006 and the NHS (Wales) Act 2006.¹⁰ The multiplicity of

⁸ Department of Health and Home Office, *No Secrets* (2000) para 3.9 and National Assembly for Wales, *In Safe Hands* (2000) para 5.3. See also Welsh Assembly Government, *Sustainable Social Services for Wales* (2011) para 3.76.

⁹ NHS Act 2006, s 75 and NHS (Wales) Act 2006, s 33.

¹⁰ NHS Act 2006, s 75 and NHS (Wales) Act 2006, s 33.

partnerships that may be required in different safeguarding situations make it difficult to establish strict rules for finding the best way to develop a safeguarding response in each case. However, we would expect the code of practice to provide concrete examples and guidance on this matter.

- 9.17 Finally, these recommendations will be reinforced in the statute by the inclusion of a general duty on agencies to co-operate, and an enhanced duty to co-operate in adult protection cases. These duties are discussed in more detail later in this Part and in Part 11 (Overlap Issues).
- 9.18 Terminology can be important, but in the current context we doubt the significance of the difference between the terms *enquiries* and *investigation*. Parliamentary Counsel will choose the appropriate term. We use the two terms interchangeably.
- 9.19 In addition, some consultees suggested that our scheme should provide clarity over the manner in which an investigation should be undertaken, including timescales for the completion of enquiries. In Part 5 (Assessments) we recommend that the Secretary of State and the Welsh Ministers should be required to make regulations on the community care assessment process. In our view, a similar legal framework should also apply to adult protection investigations. We, therefore, recommend that the statute should place a duty on the Secretary of State and the Welsh Ministers to prescribe the process for adult protection investigations in regulations. Furthermore, we consider that most of the regulations we recommend in Part 5 for the community care assessment process would be suitable for adult protection investigations; as we note in Part 3 (Structure of Reform), there may be merit in issuing a single set of regulations for both assessments and adult protection enquiries.

Recommendation 39: The statute should:

- (1) provide clearly that local social services authorities have the lead co-ordinating responsibility for safeguarding;**
- (2) place a duty on local social services authorities to investigate adult protection cases, or cause an investigation to be made by other agencies, in individual cases; and**
- (3) place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the process for adult protection investigations.**

TO WHOM SHOULD THE DUTY TO INVESTIGATE APPLY?

- 9.20 Current law uses the concept of a *vulnerable adult* to define the cohort of people who might need to be protected from harm or abuse. A “vulnerable adult” is defined in the statutory guidance *No Secrets* and *In Safe Hands* as a person aged 18 years or older who:

is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation.¹¹

9.21 This is an area where terminology is of some importance. Our consultation paper pointed to concerns that the term *vulnerable adult* appears to locate the cause of abuse with the victim, rather than placing responsibility with the actions or omissions of others. It can also suggest that vulnerability is an inherent characteristic of a person and does not recognise that it might be the context, the setting or the place which makes a person vulnerable. We, therefore, proposed that the term *vulnerable adults* should be replaced by *adults at risk*.

9.22 We also proposed that the definition of an *adult at risk* should be set out on the face of the statute. It was noted that the current definition of a *vulnerable adult* has been criticised for excluding people who do not require or qualify for community care services, such as self-funders and those who fall below the local authority eligibility criteria. We, therefore, proposed that an *adult at risk* should be defined as a person aged 18 or over and who:

- (1) is eligible for or receives any adult social care service (including carers' services) provided or arranged by a local authority; or
- (2) receives direct payments in lieu of adult social care services; or
- (3) funds their own care and has social care needs; or
- (4) otherwise has social care needs that are low, moderate, substantial or critical; or
- (5) falls within any other categories prescribed by the Secretary of State or Welsh Ministers; *and*
- (6) is at risk of *significant harm*, where harm is defined as ill treatment or the impairment of health or development or unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft and fraud).

9.23 We considered that *harm* should be defined in legislation but that *significant* should continue to be left undefined.¹²

Consultation responses

9.24 A large majority of consultees who expressed a view agreed with our proposal to replace the term *vulnerable adults* with *adults at risk*.¹³ Many consultees criticised the term *vulnerable adult* as stigmatising, dated, negative and disempowering. A

¹¹ Department of Health and Home Office, *No Secrets* (2000) para 2.3 and National Assembly for Wales, *In Safe Hands* (2000) para 7.2.

¹² *Adult Social Care* (2010) Law Commission Consultation Paper No 192, paras 12.23 to 12.42.

¹³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 291.

small number of consultees did, however, argue that the term *vulnerable adults* describes more accurately the status of certain people, in particular those with long-term or profound learning disabilities.

- 9.25 Our proposed definition of an *adult at risk* produced mixed views at consultation.¹⁴ Many consultees argued that our definition was overly focused on those with social care needs and appeared to exclude people with health needs. It was suggested that there is considerable overlap between health needs and social care needs and these categories do not always correspond to neatly defined agency responsibilities. Some argued that the proposed definition would undermine partnership working.
- 9.26 Our proposal that the person must be at risk of *significant harm* also divided opinion. Some consultees argued that this requirement was essential in order to limit the numbers of cases to manageable levels that local authorities would be required to investigate. Others argued that *significant harm* sets the bar too high, and would not only undermine preventative work but would also imply that some forms of abuse and neglect are acceptable and not worthy of being investigated. Many argued that if *significant* is used then it must be defined precisely because it is too subjective. However, this view was not universal. Many were doubtful whether a precise definition of *significant* could ever be constructed given the wide range of circumstances it would need to cover.¹⁵ In addition, it was argued that the High Court sets a much lower threshold for intervening under its inherent jurisdiction and that consideration should be given to aligning this threshold with the definition of an *adult at risk* in our scheme.
- 9.27 Consultees also suggested various detailed amendments to our proposed definition of *harm*, such as the express inclusion of self-harm, self-neglect and exploitation; references to well-being and human rights; and expanded definitions of ill treatment and impairment of health or development. Some also argued that *unlawful conduct* is too restrictive, particularly in relation to financial abuse where it is almost impossible to prove a financial crime.
- 9.28 Many consultees emphasised that the definition of an *adult at risk* should not only encompass people who are known to be at risk of harm, but also those who *appear* to be at risk of harm. It was also suggested that our scheme should clarify the relationship between the community care assessment and a safeguarding investigation, for example by ensuring that an investigation takes place only if all attempts to provide services had failed or if service provision was inappropriate.
- 9.29 Some consultees argued that certain groups should be included or excluded expressly from the definition of an *adult at risk*. For example, it was argued that service users who can protect themselves – either by themselves or with the help of others – should be excluded. There were mixed views on whether victims of domestic violence and gang violence should not be included within the definition.
- 9.30 Unlike the definition of a *vulnerable adult* contained in *No Secrets* and *In Safe Hands*, our proposed definition of an *adult at risk* did not exclude carers. Many

¹⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 294.

¹⁵ See the discussion at paragraph 9.42 below of the definition of significant harm.

consultees agreed with this aspect of our proposal, including carers' organisations. However, individual carers expressed concern that they could become the subject of a safeguarding investigation inappropriately (some suggested examples of this happening now), and queried whether an *adult at risk* should cover carers in the same way as service users.

- 9.31 Some consultees put forward alternative definitions of an *adult at risk*. Many written responses favoured a definition based on section 3 of the Adult Support and Protection (Scotland) Act 2007. It was also suggested that the definition of an *adult at risk* should encompass adult abuse in its entirety. In effect, *safeguarding* should apply equally to all adults within society and not just to those who are more vulnerable to abuse and *adult protection* should simply be targeted toward those who experience abuse and cannot protect themselves without assistance.

Discussion

- 9.32 We are conscious that we are not drafting a statute, and that Parliamentary Counsel will choose the appropriate language to be used in legislation. However, there are some areas in which the implications of certain terms carry important messages for practitioners, service users and carers, and in these areas it is appropriate for us to come to conclusions. One such area is the description of those who are the subject of the duty to investigate. Consultation has confirmed our view that the term *vulnerable adults* is inappropriate for the reasons we stated above. We take the view that the term *adult at risk* should be used in the statute to describe those people to whom the duty to make enquires will apply, and that the term should be clearly defined. The legal effect we recommend consists of five elements, each of which is described in detail below.

(1) Health and/or social care needs

- 9.33 Limiting the duty to investigate to those with the appearance of social care needs was subject to considerable criticism on consultation. Some criticism we think was misdirected. Some responses proceeded on the basis of a significant re-conceptualisation of safeguarding and adult protection in order to embrace the large majority of victims of crime of all sorts. Whatever the merits of this approach, it is very far removed from how we came to postulate a duty to investigate. We do not think that our definition should be so radically removed from core adult social care functions.
- 9.34 The question of whether we should extend the definition to include those without social care needs, but with health needs, is much more closely balanced, however. Partnership working involves a number of different agencies working in various contexts, but the relationship between adult social care and health is particularly close. Consultees argued that joint working with NHS bodies would be enhanced by including those with health-only needs within the definition of an *adult at risk* for adult protection purposes. Consultees also drew attention to the message that confining the definition to social care needs alone would send to other agencies, particularly health agencies: it may, as a matter of practice if not law, undercut the commitment of health bodies to multi-agency working.
- 9.35 On the other side, it can be argued that partnership working does not require that each partner agency should have some formal responsibility for the area of operation of the other agencies. More generally, the duty to investigate is, we

argue, a modest advance on the current state of the law considered as a whole. It can be argued that it should be closely tied, therefore, to the core responsibilities of social services authorities, from which it is to be implied.

- 9.36 On balance, we prefer the view that the definition should include reference to people with only health needs, as well as those with social care needs, but we accept that the arguments are closely balanced. In assessing the arguments, it is important to bear in mind that the choice will make very little difference in practical terms to our mainstream concerns. While very many of the people with whom safeguarding and adult protection are generally concerned as a matter of practice do, indeed, have health needs, the overwhelmingly large majority also have at least some social care needs.
- 9.37 To ensure appropriate flexibility in the methodology by which local social services authorities are able to perform the duty, we further recommend that the duty to investigate is worded precisely to ensure that it can be performed through a range of *pathways* or different routes through safeguarding. As described above, the duty would be flexible enough to enable social services authorities to undertake enquires themselves, refer the matter to the appropriate agency to be investigated by them or initiate a multi-agency investigation.
- 9.38 However, by referring the matter to another agency, the local authority would not be entitled necessarily to treat its duty to enquire as discharged; the referral would be a means through which the duty is performed and it may be necessary, for example, for the local authority to continue to monitor the case to ensure that it is dealt with by the agency appropriately. The extent of a local authority's ongoing role and responsibilities would vary according to the individual circumstances of the particular case.
- 9.39 In our view, carers should be included potentially within the definition of an *adult at risk*. The definition should therefore include carers, as defined in the threshold for assessment as a carer in Part 7 (Carers' Assessments and Eligibility). However, we accept the view put to us at consultation that carers should not be covered by the duty in the same way as service users. We consider that carers should not be identified as *adults at risk* by virtue only of their caring role. This would be achieved by the separate criterion, which is discussed below, that the person must be unable to safeguard themselves as a direct result of their relevant health or social care needs (which would include a person's needs as a carer).
- 9.40 Our recommended definition of an adult at risk would potentially cover asylum seekers, those on probation, homeless people and victims of domestic violence and gang-related violence but *only* if they also have health or social care needs.

(2) At risk of harm

- 9.41 Our choice of the term *significant harm* was also subject to considerable criticism. Considered on their merits, we would tend to accept the general tenor of these criticisms. But we now think that the debate is inappropriately centred on the specific terms in question (albeit that they are used in *No Secrets* and *In Safe Hands*). It would be more appropriate for us to consider the underlying legal effect we are trying to achieve, and leave Parliamentary Counsel to choose the right words.

- 9.42 In using *significant harm* in the first place, we were trying to communicate the idea that the harm concerned should be somewhere above *minor* or *trivial* on the spectrum of harm, but not so high as *serious*.¹⁶ However, consultation has persuaded us that using some such calibration of *harm* is not a helpful means of filtering people out of the definition of *adult at risk*. We have therefore concluded that the definition only requires *harm*, and it should be left to the other criteria discussed below to do the main work of refining the category of adult at risk.
- 9.43 Before moving on, we note the power of the argument for greater consistency between the criteria used for adult protection by local authorities and the criteria for intervention applied by the High Court under its inherent jurisdiction. Case law has confirmed that the risk of significant harm is not determinative to the latter; the court's concern is instead with the person's "safety and welfare" and it will intervene "only where there is a need to protect a vulnerable adult from abuse or the real possibility of abuse".¹⁷ However, we are not persuaded that the criteria for the local authority duty should be consistent with the High Court's criteria. The legal mechanisms concerned, while linked, fulfil different purposes. The aim of an investigation is to manage cases within the powers set out in the statute. The inherent jurisdiction applies only if the person cannot be safeguarded by the adult social care statute or any other powers. Thus, not every adult being investigated by a local authority will need to be referred to the High Court and conversely, the High Court can consider cases that do not trigger the local authority duty. We do not consider that attempting to assimilate the tests would be appropriate or helpful.

(3) Inability to safeguard themselves

- 9.44 We accept that our definition of an *adult at risk* should recognise that many people can safeguard themselves from harm, either by themselves or with assistance from others. This could be achieved by adding a criterion that the person is or appears to be unable to safeguard themselves from harm.
- 9.45 In determining whether a person may be unable to safeguard themselves it will be necessary to consider their mental capacity to make the relevant decision, and whether they have been subjected to coercion or undue influence. However, it is important to recognise that some people who lack capacity may still be able to safeguard themselves, either by themselves or with help from others. Furthermore, some people with capacity may be unable to safeguard themselves, for example due to a physical disability.
- 9.46 But again we must keep in mind the importance of keeping the definition of adults at risk within the broad ambit of social services authorities' core functions, both as a matter of principle and in order to limit the resource implications. In our view, a person's inability to safeguard themselves must be or appear to be a direct result of their health or social care needs.

¹⁶ For a discussion of what constitutes "significant harm" in the context of the Children Act 1989, see *Re MA (Care Threshold)* [2009] EWCA Civ 853, [2010] 1 FLR 431.

¹⁷ *Local Authority X v MM* [2007] EWHC 2003 (Fam), (2008) 11 CCLR 119 at [115] and [118].

(4) The necessity of safeguarding intervention

- 9.47 We agree that the statute should clarify the relationship between the community care assessment and the duty to investigate an adult at risk. In particular, it should be made clear that the duty to make enquiries should apply only in cases where the local authority believes it is *necessary*; for example, where the authority is unable to carry out a community care assessment or provide appropriate support services to the adult at risk that will remove or reduce the levels of harm and abuse. In our view, the appropriate standard in applying this test is “one of necessity, not desirability”.¹⁸ The code of practice should provide concrete examples of when an adult protection investigation would be necessary. In our view, this criterion would build upon the well-being principle that we recommend in Part 4 (Statutory Principles), which includes the least restrictive course principle. Therefore, the definition of an *adult at risk* should include the criterion that the local authority believes it is *necessary* to carry out an investigation, rather than deal with the case through a general assessment.

(5) The definition of harm

- 9.48 Several consultees argued that our definition of *harm* would benefit from the inclusion of greater detail and some examples of particular forms of *harm*. We agree that some degree of detail can assist clarity. However, a degree of caution is appropriate in this respect. Too much detail may lead to confusion and unnecessarily protracted discussions over whether some activity – which is clearly adversely affecting the service user – can be defined in legal terms as *harm*. In other words, we do not want the law to get in the way of adopting a common sense approach. One way to achieve this would be to make the definition non-exhaustive.
- 9.49 Taking these concerns into account, we have reviewed our proposed definition in light of consultation and recommended several alterations. Our recommended definition is set out in the list of recommendations below. In particular, we agree with the arguments that *financial abuse*, *self-harm and neglect*, and *exploitation* should be included expressly in the definition. We also agree that terms such as *ill treatment* and *impairment* would benefit from further explanation.¹⁹ Furthermore, we accept that the definition should reflect that some people may be unable to safeguard themselves.
- 9.50 We do not agree that there should be a direct reference to the Human Rights Act 1998 in our definition of *harm*, since it is unnecessary to repeat statutory provisions that are stated elsewhere in legislation. We also do not consider that it is necessary to include a direct reference to well-being in our definition. As set out in Part 4 (Statutory Principles), the well-being principle – as the overarching principle of our scheme – would apply to all actions under the statute, including safeguarding interventions. It, therefore, does not need to be repeated here.
- 9.51 Neither do we agree that the notion of *unlawful* conduct in relation to financial abuse can be dispensed with. The argument that this would cause problems

¹⁸ See *Reid v Secretary of State for Scotland* [1999] 2 AC 512, 540 by Lord Clyde.

¹⁹ This is similar to the approach taken in section 31(9) of the Children Act 1989, which defines the terms “harm”, “development”, “health” and “ill treatment”.

because it may be difficult to prove that a crime has been committed is not, we think, right. First, the duty on social services is not confined by the criminal burden or standard of proof, nor by the rules of procedure or evidence. The authority would have to have reasonable cause to suspect that the conduct concerned was unlawful, but no more. Second, it should be clear that the notion of *unlawfulness* should not be confined to criminal offences, but extends to private law wrongs, such as breach of fiduciary duty. If we were to dispense with the notion of unlawfulness, we would have to have some other normative characterisation of the conduct to replace it, which would be necessarily vague and subjective.

Recommendation 40: *Adults at risk* should be those who appear to:

- (1) have health or social care needs, including carers (irrespective of whether or not those needs are being met by services);**
- (2) be at risk of harm; and**
- (3) be unable to safeguard themselves as a result of their health or social care needs.**

In addition, the statute should provide that the duty to investigate should apply only in cases where the local authority believes it is necessary.

***Harm* should be defined as including but not limited to:**

- (1) ill treatment (including sexual abuse, exploitation and forms of ill treatment which are not physical);**
- (2) the impairment of health (physical or mental) or development (physical, intellectual, emotional, social or behavioural);**
- (3) self-harm and neglect; or**
- (4) unlawful conduct which adversely affects property, rights or interests (for example, financial abuse).**

NEW COMPULSORY AND EMERGENCY POWERS

9.52 The consultation paper argued that it is for the Government and the Welsh Assembly Government to decide the policy of what powers and rules should apply in adult protection cases; the role of the Law Commission is to consider this policy and how the law can facilitate it, and how the existing legal framework can be expressed in our proposed scheme. We therefore concluded that our proposed statute will only include new compulsory or emergency powers if they are proposed by either Government.²⁰ However, the consultation paper also acknowledged that the distinctions we have made between law reform and politics are difficult judgements to make and we might not have got them right.

²⁰ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 12.43 to 12.46.

Part of our consultation, therefore, was to determine whether we had drawn the correct line between law reform and politics in areas such as safeguarding.

Consultation responses

- 9.53 At consultation, our approach received a mixed response. Participants at consultation events were often divided as to whether our review should cover new adult protection powers. Moreover, while the majority of written responses to this proposal agreed with our approach, a significant minority disagreed (or agreed but only on the basis that new powers must be introduced).²¹
- 9.54 The main reasons for disagreeing with the proposal were that, first, the Law Commission is entitled to express an opinion on new emergency and compulsory powers. Some queried why such powers were an appropriate subject for law reform in 1995 but not in 2010.²² Second, it was suggested that a review of emergency and compulsory powers is necessary in the light of the UK's recent ratification of the United Nations Convention on the Rights of Persons with Disabilities. Article 16 requires State Parties to take legislative as well as other measures "to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects". Third, some consultees were unclear why we had proposed a duty to investigate, but ruled out any consideration of the powers available to a local authority once the investigation has concluded that the individual being abused or neglected. In effect, adult protection powers were viewed as ancillary to the duty to investigate and there was little point in imposing an investigatory duty without considering whether existing powers are adequate to back it up. Finally, it was argued that a Law Commission review is needed because the current framework is inadequate.
- 9.55 On the other side, it was reported that local authorities are already heavy handed and too eager to intervene without proper legal authority to remove service users arbitrarily from domestic settings. These comments echoed the concerns raised in *A Local Authority v A* handed down during our consultation.²³

Discussion

- 9.56 The responses disagreeing with our proposal, albeit from a minority of consultees, offer a challenging critique of our approach to new emergency and compulsory powers. In particular, they contest the line that we have drawn between law reform and politics and put forward a strong case that introduction of new compulsory and emergency powers is an issue that falls properly within our remit. This may of course be true, but it does not by itself establish the case that a new review of the need for these powers is necessary.
- 9.57 The view that compulsory powers are ancillary to the duty to investigate does add to the general case in favour of extending the scope of our review but it is not

²¹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 303.

²² In 1995, the Law Commission recommended the introduction of a number of new compulsory intervention powers aimed specifically at adults at risk of abuse and neglect. See *Mental Incapacity* (1995) Law Com No 231.

²³ [2010] EWHC 978 (Fam), (2010) 13 CCLR 404 at [99], by Munby LJ.

determinative. Our proposal for an express duty to investigate was made in the context of the existing powers of adult social services authorities to take action, for example under general community care legislation, the Mental Health Act 1983, the Mental Capacity Act 2005 and the inherent jurisdiction of the High Court. In effect, we argued that in some circumstances local authorities are already under a duty to investigate and this needs to be formalised in the statute. It does not follow necessarily that the introduction of an express investigation duty is a prelude to *new* compulsory and emergency powers. We are formalising what we see as an existing investigative duty; the introduction of new powers is a separate issue.

- 9.58 Some consultees argued that a review is needed because the law is inadequate or needs to be updated. However, it is also the case that the Government has recently conducted a major public consultation in England and found that, while there was quite high support for a power of entry where it is suspected that a vulnerable adult is being abused (60% of consultees who responded on the question), the level of support significantly reduces in response to more invasive powers (for example, only 13% supported a power to remove an adult who is being harmed from their home). There was also less support for compulsory powers in situations where the relevant person has decision-making capacity.²⁴ In the case of the Welsh Assembly Government, the issue is still being considered. The Welsh Assembly Government has said that it will consider where other changes to strengthen adult safeguarding in Wales can be achieved, taking into account the experience of the new system in Scotland.²⁵
- 9.59 On balance, we consider that our approach to new adult protection powers as set out in the consultation paper is correct.

<p>Recommendation 41: The statute should not include any new compulsory or emergency powers, unless the Government or the Welsh Assembly Government decides that such powers are needed.</p>

SECTION 47 OF THE NATIONAL ASSISTANCE ACT 1948

- 9.60 Section 47 of the National Assistance Act 1948 gives the appropriate authority²⁶ a power to apply to a magistrates' court for an order to remove a person to "suitable premises" (such as a hospital, care home or other place). This power applies to any person who is:
- (1) suffering from grave chronic disease, or being aged, infirm or physically incapacitated, is living in insanitary conditions; and
 - (2) unable to devote to themselves, and is not receiving from other persons, proper care and attention.

²⁴ Department of Health, Home Office, and the Ministry of Justice, *Safeguarding Adults: Report on the Consultation on the Review of "No Secrets"* (2009) pp 122 to 124.

²⁵ Welsh Assembly Government, *Sustainable Social Services for Wales* (2011) para 3.77.

²⁶ Lower tier or unitary authorities in England, and counties or county boroughs in Wales.

- 9.61 The order can only be granted if a *medical officer of health* certifies that removal is necessary in the interests of the person or for the prevention of injury to the health of or serious nuisance to, other persons. The person must be given seven days' notice of the application. The order can authorise the person's detention for up to three months, renewable for further periods of up to three months.
- 9.62 The National Assistance (Amendment) Act 1951 introduced an emergency procedure whereby, if it is certified by a medical officer of health and another doctor that it is necessary to remove an individual without delay, an order can be made without notice, by a single justice and without the person being present. The maximum period of detention is three weeks and the person cannot challenge the order during this period.
- 9.63 The consultation paper argued that section 47 (and the emergency procedure) should be repealed because it has the potential to breach Article 5 of the ECHR; has several operational difficulties; and has been rendered largely obsolete as a result of alternative compulsory and emergency powers available under the Mental Health Act 1983, the Mental Capacity Act 2005, public health and environmental health legislation and the inherent jurisdiction of the High Court.²⁷

Consultation responses

- 9.64 Our proposal to repeal section 47 divided opinion at consultation. Whilst a majority of written responses to this proposal agreed that the power should be repealed, a significant number disagreed or agreed but only on the basis that it should be replaced with something similar.²⁸ A significant number of participants at consultation events also supported retaining section 47 or introducing something similar.
- 9.65 No consultee disagreed with our assertion that section 47, as currently drafted, is capable of breaching the ECHR. However, it was less clear whether the power is still used. At consultation events involving the relevant audiences (such as social workers and other local authority employees), few participants reported using it, but a scattering usually had done so in the past. No-one, however, claimed to have used the power since the implementation of the Mental Capacity Act 2005. Although some said they had, recently, considered using it.
- 9.66 Several social work practitioners reported practical difficulties with the use of this power. For example, the police were said to be reluctant to provide assistance due to confusion over whether section 47 enables professionals to enter premises (using force if necessary) where the owner has refused access, thus rendering the order unenforceable. Others pointed out that the power is given not to social services authorities who have the relevant expertise, but to district councils, who usually allocate an environmental health officer to the role with little experience of adult safeguarding cases.
- 9.67 Furthermore, in several local authority areas consultees reported they had been unable to identify the medical officer of health in their area or that the role had

²⁷ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 12.47 to 12.71.

²⁸ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 307.

been discontinued or left vacant for some time. Others reported that the person in post was qualified in communicable diseases and did not have the appropriate clinical experience to deal with, for example, severe mental health problems or cases where the person's capacity is at issue.

- 9.68 Many consultees agreed that the use of section 47 is unnecessary because in most cases more suitable legislation is available; in particular, section 135(1) of the Mental Health Act 1983 can be used to remove a person who is "believed to be suffering from a mental disorder" from their home with a view to making necessary arrangements for their "treatment or care". It was also agreed that the Mental Capacity Act 2005 provides a much more effective legal framework for dealing with most people for whom section 47 is intended to apply.
- 9.69 But a significant minority of consultees disagreed with our proposal, arguing that certain groups would be left unprotected if section 47 were repealed. The most commonly identified groups were people who have capacity, people with borderline capacity and people whose capacity is uncertain, and whose lifestyle creates a significant risk of harm to themselves or others.
- 9.70 At consultation events, Approved Mental Health Professionals argued that mental health and mental capacity legislation does not cover all potential section 47 cases. For example, the use of section 135(1) of the 1983 Act is in practice limited to people who need to be detained in hospital, even though the power does not require this. Moreover, removal to a place of safety under section 135(1) is only permitted for up to 72 hours, which was viewed as inadequate for putting in place safeguarding arrangements. Others pointed to widespread uncertainty over the amount of force that can be used to remove a person from their home in their "best interests" under section 5 of the Mental Capacity Act 2005. It was also reported that applications to the Court of Protection or the High Court under its inherent jurisdiction are subject to significant delay and can be expensive, meaning that local authorities are reluctant to initiate proceedings. Finally, consultees pointed out that existing public and environmental health powers are inadequate and that environmental health departments are reluctant in practice to exercise their powers and will only consider intervention if the person's situation is causing a significant health risk to others.
- 9.71 The current difficulties in this area were highlighted during our consultation when details were made public of the death of Mayan Coomeraswamy who suffered from schizophrenia. He died in January 2009, aged 59, from natural causes, aggravated by neglect. According to the inquest into his death, his flat was in a state of grave disrepair and barely fit for human habitation. He was compliant with depot medication from his community psychiatric nurse, and whilst a remedy for the cleaning, decorating and reliable heating was available and urged upon him by his family and others, he would not accept these. The coroner in this case, Dr Paul Knapman, blamed "a piecemeal legal framework" which he claimed was riddled with contradictions and inadequacies, and individual mistakes by the workers concerned.²⁹ Media reports suggested that Mr Coomeraswamy had decision-making capacity and that section 47 was considered but not invoked

²⁹ Letter to Phil Hope MP, 18 March 2010.

due to human rights considerations.³⁰ This case was referred to by several participants at consultation events as evidence that the existing law was inadequate and section 47 needed to be reformed to become ECHR compliant.

Discussion

- 9.72 At the outset, we were reasonably confident that it would prove acceptable to simply repeal the power. However, consultation responses – albeit from a minority of consultees – have forced us to reconsider this issue.

Should section 47 be repealed or reformed?

- 9.73 Consultation has confirmed our view that section 47 cannot be retained in its current form. In many cases its use will breach Article 5 and there are numerous operational difficulties that render it impracticable. It is less clear, however, whether section 47 should be repealed entirely or replaced by a similar power that is both ECHR compliant and workable. The answer turns largely on whether the repeal of section 47 will leave people unprotected who are currently protected from abuse and neglect. In other words, would public bodies lose safeguarding powers, and, if so, are these powers used in practice?

WOULD PUBLIC BODIES LOSE SAFEGUARDING POWERS?

- 9.74 There are, in general terms, two legal categories of persons that section 47 covers: people with “grave chronic illness” and those living in “insanitary conditions”.
- 9.75 If section 47 were repealed, public bodies would still have powers to intervene under public and environmental health law to protect people with *grave chronic illness*, if the illness is infectious. We recognise concerns that, in practice, environmental health departments are reluctant to exercise these powers and often set a high threshold for their use. In our view, however, decisions concerning infection control should rest with agencies such as environmental health and the NHS, and it is inappropriate to use social care legislation for this purpose. If section 47 was repealed, local authorities would lose their ability to intervene to protect people with *non-infectious* grave chronic illness. But Article 5(1)(e) only permits the detention of people suffering from a grave chronic illness if the illness is infectious. We, therefore, consider that section 47 can and should be repealed entirely in relation to people suffering from *grave chronic illness*.
- 9.76 The detention of a person living in insanitary conditions would not breach article 5(1)(e) only if the person was also of *unsound mind* (unless they are alcoholic, drug addicts or vagrants). According to Strasbourg jurisprudence, the term *unsound mind* includes people who lack capacity, and extends to those with capacity but who are suffering from a mental disorder.³¹
- 9.77 If section 47 were repealed, local authorities and other agencies would still have powers to intervene to protect people who lack capacity and are living in

³⁰ See <http://www.guardian.co.uk/society/2010/mar/31/mental-health-law-vulnerable-people-intervention> (last visited 7 April 2011).

³¹ *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73).

insanitary conditions – primarily under the Mental Capacity Act 2005 and the Mental Health Act 1983. We accept that in practice the extent of these powers can be unclear when dealing with such cases (such as the limits of *best interests* decisions), which may make public bodies and others reluctant to intervene. However, in our view this is a practice issue which could be clarified in guidance, rather than being an argument for law reform in the distinct context of adult protection as part of social care law.

- 9.78 However, if section 47 were repealed, local authorities and other agencies would lose powers to intervene to protect some people who have capacity and are living in insanitary conditions. Where the person suffers from a mental disorder, the Mental Health Act 1983 may be used to detain them in hospital or provide care and treatment in the community; there is no requirement that the person must lack capacity. Although the Act does not provide express powers to enforce environmental improvements, it can be used to treat any underlying disorder that has contributed to the situation, and since the property is vacated temporarily, mental health services may be able to arrange for the necessary cleaning or repairs to be completed. However, many people of *unsound mind* who are living in insanitary conditions will not need to be detained in hospital for assessment or treatment of a mental disorder, and therefore will not come within the remit of the 1983 Act.
- 9.79 Section 135(1) of the 1983 Act can be used in wider safeguarding situations but the relatively short time limit of this power restricts its effectiveness in dealing with cases of extreme squalor and disrepair. In some cases, the use of guardianship under the 1983 Act may assist by putting in place a formal community-based support structure under which care and treatment can be provided more coercively than in ordinary situations. However, guardianship provides few powers to override a refusal by the relevant individual.
- 9.80 The High Court may offer protection to “vulnerable adults” under its inherent jurisdiction, including in some cases adults with capacity.³² However, the inherent jurisdiction cannot be used to compel a capacitated but *vulnerable* person to do or not do something which they have, after due consideration, decided to do or not to do; the jurisdiction acts to “facilitate the process of unencumbered decision making” by those who have capacity “free of external pressure or physical restraint in making those decisions”.³³ Also, as many consultees pointed out, High Court proceedings can be costly and time consuming and are, therefore, an inappropriate way of dealing with emergency safeguarding cases.
- 9.81 Local authorities have compulsory powers to enter and cleanse premises where there are risks to public health under the Public Health Act 1936, the Public Health (Control of Disease) Act 1984 and the Environmental Health Act 1990. However, as noted above, consultation suggested that environmental health departments often set high thresholds for intervention under this legislation and accordingly the powers are only used as a last resort. In any event, these powers

³² *Re SA (Vulnerable Adult with Capacity: Marriage)* [2005] EWHC 2942 (Fam), [2006] 1 FLR 867.

³³ *LBL v RYJ* [2010] EWHC 2665 (COP) at [62].

are aimed at protecting *public* health, rather than being focused on the harm that may be caused to the person responsible for the insanitary conditions.

9.82 In summary, the analysis above suggests that the section 47 power could be removed entirely in relation to people with grave chronic illness and people who lack capacity. However, if section 47 were repealed, public bodies would lose powers to intervene only if the person:

- (1) is of *unsound mind* but not of a nature or degree to warrant hospital admission;
- (2) makes a capacious decision, which is free of external pressure or physical restraint, to live in insanitary conditions (and those conditions are not such to necessitate intervention under public and environmental health powers); and
- (3) is unable to devote to themselves and are not otherwise receiving proper care and attention.

9.83 Clearly, this group is likely to be very small and it is at the very least questionable whether the state should have powers to detain such people.

9.84 However, it may be the case that section 47 still plays a useful role in practice and continues to be used even though other compulsory powers may be available (other than in relation to people with grave chronic illness and those identified in the list above). In our view the only principled reason for reforming section 47 is on the basis of empirical data which demonstrates that the power is exercised in practice.

IS SECTION 47 USED IN PRACTICE?

9.85 The limited research available on the use of section 47 suggests that it is used rarely, but does not appear to be entirely obsolete.³⁴ However, most of this research was conducted in the 1970s and 1980s, and for example predates the introduction of the Human Rights Act 1998 and the Mental Capacity Act 2005.

9.86 In the light of this, and given the absence of any specific examples in written responses, we have concluded that the very limited evidence from consultation events is insufficiently robust to justify us coming to the factual conclusion that would warrant us proposing the reform of section 47. As the whole issue hinges on a factual question, we think it more appropriate for the Government and the Welsh Assembly Government to seek to clarify what does in fact happen, and to take forward consideration of any replacement for section 47 in the light of those findings.

9.87 In this next section, we consider how section 47 *might* be reformed, should it become apparent that repeal without reform would remove a power that local authorities sometimes relied on.

³⁴ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 12.62 to 12.64.

How could section 47 be reformed?

- 9.88 If section 47 were to be retained, it would be necessary to reform the section to ensure that it is ECHR compatible, to make it effective operationally and to modernise some of its provisions. In order to achieve this, the following matters would have to be addressed.
- 9.89 First, we consider that the power to issue the detention order could remain with lay magistrates. Although some consultees argued this does not provide an effective safeguard, in our view the alternatives would not be without their difficulties. For instance any expansion of the role of mental health tribunals or the Court of Protection would entail a significant change in law and practice. An alternative would be to authorise the High Court to consider these cases. However, this will have potentially significant resource implications. On balance, we take the view that there are no significant advantages to transferring the responsibility for issuing compulsory removal orders from the magistrates' court to any other court.
- 9.90 Second, in order to be ECHR compatible, the section 47 criteria would need to specify that the compulsory removal power applies only to people suffering from a grave chronic and infectious disease; or people who are of *unsound mind* and who being aged, infirm or physically incapacitated, are living in insanitary conditions. As argued previously, we do not think there is a need to cover the first category. Whilst the second category is ECHR compliant, it is difficult to justify why older, infirm and physically incapacitated people are targeted expressly and not others or why older people living in insanitary conditions are included, irrespective of whether they are infirm or physically incapacitated, but not younger people living in insanitary conditions. Moreover, much of the terminology in section 47 is outdated and stigmatising (such as "being aged"), or lacks sufficient clarity and precision (for example, it is also unclear how "infirm" or "physically incapacitated" a person would need to be in order to be removed). In our view, it is unnecessary to specify the groups that this power could apply to beyond providing that the person is of *unsound mind*.
- 9.91 Third, in order to be compatible with the ECHR, the section 47 criteria would need to be reformed to require that a mental disorder has been established by objective medical expertise (except in an emergency); the mental disorder is of a kind or degree warranting compulsory confinement; and detention is a proportionate response to the person's circumstances.³⁵
- 9.92 Fourth, it would be necessary to amend the requirement that the person must be living in "insanitary conditions" *and* "unable to devote to themselves, and are not receiving from other persons, proper care and attention". Consultation suggested that these criteria set the bar unrealistically high for the use of the power and the reference to "insanitary conditions" confuses this power with alternative public health powers. One option would be to remove the "insanitary conditions" requirement altogether. This criterion not only seems anachronistic, but its removal would be effective in clearly differentiating between the role of environmental health, with its concern for insanitary conditions for public health

³⁵ *Winterwerp v Netherlands* (1979-80) 2 EHRR 387 (App No 6301/73) and *Litwa v Poland* (2001) 33 EHRR 53 (App No 26629/95).

reasons; and social services, for which insanitariness is not obviously a relevant criterion for intervention. On the other hand, the requirement of *insanitary conditions* does act as a major limiting factor on the use of this power.

- 9.93 Fifth, a number of procedural changes would be necessary. In our view, the emergency procedure should be amended to ensure that the person subject to the order is capable of properly contesting it on the application itself and post-detention. Moreover, section 47 contains no provision for the authority responsible for the detention to discharge the order; for example if the person's situation improves. In order for section 47 detentions to be compatible with Article 5(1), the local authority will need to be given the power to discharge the order and review the ongoing necessity of the detention at *regular periods*.
- 9.94 We also consider that section 47, which sets a six-week time limit in all cases before a detained person is able to initiate a challenge, is arbitrary and likely in many cases to be incompatible with article 5(4). In order to reform section 47, it will therefore be necessary to introduce a right for the detainee to apply to the court to have the order revoked at any time during their detention (subject to the normal case management rules of the court). In cases where the person lacks capacity to decide to instigate an appeal, procedures should be available to enable an appeal to be initiated on their behalf (where there is reason to believe that they would wish to do so).³⁶ Section 47, however, contains no such safeguard and in such cases will breach article 5(4). Any reform of section 47 will therefore need to introduce a mechanism to enable this.
- 9.95 Finally, section 47 has numerous operational difficulties which need to be reformed. In our view, any reformed power will need to specify that a police officer is authorised, if needs be, to enter into premises where the person is believed to be residing and remove the person, by force if necessary. It was also widely accepted at consultation that social services – as opposed to environmental health – are the more appropriate agency for dealing with self-neglect by people of *unsound mind*. In our view, any reform of section 47 must make local social services the responsible authority for implementing the compulsory removal power.
- 9.96 In summary, the analysis above suggests that section 47 cannot become ECHR compliant and operationally workable without numerous and substantial reform. This would not only extend the scope of the power but also would transform radically its nature. Amongst other matters, there would be new criteria for detention and increased rights to contest applications and any resulting detention. Responsibility for implementing the power would also pass from environmental health to social services. In effect, section 47 cannot be amended without creating a completely new compulsory safeguarding order.

³⁶ *R (H) v Secretary of State for Health* [2005] UKHL 60, [2006] 1 AC 441.

Recommendation 42: The compulsory removal power under section 47 of the National Assistance Act 1948 should be repealed. The Government and the Welsh Assembly Government should consider commissioning research into the existing use of section 47, and then decide, on the basis of that research, whether it would be appropriate to reform the section, following public consultation.

DUTY TO PROTECT PROPERTY

9.97 Section 48 of the National Assistance Act 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 1948 Act or removed under section 47 of the 1948 Act. 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.³⁷

9.98 Local authorities are empowered to enter premises in order to protect property and recover any reasonable expenses incurred. The consultation paper proposed that the section 48 duty should be retained in the statute, since it appears to provide an important safeguard where a person's property is at risk.³⁸

Consultation responses

9.99 All responses to this proposal agreed that section 48 should be retained.³⁹ Some consultees did, however, suggest that more guidance is needed on how local authorities should carry out this duty, particularly in relation to pets and gaining access to property. A number of consultees argued that the duty should apply only if there is no other person who can act in the individual's interests. It was also argued that section 48(3) of the 1948 Act, which allows local authorities to recover any "reasonable costs" from the person concerned, should be extended to authorise recovering costs from family members. Some consultees queried why this duty should apply only to local authorities and suggested that the NHS should also bear some responsibility.

Discussion

9.100 Consultation has confirmed our view that section 48 should be retained. We agree that the code of practice should provide concrete examples to explain what is required in relation to pets and gaining access to property.

9.101 We do not agree that section 48(3) should be extended to allow local authorities to recover *any reasonable costs* from family members. In our view, the principle of *liable relatives*, which dates back to the poor law and was abolished recently in

³⁷ National Assistance Act 1948, s 48(1).

³⁸ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 12.72 to 12.73.

³⁹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 313.

relation to the recovery of residential accommodation costs, is outdated and should not be reintroduced.⁴⁰ We also do not agree that the duty should apply only as a last resort where no-one else is considered to be in a position to protect the property. However, it is important that this duty does not impose onerous demands on local authorities and that, where appropriate, friends and family members should be expected to look after a person's property in such cases (supported by the local authority if necessary). In our view, the current duty is sufficiently flexible and only requires action by the local authority if *no other suitable arrangements* can be made.

- 9.102 We understand the view that the duty to protect property should also fall on the NHS, especially in cases where the individual is being admitted to hospital. Although it is beyond the scope of our review to recommend new duties on the NHS, it is noted that this function could be delegated or carried out in partnership with health services under section 75 of the NHS Act 2006 or section 33 of the NHS (Wales) Act 2006.

Recommendation 43: Local authorities should be required to protect property when a person is admitted to hospital or residential care.

ADULT SAFEGUARDING BOARDS

- 9.103 Local adult safeguarding boards are multi-agency partnerships, made up of a wide range of statutory agencies and voluntary organisations. They are aimed at facilitating joint working in adult protection and their responsibilities include ensuring that multi-agency policies and procedures are in place, conducting serious case reviews, and providing training and information.
- 9.104 Currently, adult safeguarding boards are not provided for in statute law, although they are referred to briefly in statutory guidance.⁴¹ The previous Government, however, announced plans to introduce new legislation to place adult boards on a statutory footing.⁴² On this basis, the consultation paper proposed that the statute should place a duty on each social services authority to establish a safeguarding board and set out the functions and membership of the board, requirements to share information and a duty to contribute to serious case reviews.⁴³ The Coalition Government has confirmed it is reviewing policy on this issue.⁴⁴

Consultation responses

- 9.105 An overwhelming majority of responses to this proposal agreed that adult safeguarding boards should be placed on a statutory footing.⁴⁵ It was argued this

⁴⁰ Health and Social Care Act 2008, s 147.

⁴¹ Department of Health and Home Office, *No Secrets* (2000) para 3.4 and National Assembly for Wales, *In Safe Hands* (2000) para 5.5.

⁴² Department of Health, *Written Ministerial Statement: Government Response to the Consultation on Safeguarding Adults: The Review of the No Secrets Guidance* (2010).

⁴³ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 12.74 to 12.79.

⁴⁴ Department of Health, *A Vision for Adult Social Care* (2010) para 6.6.

⁴⁵ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 315.

would ensure attendance and engagement from relevant organisations, a standardised approach across the country and an enhanced status for boards resulting in better outcomes for adults at risk.

- 9.106 Most consultees also agreed that the local social services authority should be given the lead role in establishing adult safeguarding boards. While recognising the need to ensure multi-agency working, it was considered that a single agency should be charged with co-ordinating the adult safeguarding board and that the social services authority is best placed to take on this role.
- 9.107 The consultation paper asked for comments on the approach taken by the Adult Support and Protection (Scotland) Act 2007, which specifies the following functions for Adult Protection Committees:
- (1) to keep under review the procedures and practices of public bodies which relate to safeguarding adults at risk;
 - (2) to give information or advice, or make proposals, to any public body on the exercise of functions which relate to adult protection; and
 - (3) to improve the skills and knowledge of professionals who have responsibilities relating to safeguarding adults.⁴⁶

The convener must also produce a report every two years on the exercise of the committee's functions.

- 9.108 Most consultees agreed that these functions should also be specified in the statute. In addition, it was suggested that adult safeguarding boards should be responsible for monitoring and researching levels of abuse and neglect in its area and identifying any trends in referrals to adult safeguarding teams, including gaps and over-representation in relation to certain groups or certain types of abuse. It was also argued that boards should be given responsibility for the agreement of multi-agency protocols and, where necessary, to arrange operational strategic meetings to address specific abuse situations.
- 9.109 The consultation paper also asked for comments on the approach taken by the Adult Support and Protection (Scotland) Act 2007 which provides that the council, the health board, the police and any other body specified by the Scottish Ministers must nominate a representative to be a committee member who has the appropriate skills and knowledge, and the Care Commission may nominate an appropriate representative to attend meetings. The council must appoint these persons and may appoint any other person with the "skills and knowledge relevant to the functions of the Adult Protection Committee".⁴⁷
- 9.110 Most consultees agreed that the local authority, NHS and the police should be required to nominate a representative who has the appropriate skills and knowledge. In addition, consultees suggested that the following should be required to attend:

⁴⁶ Adult Support and Protection (Scotland) Act 2007, ss 42(1) and 46.

⁴⁷ Adult Support and Protection (Scotland) Act 2007, s 43.

- (1) probation services;
- (2) individual GPs;
- (3) coroner services;
- (4) representatives from service providers and the voluntary sector; and
- (5) service users and organisations that represent abused adults.

9.111 Some consultees argued that our recommendation should go further than addressing representation at meetings and should require active participation at a senior level. Others argued that the boards should be required to appoint an independent chair. It was also suggested that if an individual or institution was invited to a safeguarding meeting and was unable to attend that there should be some requirement that a report was submitted instead. A small number of consultees were, however, opposed to this aspect of the proposal and argued it would be unduly prescriptive and possibly constrain local action.

9.112 The consultation paper asked for comments on the approach taken by the Adult Support and Protection (Scotland) Act 2007 which provides that the council, health board, police, Care Commission, Mental Welfare Commission for Scotland and Public Guardian must provide the committee with any information that the committee may reasonably require in order to carry out its functions.⁴⁸ Most responses on this question supported the introduction of a similar duty in the statute and some proposed that this duty should be widened to incorporate a requirement to share information in any investigation concerning an adult at risk.

9.113 The previous Government's review of safeguarding policy in England raised for discussion the possibility that adult safeguarding boards should commission serious case reviews and that there should be a duty to contribute to these reviews.⁴⁹ Our consultation paper asked for further views on this. The majority of responses on this question were in agreement with the introduction of these duties. Some consultees suggested that the serious case review criteria and procedures should be national and not local. Some participants at consultation events considered there should be greater prescription for how serious case reviews were undertaken, pointing to the lack of consistency in practice. In response, other participants suggested that too much prescription may turn serious case reviews into an industry in itself, and shift the culture from one of learning to one of blame.

Discussion

9.114 As explained above, there is something of a vacuum in policy terms in relation to this question. Nevertheless, consultation has demonstrated compelling reasons for the introduction of statutory safeguarding boards. Primarily it would enhance the status of boards and allow for greater leverage in encouraging other agencies to participate. Furthermore, it would help to strengthen local safeguarding

⁴⁸ Adult Support and Protection (Scotland) Act 2007, s 45.

⁴⁹ 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.

leadership and address inconsistencies in the current operation of boards. Most consultees viewed the approach taken by the Adult Support and Protection (Scotland) Act 2007 as a successful innovation which has assisted greatly the effectiveness and prominence of the boards.

- 9.115 Since political policy continues to be uncertain, one option would be for the statute to give the Secretary of State and Welsh Ministers a general regulation-making power to prescribe the detail of the functions, membership and other matters relating to adult safeguarding boards. This would leave it open to the Government and the Welsh Assembly Government to decide whether and/or when to introduce a more formal regime for adult safeguarding boards.
- 9.116 However, we are persuaded that certain elements of adult safeguarding boards are of such importance that they should be the subject of primary legislation, not regulations. We think this is true of which agency is given the lead responsibility for establishing the board, the functions of the board and who must attend. We, therefore, consider that the statute should establish the following regime for adult safeguarding boards.
- 9.117 First, the local social services authority should be given the lead role in establishing adult safeguarding boards. This would reflect, and be reinforced by, our earlier recommendation that under our scheme the local social services authorities have the lead co-ordinating responsibility overall for safeguarding; including strategic responsibility and putting in place multi-agency arrangements.
- 9.118 Second, the statute should specify the following functions for adult safeguarding boards:
- (1) to keep under review the procedures and practices of public bodies which relate to safeguarding adults;
 - (2) to give information or advice, or make proposals, to any public body on the exercise of functions which relate to safeguarding adults;
 - (3) to improve the skills and knowledge of professionals who have responsibilities relating to safeguarding adults; and
 - (4) to produce a report every two years on the exercise of the board's functions.

The Secretary of State and the Welsh Ministers should be given a regulation-making power to add to this list.

- 9.119 Consultees suggested that the statutory functions of safeguarding boards should include express reference to carrying out research into abuse and neglect, the agreement of multi-agency protocols and, where necessary, arranging operational strategic meetings. We are not persuaded that this is necessary since these specific roles would be incorporated under the general requirement to *keep under review the procedures and practices of public bodies that relate to safeguarding adults*. The code of practice should provide further guidance on how to carry out this function, including the commissioning and use of research, the development of multi-agency protocols and the use of operational strategy meetings.

- 9.120 Third, the statute should require certain agencies to nominate a representative to be a board member who has the appropriate skills and knowledge. We are mindful that this list should not be unduly prescriptive or require attendance at every meeting where this would be unnecessary and onerous. We do, however, consider that there are a small number of key agencies who must be required to appoint a representative because without the full participation of these agencies the board is unlikely to be fully effective. These agencies are:
- (1) the local social services authority;
 - (2) the NHS; and
 - (3) the police.
- 9.121 The Secretary of State and the Welsh Ministers should be given a regulation-making power to add to this list. In addition, the Care Quality Commission, the Care and Social Services Inspectorate Wales and the Healthcare Inspectorate Wales should be given a power to nominate an appropriate representative to attend meetings. The local authority should also have a power to appoint any other person with the necessary skills and knowledge relevant to the board and be given responsibility for appointing the chair.
- 9.122 We recognise that it is important to ensure a range of agencies attend meetings beyond those specified above. The code of practice should provide specific examples in order to assist local authorities in exercising their power to appoint other board members. Many consultees recommended that general practitioners should be required to attend board meetings because of their vital role in safeguarding adults. However, this would be difficult to achieve in law because general practitioners are contracted individually to the NHS.
- 9.123 Several consultees argued it was important for independent chairs to be appointed to adult safeguarding boards. We do not agree that the statute should require local authorities in all cases to appoint an independent chair, but local authorities would retain this option subject to the person possessing the necessary skills and knowledge for membership of the board.
- 9.124 Finally, we agree that adult safeguarding boards should commission serious case reviews and that there should be a duty to contribute to these reviews. We are not persuaded, however, that our proposal should go further and require national serious case reviews criteria and procedures. Whilst there are strong arguments for a consistent approach to serious case reviews, this would have serious resource implications. And we do not feel that we are in a position to make a judgement about whether local flexibility or a national system is to be preferred, either now or in the future. However, it would be appropriate for the Government and the Welsh Assembly Government to introduce national criteria in the future if they wish to do so. We, therefore, recommend that the statute should give a power to the Secretary of State and the Welsh Ministers to make regulations to establish national criteria.
- 9.125 We do not agree that there should be duties on Government to provide adequate funding or establish standardised data monitoring systems. These are matters for political judgement and not law reform. We note that in relation to data monitoring in England, the NHS Information Centre for Health and Social Care has initiated a

scheme for the collection of data relating to adult protection. In Wales, the Care and Social Services Inspectorate Wales publishes annual monitoring reports.⁵⁰

- 9.126 We have not recommended a duty to share information with adult safeguarding boards (with the exception of the duty to contribute to serious case reviews). There is already a vast amount of law regulating the sharing of information in adult protection, arising from general administrative law, the Human Rights Act 1998 and the European Convention on Human Rights, the common law duty of confidence, and the Data Protection Act 1998. Introducing a new duty to share information would add another layer to this and may obscure the fact that bodies should already have a power to share information with the board, having regard to the above law. Creating a new duty can also lead to difficulties in terms of defining who must share information and what information must be shared. Specifying such matters may have the unfortunate consequence of giving the impression that non-specified bodies cannot share information or non-specified information cannot be shared. We therefore consider that the code of practice should provide guidance on when information can and should be shared with adult safeguarding boards.

Recommendation 44: Adult safeguarding boards should be placed on a statutory footing. In order to achieve this, the statute should:

- (1) give the local social services authority the lead role in establishing and maintaining adult safeguarding boards;**
- (2) specify the following functions for adult safeguarding boards:**
 - (a) to keep under review the procedures and practices of public bodies which relate to safeguarding adults;**
 - (b) to give information or advice, or make proposals, to any public body on the exercise of functions which relate to safeguarding adults;**
 - (c) to improve the skills and knowledge of professionals who have responsibilities relating to safeguarding adults; and**
 - (d) to produce a report every two years on the exercise of the board's functions;**
- (3) give the Secretary of State and the Welsh Ministers a regulation-making power to add to this list;**
- (4) require each of the following to nominate a board member who has the appropriate skills and knowledge:**

⁵⁰ NHS Information Centre for Health and Social Care, *Information and Guidance on the Abuse of Vulnerable Adults Collection* (2009) and Care and Social Services Inspectorate Wales, *Protection of Vulnerable Adults Monitoring Report 2007-2008* (2009).

- (a) the local social services authority;
 - (b) the NHS; and
 - (c) the police;
- (5) give the Secretary of State and the Welsh Ministers a regulation-making power to add to this list;
- (6) give the Care Quality Commission, the Care and Social Services Inspectorate Wales and the Healthcare Inspectorate Wales a power to nominate an appropriate representative to attend meetings;
- (7) give the local social services authority a power to appoint any other person with the necessary skills and knowledge relevant to the board, and responsibility for appointing the chair; and
- (8) provide that adult safeguarding boards should commission serious case reviews and establish a duty to contribute to these reviews.
- The code of practice should provide guidance on when information can and should be shared with adult safeguarding boards.**

DUTY TO CO-OPERATE

- 9.127 Currently there is no express duty on agencies to co-operate in cases of abuse and neglect. The need for multi-agency co-operation in adult protection cases is noted in *No Secrets* and *In Safe Hands*, which set out a framework for inter-agency arrangements.⁵¹ The lead agency is identified as the local social services authority and the partner organisations include health, social care and housing service providers, regulators, law enforcement agencies, service user groups, support organisations, legal advice centres and welfare agencies.
- 9.128 As discussed in Part 11 (Overlap Issues), the consultation paper proposed that the statute should introduce a general duty and an enhanced duty to co-operate. The enhanced duty would provide that a local authority can request certain bodies to provide assistance, for example during an assessment and in providing services. In such cases, the requested body would be under a duty to give *due consideration* to the request. We proposed that this duty should apply expressly in adult protection cases.⁵²

Consultation responses

- 9.129 The overwhelming majority of consultees who expressed a view agreed with the proposal.⁵³ However, some argued that our recommendation should go further; for example, by giving health authorities specific responsibilities to identify health

⁵¹ Department of Health and Home Office, *No Secrets* (2000) para 4.3 and National Assembly for Wales, *In Safe Hands* (2000) paras 1.1, 3.1 and 3.2.

⁵² Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 12.80 to 12.82.

⁵³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 319.

risks and contribute to the safeguarding assessment process or to extend the duty to include individual GPs.

Discussion

- 9.130 In Part 11 (Overlap Issues) we consider in more detail the introduction of duties to co-operate. In that Part, we recommend the introduction of a general duty to co-operate which would require local authorities to make arrangements to promote co-operation between the authority and other organisations. In Part 11 we also recommend that an enhanced duty would provide that an authority can request certain bodies to provide assistance during an assessment and in providing services, and that this should apply expressly in adult protection cases.
- 9.131 These duties would be reinforced by our earlier recommendation that under the statute the local social services authorities have the lead co-ordinating responsibility (overall) for safeguarding; including strategic responsibility and putting in place appropriate multi-agency arrangements.
- 9.132 We understand the spirit in which the proposals for stronger-still duties of co-operation are offered. However, we think that, as a matter of detail, there are drawbacks or wider implications of most that militate against accepting them. For instance, applying the duty to individual people, rather than the authorities concerned, would be a radical departure in public law terms, and it is by no means apparent how the duties would be enforced.
- 9.133 More generally, we are proposing what we hope will be a general, simple, strong and well understood two-tier duty to co-operate. Keeping it general and simple has significant advantages that we do not want to water down by making special provision in relation to safeguarding.
- 9.134 Some of the other issues raised, such as including general practitioners and adding sanctions are discussed in more detail in Part 11 (Overlap Issues).

<p>Recommendation 45: The enhanced duty to co-operate should include specific provision to promote co-operation between relevant organisations in adult protection cases.</p>
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THE LEGAL BASIS OF NO SECRETS AND IN SAFE HANDS

- 9.135 Both *No Secrets* and *In Safe Hands* were issued under section 7 of the Local Authority Social Services Act 1970. The consultation paper raised concerns that while section 7 guidance must be linked to a local authority's statutory functions, *No Secrets* and *In Safe Hands* cover an area of law where there is currently no specific statute. Therefore, we argued that while the guidance will be effective in guiding local authorities in the exercise of their existing statutory functions, it cannot provide a free-standing justification for any act. It was therefore proposed that *No Secrets* and *In Safe Hands*, or their successors, are linked clearly to a local authority's statutory functions to safeguard adults from abuse and neglect, as set out in the statute. We also asked for further evidence on whether some local authorities are relying on *No Secrets* and *In Safe Hands* to justify their actions, rather than referring to the underlying legal power.

- 9.136 The overwhelming majority of responses that expressed a view agreed with the proposal. However, no evidence was provided by consultees on whether local authorities are relying on guidance rather than statute law to justify safeguarding interventions.⁵⁴
- 9.137 In our view, it is not necessary to make any specific recommendation on this matter. The proposal will be implemented as a necessary consequence of the introduction of the statute (including the adult protection provisions) and the introduction of a code of practice as we recommend in Part 3 (Structure of Reform).

OTHER ISSUES RAISED AT CONSULTATION

- 9.138 Several consultees put forward wider safeguarding issues that they considered should be taken forward by our review. Whilst these were often beyond our remit, such as the introduction of new safeguarding duties on the NHS, others did identify alleged deficiencies in the law that, in our view, merit further consideration. These issues are summarised below.

Guardianship

- 9.139 Consultees argued that the Mental Health Act 1983 should be amended to ensure that protection arrangements under guardianship can apply to people with learning disabilities. The 1983 Act prohibits guardianship for people with learning difficulties unless it is “associated with abnormally aggressive and seriously irresponsible conduct”.⁵⁵
- 9.140 It was contended that this prohibition removes a significant potential framework for the protection of adults with learning difficulties, particularly those who live at home and where concerns are raised about the abilities of the carer to provide necessary care rather than the behaviour of the person with learning disabilities themselves. In effect, the prohibition means that it is not possible to make a guardianship application where a person with a learning disability is “passively enduring the seriously irresponsible conduct of others”.
- 9.141 Removing the qualification would, therefore, enable professionals in an adult safeguarding situation to set conditions to protect the person – such as to allow professionals access to visit the person who is subject to guardianship and specifying where the person should live.

Ill treatment or wilful neglect

- 9.142 Both the Mental Health Act 1983 and the Mental Capacity Act 2005 establish criminal offences of ill treatment or wilful neglect in relation to mental health patients and those who lack capacity respectively.⁵⁶ Proceedings can be

⁵⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 322.

⁵⁵ Mental Health Act 1983, s 1 (2A) and (2B).

⁵⁶ Mental Health Act 1983, s 127 and Mental Capacity Act 2005, s 44.

instituted by the Director of Public Prosecutions or by a local social services authority with the Director's consent.⁵⁷

- 9.143 Some consultees argued that these provisions should be extended to protect adults at risk who are being ill treated or neglected but who are not subject to the powers of the Mental Health Act 1983 or mentally incapacitated. For example, one participant at a consultation event suggested that a situation could arise whereby three adults at risk had been placed in a care home where they suffered abuse and neglect – one has been placed there under the Mental Health Act 1983, one lacks capacity and has been admitted following a *best interests decision* under the Mental Capacity Act 2005 and the other person has capacity and has been placed there under the National Assistance Act 1948. A prosecution on their behalf for ill treatment or wilful neglect could only be initiated in the case of the first two people.
- 9.144 At consultation events with police officers it was suggested that prosecutions were being dropped in practice because doctors cannot confirm or have not documented that the person lacks capacity. There are clearly issues of principle about the proper bounds of criminal liability in this suggestion.

The Family Law Act 1996

- 9.145 The Family Law Act 1996 provides a framework for, amongst other matters, protection in the area of domestic violence. Part 4 of the 1996 Act provides two main remedies. The first is the use of non-molestation orders to protect individuals in certain family or domestic arrangements and/or certain children from the use of violence or other forms of molestation. The second is the use of occupation orders to regulate occupation rights in the family home between those in certain family or domestic proceedings. These are civil orders, but breach of such orders is a criminal offence. For such orders to be given there needs to be a defined association between the two people involved.⁵⁸
- 9.146 It was suggested at consultation that local authorities should be given a power to apply for these orders on behalf of adults at risk in a similar way that Part 4A of the 1996 Act allows authorities to apply for forced marriage protection orders. There is provision in section 60 the 1996 Act for other, specified people (a representative) to make an application for the occupation order on the person's behalf. However, this provision has never been brought into force.

Recommendation 46: The Government and the Welsh Assembly Government should consider reviewing the following issues:

- (1) the application of guardianship under the Mental Health Act 1983 to people with learning disabilities;**
- (2) protecting adults at risk who are being ill treated or neglected but who are not subject to the powers of the Mental Health Act 1983 or mentally incapacitated; and**

⁵⁷ Mental Health Act 1983, s 130.

⁵⁸ Section 62 of the Family Law Act 1996 defines the circumstances in which a person is to be associated with another person.

(3) the powers of local authorities to apply for occupation orders on behalf of a person under the Family Law Act 1996.

PART 10

ORDINARY RESIDENCE AND PORTABILITY

INTRODUCTION

- 10.1 This Part of the report considers how the ordinary residence rules should apply in our scheme, how the responsibility for providing carers' services should be defined and how our scheme should enable portability of care and support.

ORDINARY RESIDENCE

- 10.2 The ordinary residence rules are used to establish which local authority is responsible for providing community care services to an individual. Some local authority duties to provide such services depend upon the individual concerned being ordinarily resident in their area. If they are not ordinarily resident, then the duty may be downgraded to a mere discretion.
- 10.3 However, the relevance of the ordinary residence rules varies across adult social care legislation. For example, the rules apply to services provided under the National Assistance Act 1948 and the Chronically Sick and Disabled Persons Act 1970 but do not apply to services provided under the Health Services and Public Health Act 1968, the NHS Act 2006 and the NHS (Wales) Act 2006.
- 10.4 As noted in our scoping report, the remit of our review does not include the meaning of ordinary residence or whether the concept of ordinary residence is the most effective way of determining which local authority is responsible for the provision of services.¹ Our remit is limited to how the current ordinary residence rules can operate effectively in the context of a single adult social care statute.
- 10.5 The consultation paper proposed that the concept of ordinary residence should apply to all community care services. In effect, a local authority would have a *duty* to provide services to those ordinarily resident in its area (subject to its eligibility criteria) and a *power* to provide services for people not ordinarily resident or of no settled residence. In addition, there would be a duty to provide residential accommodation where a person is not ordinarily resident but is in urgent need of accommodation; a duty to carry out an assessment of needs, irrespective of ordinary residence; and a power to provide temporary urgent services, without carrying out an assessment, irrespective of ordinary residence. As we explained in the consultation paper, this approach, while simplifying and generalising the rules, effectively replicates the current legal position.²

Consultation responses

- 10.6 The majority of consultees who expressed a view agreed with the proposal.³ In the consultation paper we acknowledged that our proposals would, in theory at least, widen the application of the ordinary residence rules to services currently

¹ Law Commission, *Adult Social Care: Scoping Report* (2008) para 4.102.

² *Adult Social Care* (2010) Law Commission Consultation Paper No 192, paras 8.2 to 8.14.

³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 150.

provided under the Health Services and Public Health Act 1968, the NHS Act 2006 and the NHS (Wales) Act 2006. None of the responses however disagreed with our contention that it is unlikely that authorities currently make what are often subtle distinctions between services provided under the different statutes and instead generally apply the ordinary residence rules to all services.

- 10.7 Some consultees did, however, suggest some adjustments to our proposals; for example, that the duty to provide residential accommodation to non-residents in urgent cases should be extended to include non-residential services in safeguarding cases and time limits should be placed on the duration of temporary urgent services for those not ordinarily resident. Others suggested that if a service user has been placed outside their area of residence, the local authority in which the person is located should be responsible for ensuring that the person's needs are met, whether that is through the authority itself, or working with the area in which the person is considered ordinarily resident.
- 10.8 Some consultees argued that the remit of our review should be extended to cover both the meaning of ordinary residence and alternative ways of determining which local authority is responsible for service provision. For example, it was suggested that service users should have the right to choose where they live and the costs of providing services should follow them.

Discussion

- 10.9 Consultation has confirmed our view that the concept of ordinary residence should apply to all community care services. We do not propose to extend the duty to provide residential accommodation where the person is not ordinarily resident to include non-residential services in safeguarding cases. Under our scheme, local authorities will continue to have powers to provide non-residential services in these circumstances. Furthermore, we consider that the duties to co-operate (in Part 11 (Overlap Issues)) would help to ensure that the local authority in which the person is located can liaise effectively with the local authority in which they are ordinarily resident to provide any necessary care and support.
- 10.10 We do not agree that statute law is the appropriate place to clarify matters such as the duration of temporary urgent services and when the power to provide services to those not ordinarily resident arises. The code of practice should provide guidance on how these powers should be exercised by local authorities.
- 10.11 Finally, we do not propose to extend the scope of our review of ordinary residence. In our view, the meaning of ordinary residence and alternative ways of determining local authority responsibility for service provision are matters for political policy and not law reform.

Recommendation 47: Under our scheme, a local authority should have:

- (1) a *duty* to provide services where the person is ordinarily resident (subject to the application of the local authority's eligibility criteria);**
- (2) a *power* to provide services for people not ordinarily resident or of no settled residence;**

- (3) a *duty* to provide residential accommodation where a person is not ordinarily resident but is in urgent need of accommodation;
- (4) a *duty* to carry out an assessment of needs, irrespective of ordinary residence; and
- (5) a *power* to provide temporary urgent services, without carrying out an assessment, irrespective of ordinary residence.

RESPONSIBILITY FOR PROVIDING CARERS' SERVICES

- 10.12 The current law gives primary responsibility to the local authority in which the cared-for person lives for carrying out a carer's assessment and providing carers' services. The consultation paper proposed that this rule should continue.⁴

Consultation responses

- 10.13 The majority of consultees who expressed a view agreed with this proposal, including all the main carers' organisations and most local authorities.⁵ However, several consultees also argued that the numbers of carers living at a distance but still providing essential support is on the increase, and that our scheme needed to take into account the needs of this group. A small number of consultees argued that some services would be best delivered in the area where the carer lives and there should be protocols in place to ensure this can be given effect.

Discussion

- 10.14 Consultation has confirmed our view that the local authority in which the cared-for person lives should be given primary responsibility for providing carers' services. Nonetheless, we accept that particular difficulties can arise where the carer lives at a distance from the cared-for person. The particular difficulties faced by carers in these circumstances are currently dealt with in practice guidance, which advises that local authorities must work in partnership with other authorities in such cases.⁶ We consider that the position of such carers should be addressed in the code of practice issued under our scheme. Furthermore, the enhanced duty to co-operate that we recommend in Part 11 (Overlap Issues) would enable local authorities to request the assistance of other authorities where a carer lives at a distance. Moreover, our scheme would maintain the general powers of local authorities to provide services to carers, including those who live in the authority's area and care for someone living in another authority's area. Our approach to general powers and duties is considered in more detail in Part 5 (Assessments).

Recommendation 48: The local authority in which the cared-for person lives should be given primary responsibility for providing carers' services. The code of practice should provide guidance on how local authorities are to address the particular needs of carers living at a distance.

⁴ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 8.15 to 8.19.

⁵ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 155.

⁶ 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.

PORTABILITY OF SERVICES

- 10.15 The term *portability of services* refers to the ability of service users to ensure continuity of support when they move between local authority areas. Currently, when a service user moves they often have to start again from scratch to negotiate a new care package, based on a new assessment with the new authority, even if their needs have not changed.
- 10.16 The consultation paper proposed that the enhanced duty to co-operate should include specific provision to promote co-operation between local authorities when individuals are moving areas. We also proposed that if Government decided to introduce a national portable assessment (as the previous Government had proposed to do in England), this would be provided for expressly in the statute.⁷

Consultation responses

- 10.17 Many consultees provided evidence that the existing legal framework and, in particular, the ordinary residence rules, impede service users' freedom of movement.⁸ The majority of responses to this proposal agreed that an enhanced duty to co-operate when people move will be helpful in enabling transition for people needing support. In addition, it was suggested that the duty to co-operate should include provisions to ensure that there is no delay in starting up services after the person moves and that the statute should clarify that the receiving authority's duty to assess arises when they become aware that the person wishes to move to their area. Others argued that the statute should place a duty on the receiving authority to accept the previous authority's assessment until they are able to carry out their own assessment.
- 10.18 Some consultees suggested that our proposals had not gone far enough and argued in favour of an enforceable right to portable care packages. Several consultees called for a national care service to be introduced. Many local authorities argued that any proposal for portability of service provision is an unrealistic expectation whilst there remains local discretion to set eligibility criteria. It was also suggested that the very fact of moving will often alter a person's needs and, therefore, the introduction of a portable assessment will not remove the duty of a local authority to carry out a new assessment.
- 10.19 The Government's response did not express a view on the proposals but they have since confirmed their support for "greater portability of assessments" and intend to pursue this in the light of the reviews undertaken by the Law Commission and the Commission on the Funding of Care and Support.⁹ Since consultation, the Welsh Assembly Government has also announced that it will be working with stakeholders to introduce "a portable assessment of need".¹⁰

⁷ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 8.20 to 8.41.

⁸ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 158.

⁹ Department of Health, *A Vision for Adult Social Care* (2010) para 4.7.

¹⁰ Welsh Assembly Government, *Sustainable Social Services for Wales* (2011) para 3.47.

Discussion

- 10.20 Consultation has confirmed our view that the enhanced duty to co-operate should include specific provision to promote co-operation between local authorities when individuals are moving areas. Our specific recommendations on duties to co-operate are set out in Part 11 (Overlap Issues).
- 10.21 We are persuaded that the statute should clarify that the receiving authority's duty to assess arises when it becomes aware that the person wishes to move to their area. The receiving authority's duty to assess is currently stated in statutory guidance but consultation has shown it is an important aspect of portability that appears to be widely misunderstood. Also, the statute should clarify that if the local authority decides to give a significantly different support package, it should be required to produce a clear and written explanation to the service user and where appropriate their carer. This is also in line with the statutory guidance.¹¹
- 10.22 Finally, given that both Governments have indicated their support for portable assessments but have not announced specific plans, our scheme should allow for the future development of policy. The statute should give the Secretary of State and Welsh Ministers powers to make regulations requiring that when service users move from one authority to another, the new authority must provide the person with equivalent services or direct payments to those provided by the original authority to cover their support needs until they undergo an assessment in the new authority. The aim of this provision is to remove the incentive on the receiving authority to delay an assessment so as to delay the provision of services and direct payments. It would be left to both Governments to decide, as a matter of policy, whether or not to introduce this provision.

Recommendation 49: The enhanced duty to co-operate should include specific provision to promote co-operation between local authorities when individuals are moving areas.

Recommendation 50: The statute should establish that when a service user moves from one local authority to another, or has a clear intention to move, the receiving authority must carry out an assessment. If the new authority decides to give a significantly different support package, it should be required to produce a clear written explanation to the service user and where appropriate their carer.

The Secretary of State and Welsh Ministers should have a power to make regulations requiring that when service users move from one authority to another, the new authority must provide the person with equivalent services or direct payments to those provided by the original authority to cover their support needs until they undergo an assessment in the new authority.

¹¹ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) p 29.

PART 11

OVERLAP ISSUES

INTRODUCTION

- 11.1 This Part examines those areas where adult social care overlaps with other areas of law. In particular, it considers the health and social care divide; prohibitions; children and young people, young carers and parent carers; section 117 of the Mental Health Act 1983; hospital discharge; prisons; and duties to co-operate.

THE HEALTH AND SOCIAL CARE DIVIDE

- 11.2 The boundary between health and social care is determined largely by reference to the National Assistance Act 1948 and the NHS Acts 2006.¹ Both place responsibility on local authorities and the NHS to accommodate older people, ill people and disabled people. Given the potential for overlap, section 21(8) of the 1948 Act states that nothing in section 21 authorises or requires a local authority to make any provision “authorised or required to be provided under” the NHS Acts 2006. This was considered by the Court of Appeal in *R v North and East Devon Health Authority ex parte Coughlan*, which held that section 21(1) does not prevent a local authority from providing any health services:

The subsection’s prohibitive effect is limited to those health services which, in fact, have been authorised or required 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.²

- 11.3 This does not mean, however, that local authorities are responsible for providing all health services that the Secretary of State and Welsh Ministers have decided it is not necessary for the NHS to provide; the health services that can be provided by local authorities as part of a social care package are restricted to those services that can be provided *lawfully* under section 21.
- 11.4 In order to identify which health services it is lawful for a local authority to provide under section 21 of the 1948 Act, the courts have developed the *quantity and quality test*. This test provides that healthcare services can be provided by a local authority if those services 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 1948 Act; and

¹ In this Part, “the NHS Acts 2006” refers to the NHS Act 2006 and NHS (Wales) Act 2006.

² *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213, 232.

- (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.³
- 11.5 The effect of the *quantity and quality test* is that there is a legislative possibility of a gap between the provision of healthcare and the provision of social care services together with incidental or ancillary healthcare. Notwithstanding this possibility, it is the policy of the Government and the Welsh Assembly Government that such a gap should not arise. It is acknowledged that, where an individual's primary needs are not health needs, the NHS is still responsible for meeting a person's health needs in so far as these health needs are beyond the powers of the local authority to provide. This could be provided as part of a joint package of continuing care (including NHS Funded Nursing Care and other NHS services which are beyond the powers of the local authority to meet) under which the NHS is responsible for the provision of health care services and the local authority is responsible for the provision of social care services together with any health care services which are within their powers to provide.
- 11.6 In addition, both the Government and the Welsh Assembly Government have developed policies on NHS continuing healthcare. This is defined as a complete package of ongoing care arranged and funded solely by the NHS where it has been assessed that the individual's primary need is a health need.⁴ The national frameworks in England and in Wales set out four characteristics of need, namely *nature, intensity, complexity* and *unpredictability*, which help determine whether the quantity or quality of care required is beyond the limit of a local authority's responsibilities. Each of these characteristics may, alone or in combination, demonstrate a primary health need, because of the quality and/or quantity of care that is required to meet the individual's needs.⁵
- 11.7 In England and in Wales, a *Decision Support Tool* provides guidance on whether the nature, complexity, intensity or unpredictability of a person's needs are such that they have a primary health need. It divides needs into 12 care domains, or generic areas of need. These are sub-divided into statements of need, representing low, moderate, high, severe or priority levels of need, depending on the domain. The care domains range from "behaviour" and "cognition" to "continence", "skin (including tissue viability)" and "breathing", and include a catch-all of "other significant needs". Cases qualify for NHS continuing healthcare according to formulae which weigh the severity of the case across different domains.⁶

³ *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213, 233.

⁴ NHS Continuing Healthcare (Responsibilities) Directions 2009, direction 2(6) and EH/ML/018/10 WAG Circular 015/2010, *Continuing NHS Healthcare: The National Framework for Implementation in Wales* (2010) paras 4.1 to 4.3.

⁵ Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care: July 2009 Revised* (2009) paras 25 and 28 and EH/ML/018/10 WAG Circular 015/2010 *Continuing NHS Healthcare: The National Framework for Implementation in Wales* (2010) paras 4.2 and 4.3.

⁶ Department of Health, *Decision Support Tool for NHS Continuing Healthcare* (2009) p 9 and EH/ML/018/10 WAG Circular 015/2010 *Continuing NHS Healthcare: The National Framework for Implementation in Wales* (2010) Annex 6.

- 11.8 There are two further statutory prohibitions on the provision of health services by local authorities. First, section 29(6) of the 1948 Act prohibits local authorities from providing any services under section 29 which are “required to be provided under” the NHS Acts 2006. In general terms, section 29 enables local authorities to provide a range of non-residential services for disabled people. The section 29(6) prohibition applies only where there is a *duty* on the NHS to provide a service and does not extend to services that the NHS has been *authorised* to provide by the Government or the Welsh Assembly Government as a matter of policy. It follows that a range of community care services can be provided for a person living in the community who is eligible for NHS continuing healthcare, notwithstanding Government policy that the NHS is responsible for service provision. Where disputes have arisen, the courts have applied and developed the *quantity and quality test*.⁷
- 11.9 Second, section 49(1) of the Health and Social Care Act 2001 prevents local authorities from providing nursing care by a registered nurse. This prohibition does not apply to *any* services which are in fact provided by a registered nurse but only those services that are *required* to be provided by a registered nurse.⁸
- 11.10 The consultation paper proposed that the existing interface between health and social care should be maintained as far as possible. In effect, local authorities would be prohibited from providing residential accommodation which is *authorised or required to be provided under* the NHS Acts 2006; non-residential services which are *required to be provided under* the NHS Acts 2006; and nursing care which is required to be provided by a registered nurse.⁹

Consultation responses

- 11.11 The overwhelming message from consultation was that the arrangements for NHS continuing healthcare is an area that continues to be contentious between health and social care authorities and lacks transparency for service users.¹⁰ Most responses on this issue pointed to the need to introduce greater clarity to the interface between health and social care, not least with regard to the limits of what local authorities are able to provide. Indeed, it was suggested that a *whole industry* has been established which is dedicated to trying to interpret and implement the dividing line between health and social care, which consequently costs a significant amount of money to administer and police.
- 11.12 Many criticised our proposals for replicating the confusing terminology used in the 1948 Act to describe the health and social care divide. Some criticised as unnecessarily obscure the use of the term *under* to signify services that are authorised by the NHS Acts 2006 in guidance or directions. Others suggested that the terms *authorised* and *required* were confusing and should be replaced by

⁷ *R (T) v Haringey London Borough Council* [2005] EWHC 2235 (Admin), (2006) 9 CCLR 58 at [62] to [65].

⁸ *R (Grogan) v Bexley NHS Care Trust* [2006] EWHC 44 (Admin), (2006) 9 CCLR 188 at [24].

⁹ Adult Social Care (2010) Law Commission Consultation Paper No 192, para 9.62 to 9.71.

¹⁰ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 189.

more straightforward language which stated clearly that the prohibitions applied when the NHS has a legal power and/or a duty to provide the service.

- 11.13 Consultees argued that the prohibitions rely too heavily on the ability to identify services that the NHS must or can provide. The duties under the NHS Acts 2006 are target duties, and it can therefore be difficult in practice to distinguish between services that are required and those that are authorised. Moreover, the provision of NHS services can be subject to eligibility criteria developed locally, which can obscure further the identification of powers and duties. In addition, many duties and powers must be discerned from a range of Government circulars and guidance. Consultees argued this not only creates difficulties in identifying and locating the relevant documents, but it is often not clear from the language used in them whether duties or powers are being established.
- 11.14 Some argued that statute law should codify the limits of what a local authority can lawfully provide, and that such an important legal provision should not be left to case law. Others were critical of the *quantity and quality test*, arguing that it does not fit easily with the concept of a primary health need because the landmark cases have established that only if a person's healthcare needs are at a low level must the local authority fund the package. Moreover, deciding whether services are of a *nature* that a local authority can be expected to provide is a circular exercise, based on defining *what social services can do by reference to what they can do*. This is not helped by the lack of legal definition of adult social care.
- 11.15 As set out above, despite the legislative possibility of a gap between the provision of healthcare and the provision of social services together with incidental or ancillary healthcare, it is the policy of the Government and the Welsh Assembly Government that such a gap should not arise. Some argued that our scheme should rule out altogether the legal possibility of a gap by stating in the statute that any need beyond the *quantity and quality test* must be met by the NHS. Others favoured replacing the *quantity and quality test* with a requirement on the Secretary of State and Welsh Ministers to specify in regulations what combination of needs in the *Decision Support Tool* must be construed as beyond the powers of local authorities, and therefore of necessity constituting a primary health need.

Discussion

- 11.16 In our view, the concerns expressed about the incomprehensibility of the statutory prohibitions are justified. The meaning of the prohibitions is not obvious from their wording. It is notable that the precise meaning of the prohibitions has needed to be clarified by the courts and as noted by Lord Woolf in *Coughlan*, each word requires "detailed analysis".¹¹ We consider that the existing language of the prohibitions should be reviewed and where appropriate revised to clarify their meaning. These are essentially drafting points for Parliamentary Counsel but it is worth emphasising the importance of legislation in this area being as comprehensible as possible to the very many non-lawyer users.
- 11.17 At consultation, there were concerns about the impact of the NHS target duties on the health and social care divide. It is beyond the remit of our review to

¹¹ *R v North and East Devon Health Authority ex p Coughlan* [2001] QB 213, 232.

recommend any reform of the nature of these duties, since this would amount to a fundamental overhaul of the NHS Acts 2006. However, there are two legal reforms that we consider would help to ameliorate the problems caused by NHS target duties. First, wherever possible both Governments should issue clear guidance and directions for the NHS which distinguishes between legal powers and duties. Second, the statute should include a clear statement to the effect that the powers and duties of the NHS, referred to in the prohibitions, includes those powers and duties set out in regulations and guidance issued under the NHS Acts 2006.

- 11.18 We are persuaded that the *quantity and quality test* should be codified in statute law. The wording of the 1948 Act makes no explicit reference to the limits of a local authority's ability to provide health services, and the prohibitions can only be understood correctly when read in light of the *quantity and quality test* established in *Coughlan*. We agree that a clear provision on the face of the statute setting out the full meaning of the prohibition would help to ensure greater legal clarity.
- 11.19 On consultation, many problems in the interpretation of this test were highlighted. In Part 4 (Statutory Principles), we recommend the introduction of a single overarching principle that adult social care must promote or contribute to the well-being of the individual. While not providing a precise definition of adult social care, it would provide a more coherent approach and a positive statement about the nature and purpose of adult social care. In effect, this principle cannot substitute for, but would assist in interpreting the *quantity and quality test*. In addition, the code of practice should provide guidance on how the test is to be interpreted.
- 11.20 Finally, although there are advantages to closing the potential gap between health and social care, not least in terms of legal clarity, this is not an area in which we can legitimately make recommendations. First, it is a matter for political policy not law reform. Current political policy is that a gap should not arise. However, this policy could change in the future; for example, as a result of resource constraints. Whatever policy is adopted could have substantial resource implications. Second, the gap is currently filled by expanding NHS responsibilities. We cannot make recommendations about what is a matter of health service, rather than social care, law. Similarly, while there may be valid concerns about the threshold for NHS continuing healthcare set in guidance, decisions about which services must be met by the NHS is beyond our remit.
- 11.21 However, our scheme should allow for the development of political policy on this issue. The Secretary of State and the Welsh Ministers should be given a power to establish in regulations an eligibility framework for the provision of NHS continuing healthcare and to specify what combination of needs establish a primary health need. This would allow both Governments to decide, if they so wish, to close the potential gap between health and social care in law. The content of the eligibility framework and the eligibility criteria would similarly be a matter for political policy.

Recommendation 51: The existing statutory prohibitions on the provision of healthcare by local authorities should be retained, and:

- (1) the wording of the prohibitions should be reviewed and where appropriate simplified;
- (2) where possible NHS guidance and directions should always distinguish between legal powers and duties;
- (3) the prohibitions should include a clear statement to the effect that the range of powers and duties given to the NHS are those set out in regulations and guidance issued under the NHS Acts 2006;
- (4) the *quantity and quality test* should be set out in statute law; and
- (5) the Secretary of State and Welsh Ministers should be given a power to establish in regulations an eligibility framework and what combination of needs would make a person eligible for NHS continuing healthcare.

Other issues raised at consultation

Joint working

- 11.22 Several consultees pointed out that in practice there is increasing overlap between health and social care. For example, social care professionals often undertake tasks that would previously have been considered the province of nursing or medical staff, such as the administration of medication and hygiene procedures. Furthermore, many social workers are located in joint health and social services teams, with team identity often overriding professional allegiance. The key issue for these consultees was not establishing clear boundaries but recognising the fluidity and inter-working relationship between health and social care. Accordingly, they argued that the statute should support greater co-operation and promote partnership working and joint financial arrangements, such as the pooling of budgets, across social care and the NHS.
- 11.23 Whilst the law has an important role to play in defining boundaries, it can at the same time encourage joint working both within these boundaries and when service users cross the divide between health and social care. Our scheme would promote joint working in a number of ways. First, the enhanced duty to co-operate, which we recommend later in this Part, would apply when a request is made by a local authority for an assessment for NHS continuing healthcare and where someone moves from local authority care into NHS care. Second, we suggest that the code of practice clarify that local authorities can have ongoing involvement where appropriate when someone becomes eligible for NHS continuing healthcare or where the local authority is not currently involved in funding. This may be particularly important when someone is in receipt of NHS continuing healthcare but is living at home because the local authority may nevertheless have responsibilities to assess for and provide community care services. Finally, our scheme would promote where appropriate joint health and social care assessments (see Part 5 (Assessments)).

Recommendation 52: The enhanced duty to co-operate should apply when a request is made by a local authority for an NHS continuing healthcare assessment and where someone moves from social care into NHS care.

Direct payments

- 11.24 The Health and Social Care Act 2001 places a duty on local authorities, in certain cases, to provide direct payments to individuals in lieu of community care services but makes no provision for such payments to be made for NHS services. Community care service users will therefore lose their entitlement to direct payments and the choice and control afforded by such payments if they qualify for NHS continuing healthcare; for example, they may be provided with staff organised and scheduled by the NHS care agency rather than those they had previously employed themselves using their direct payment. Consultees argued that the fear of losing their direct payments can lead to some service users refusing an assessment for NHS continuing healthcare.¹² In such cases, the Association of Directors of Adult Social Services and the Local Government Association advise that the local authority must make a judgement whether that person still has needs that the local authority is responsible for meeting and if not, it may have to give reasonable notice of their intention to withdraw funding and service provision for all or part of the support package.¹³
- 11.25 At consultation, there was widespread support for extending direct payments to cover NHS continuing healthcare.¹⁴ However, whilst direct payments for health needs cannot be made under the 2001 Act, this does not mean that direct payments for health needs cannot be made at all. It has been held that the provisions of the NHS Act 2006, give health authorities “very wide powers” to enable them to do that which in any given circumstances seem to them to achieve the necessary provision of services, in that case a direct payment to an Independent User Trust.¹⁵ Moreover, the Health Act 2009 has amended the NHS Act 2006 to establish pilot schemes in England for the provision of direct payments to patients for health services, including NHS continuing healthcare.¹⁶ The pilots will run until 2012 and following a review, there is an order-making power to remove the requirement that payments be made through a pilot scheme so that direct payments could become more generally available.
- 11.26 Extending direct payments to health services is a policy decision for both Governments. Nonetheless we consider there are strong legal reasons for establishing direct payments for NHS continuing healthcare. In particular, it would ensure greater continuity of care when people cross the health and social care divide and would establish greater legal clarity about when NHS direct payments can be made. If direct payments are introduced for healthcare, the statute should encourage, where appropriate, the continuation of care packages where a successful direct payment arrangement was previously in place. First, the NHS should be placed under a duty to consider reasonable requests to continue to

¹² See Law Commission, *Adult Social Care: Consultation Analysis* (2011) para 9.150.

¹³ Association of Directors of Adult Social Services and Local Government Association, *Commentary and Advice for Local Authorities on the National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care* (2007) para 4D.

¹⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) paras 9.149 and 9.150.

¹⁵ *R (Gunter) v South Western Staffordshire Primary Care Trust* [2005] EWHC 1894 (Admin), (2006) 9 CCLR 121 at [26] by Collins J.

¹⁶ NHS Act 2006, s 12A to 12C.

provide direct payments to community care service users who become eligible for NHS continuing healthcare. Second, where the NHS has decided not to provide direct payments, it would be required to consider whether existing service provider or agency arrangements should be kept in place.

Recommendation 53: If direct payments are extended to healthcare, the statute should require the NHS to consider reasonable requests to continue to provide direct payments to social care service users who become eligible for NHS continuing healthcare, and where the NHS has decided not to provide direct payments, it would be required to consider whether existing service provider or agency arrangements should be kept in place.

Disputes

- 11.27 As noted in Part 12 (Other Issues), the efficacy of the complaints and redress system was formally excluded from the scope of our review. Nonetheless, some consultees argued that our scheme should address disputes between health and social services. Particular difficulties were said to include inconsistent local practices for resolving disputes and gaps in service provision whilst a decision is made as to primary responsibility.¹⁷
- 11.28 The NHS Continuing Healthcare (Responsibilities) Directions 2007 require that disputes between health and social services must be resolved by reference to a local dispute resolution procedure.¹⁸ Guidance advises that a local protocol should be in place to make clear how funding will be provided pending resolution of any dispute and that neither the NHS nor the local authority should withdraw unilaterally from funding an existing package without appropriate re-assessment, identification of the body responsible for funding and alternative funding being put in place.¹⁹ Most local procedures consist of steps to prevent disputes, including an informal stage, a disputes panel and referral to the chief executives of the partner agencies. Beyond that, cases would need to be taken to court by way of judicial review. Some consultees suggested such cases should be resolved by a tribunal or reference to the Secretary of State or Welsh Ministers.
- 11.29 The policy of both Governments is that the funding of service provision pending the outcome of the local dispute resolution procedures should be a matter to be determined locally by local authorities and the NHS. The concerns raised at consultation concerning variations in local practice and failure to issue local protocols, are in our view matters for the Government and the Welsh Assembly Government to take forward, if they wish to do so, in the relevant NHS guidance and directions. However, we recognise the concerns of consultees, which were echoed by the Court of Appeal, that disputes between two public authorities over NHS continuing healthcare should not be litigated in the courts, particularly because of the excessive costs that this can entail.²⁰ In our view, both

¹⁷ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) para 9.143.

¹⁸ Direction 3(4).

¹⁹ Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care: July 2009 Revised* (2009) paras 143 and 161.

²⁰ *R (Manchester City Council) v St Helens Borough Council* [2009] EWCA Civ 1348, (2008) CCLR, 774 at [1] and [39].

Governments should take the opportunity of a new statutory framework to review whether the courts are the appropriate forum for such cases.

Recommendation 54: The Government and Welsh Assembly Government should consider reviewing whether the courts are the appropriate forum for determining disputes over NHS continuing healthcare.

Community based NHS continuing healthcare

- 11.30 Where a person is living in the community, the relevant prohibition on the provision of social care is section 29(6) of the 1948 Act which prevents local authorities from providing any services under section 29 if they are “required to be provided” under the NHS Acts 2006. As noted above, this prohibition applies only where there is a *duty* (as opposed to a power) on the NHS to provide a service and there will consequently often be an overlap between health and social care provision. The fact that the individual qualifies for NHS continuing healthcare does not displace the local authority’s duty to assess since that duty is triggered by the mere appearance of need; nor does it displace the duty to provide services, subject to the *quantity and quality test*. Consequently, guidance advises that individual arrangements may have to be reached between health and local authorities with respect to the provision of services.²¹
- 11.31 Some consultees argued it is confusing to have two different legal prohibitions on the provision of social services based on whether residential or community support is being considered, and suggested the two prohibitions should be equalised.²² There are two ways this could be achieved. First, the prohibitions could be equalised at the level currently set for residential services, in which case local authorities would be prohibited from providing any services that are *authorised or required* to be provided *under* the NHS Acts 2006. However, this would in law reduce the amount of support that a local authority can provide and would therefore, have resource implications for the NHS or possibly leave people without any support. Second, the prohibitions could be equalised at the level currently set for non-residential services, in which case local authorities would be prohibited from providing any services that are *required* to be provided *under* the NHS Acts 2006. This would in law increase the amount of support that social services can provide. In effect, there would be a significant overlap between local authority and NHS residential care provision, which would lead to an increase in the financial responsibilities of local authorities, or at the very least to an increase in disputes. We, therefore, consider that the best option would be to maintain the existing prohibitions. Equalising the prohibitions may achieve greater legal clarity but would alter significantly the existing health and social care divide. However, the code of practice should provide concrete examples of how the prohibitions apply in cases involving residential or community services.

²¹ Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care: July 2009 Revised* (2009) para 101.

²² See Law Commission, *Adult Social Care: Consultation Analysis* (2011) paras 9.140 to 9.141.

Recommendation 55: The code of practice should provide concrete examples of how the prohibitions apply in cases involving residential or non-residential services.

PROHIBITIONS

- 11.32 As well as setting out an interface between health and social care, statute law establishes a divide between adult social care and other areas, such as housing and immigration and asylum law. The consultation paper noted that our proposals in this area are limited to examining how the existing prohibitions would operate in the context of a single statute and do not attempt to alter the responsibilities of social services or other authorities in any significant way. We, therefore, proposed that social services authorities should continue to be prohibited from providing ordinary housing and connected services which are authorised or required to be provided by or under other legislation. We also asked what would be the likely consequences of retaining the current prohibition on services to people subject to immigration control solely because they are destitute or because of the physical effects of being destitute.²³

Consultation responses

- 11.33 Most responses to this proposal agreed that the existing divide between adult social care and housing should be maintained.²⁴ Several consultees highlighted the importance of encouraging joint working between social services and housing authorities. However, some responses expressed concern that the current division has a negative impact on service users, especially those judged to be intentionally homeless.
- 11.34 A significant number of responses provided evidence on the effect of the current prohibition on providing social care services to those subject to immigration control.²⁵ Consultees pointed to the negative impact of the existing prohibition on people's mental and physical health. Many argued that a review of political policy is required to ensure that the social care needs of vulnerable people are met.

Discussion

- 11.35 In our view, the existing divide between adult social care and housing should be maintained in our scheme. Earlier in this Part, we recommend that the current language of the statutory prohibitions should be reviewed and where appropriate revised to clarify their meaning. Although this recommendation was made in the context of discussing the health and social care divide, it also extends to the prohibition on the provision of housing.
- 11.36 We accept that our scheme must encourage joint working between social services and housing authorities. This is addressed later in this Part, where we discuss and recommend duties to co-operate. In addition, the code of practice should provide guidance on how social services and housing authorities should

²³ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 9.72 to 9.81.

²⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 195.

²⁵ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 198.

work together to support people with social care needs who are judged to be intentionally homeless.

- 11.37 We do not make any recommendation in relation to the prohibition on providing adult social care services to those subject to immigration control. If the policy of the Government and the Welsh Assembly Government towards asylum seekers continues, the likely consequences identified by consultees are that vulnerable asylum seekers will continue to be excluded from access to support, with the result that their physical health and well-being may deteriorate, and existing mental health problems will be exacerbated. Retaining the prohibition would continue to place a heavy burden on surrounding families, including children, to care for the asylum seekers, and would also perpetuate the existing legal confusion about the assessment process for asylum seekers.²⁶

Recommendation 56: Our scheme should prohibit social services authorities from providing ordinary housing and connected services, if these services are authorised or required to be provided under other legislation.

CHILDREN AND YOUNG PEOPLE, YOUNG CARERS AND PARENT CARERS

- 11.38 This section considers the interface between adult social care and the legal framework for social care provision to children and young people. Specifically, it considers the overlap between adult and children's social care legislation; the transition from children's to adults' services; young carers; and parent carers.

The overlap between adult and children's social care legislation

- 11.39 As noted in our consultation paper, most adult social care law applies to those over 18 years of age. However, the following provisions also apply to children and young people: section 2(1) of the Chronically Sick and Disabled Persons Act 1970; section 4 of the Disabled Persons (Services, Consultation and Representation) Act 1986; section 117 of the Mental Health Act 1983; paragraph 3 of schedule 20 to the NHS Act 2006; the Carers (Recognition and Services) Act 1995; and the Carers and Disabled Children Act 2000.
- 11.40 The consultation paper proposed that the adult social care statute should apply to those aged 18 and above. In general terms, this would mean that children's services would be provided primarily under the Children Act 1989, and adults' services under our scheme. To ensure that children did not lose their existing enforceable rights to services, we argued that the Chronically Sick and Disabled Persons Act 1970 should be retained but amended so that it would apply only to those under 18 (or the Children Act could be amended to include similar rights to services).²⁷

²⁶ As above.

²⁷ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 11.2 to 11.9.

Consultation responses

- 11.41 The majority of responses to this proposal agreed that the Children Act should be the principal mechanism for providing support to children and young people.²⁸ Many consultees highlighted that this would clarify the current position, and encourage greater consistency. However, some consultees argued that distinguishing between adults and children at the age of 18 is often artificial and the statute needs to accommodate those who need to remain in children's services for longer and those who need to move to adult services earlier.

Discussion

- 11.42 The existing overlap in law creates an awkward relationship between adult social care and the Children Act. At consultation there was widespread confusion amongst service users and professionals over which legislation can apply to children and which can apply to adults. In general terms, we consider that our scheme should apply to those aged 18 and over, subject to a mechanism to allow for transitional service provision (discussed below).
- 11.43 We recognise concerns that the provision of services to children may continue to be governed by various different statutes, most notably the Chronically Sick and Disabled Persons Act 1970. Although the provision of services to children is strictly speaking beyond the remit of our review, in our view both Governments should consider amending the Children Act to incorporate the same rights to services for disabled children that are currently contained in adult social care legislation.

Recommendation 57: The adult social care statute should apply to those aged 18 and above (subject to a power to provide transitional services).

The Government and the Welsh Assembly Government should consider amending the Children Act 1989 to incorporate the same rights to services for children that are currently contained in the Chronically Sick and Disabled Persons Act 1970, the Disabled Persons (Services, Consultation and Representation) Act 1986 and the NHS Acts 2006.

The transition from children's to adults' services

- 11.44 Some children, for example disabled children, will need continuing services into adulthood. In order to provide a framework to ensure an effective transition from children's to adults' services, the consultation paper proposed that local authorities should be given a power to assess and provide services to young people aged 16 and 17 under the adult social care statute. In addition, young people aged 16 and 17 (and their parents on their behalf) would be given a right to request that they be assessed under the adult social care statute rather than the Children Act and the local authority would then be required to give written reasons if it decides not to carry out the assessment. Finally, we proposed new duties to co-operate, which would apply when a young person is moving from children's to adults' services.

²⁸ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 223.

Consultation responses

- 11.45 The majority of consultees who expressed a view agreed with the proposal.²⁹ Some argued we should go further by establishing a duty rather than a power to assess young people aged 16 and 17 under adult social care legislation and giving carers of the young person – in addition to parents – the power to request an assessment on behalf of a 16 or 17 year old. A small number of consultees rejected the proposals outright, arguing that transferring any 16 and 17 year olds to adult social care legislation could never be in their *best interests*.
- 11.46 Some consultees put forward alternative proposals; for example, a duty on adult services to assess young people who lack capacity if this is likely to persist into adulthood and the failure to assess would place them at risk of harm; and a duty on adult services to assess any disabled child who will need continuing services into adulthood, at a *reasonable time* before they reach 18.
- 11.47 Some consultees raised concerns that local authorities may favour providing services under adult legislation on the basis that it is easier to charge for community care services than for services under the Children Act, and therefore some young people may be affected adversely by our proposals. Others argued that issues relating to consent needed to be clarified, particularly where parents request an assessment on behalf of a 16 or 17 year old who does not want to be assessed and has the capacity to make this decision.

Discussion

- 11.48 At consultation there was widespread support for our proposal to introduce duties to co-operate, which would apply when a young person is moving from children's to adults' services. We consider that the statute should include an enhanced duty to co-operate in this situation. Our overall recommendations in relation to duties to co-operate are discussed in more detail later in this Part.
- 11.49 Consultation has confirmed our view that local authorities should be given powers to support 16 and 17 year olds under adult social care legislation in certain cases. This could include, for example, where a young disabled person is likely to need services beyond the age of 18. We do not agree that it can *never* be in a young person's interests to secure access to services under adult legislation. There are cases where this would be the best option, not least because it will encourage an effective transition from children's to adults' services. Furthermore, certain young people will benefit from the greater availability of direct payments under adult legislation and being able to establish individually enforceable entitlements to services that are not available under the Children Act.³⁰
- 11.50 However, we recognise concerns that if local authorities were given this general power, there may be an incentive to choose between children's and adult legislation for reasons other than what is most appropriate for the young person – such as choosing the legislation that allowed it to charge more for services or reduce services. While we do not comment on the validity of these claims, the

²⁹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 225.

³⁰ *R (G) v Barnet London Borough Council* [2003] UKHL 57, [2004] 2 AC 208.

underlying point being made – that this power needs to be exercised in a clear and principled way – is in our view important.

- 11.51 Under our scheme this would be addressed in a number of ways. First, when a local authority is deciding whether or not to exercise its general transitional power, it will be required to apply the well-being principle of the statute. As we recommend in Part 4 (Statutory Principles), this will require the local authority – amongst other matters – to assume that the person themselves is the best judge of their own well-being; to follow their wishes, views and feelings wherever possible and appropriate; and to involve fully the person concerned. This should help to ensure that decisions are made which are most appropriate for the young person concerned. Second, we suggest that the code of practice should provide guidance to local authorities on how to exercise its transitional power and provide concrete examples of when it would and would not be appropriate to exercise this power.
- 11.52 We also consider that a request mechanism for 16 and 17 year olds would help to promote good decision making, for example by ensuring that in most cases the transitional power would only be exercised where the young person consents to the assessment. As noted in Part 5 (Assessments), there are various difficulties associated with request mechanisms, particularly when they operate alongside a statutory duty, such as the duty to assess. However, where a local authority has a power rather than a duty to act, request mechanisms can help to clarify the reasons why an authority decides in an individual case not to exercise its discretion.
- 11.53 We accept that any suggestion of introducing a *right to request an assessment* is misleading. Any individual has a *right* to make a request to a local authority that it exercise a power. This right applies irrespective of whether it is stated in statute law. Indeed, some consultees suggested that by stating in statute law that certain people can make such a request, local authorities will only consider these requests and ignore their wider public law responsibilities to consider all requests. Notwithstanding these concerns, we consider that a request mechanism would add value in cases where a local authority does not utilise its transitional power. First, it will ensure that the reasons are provided in writing to the person making the request, which would not necessarily be the case under general public law principles. Second, as noted above, it will help to clarify how local authorities are exercising their discretion in this area. We also suggest that the code of practice should state clearly that all requests must still be considered by the authority.
- 11.54 We do not consider that there should be any particular formalities about the format of the request. Similarly, there should not be a set format for local authorities giving written reasons if it fails to carry out the requested assessment. However, we suggest that the code of practice should provide guidance on the format of the written reasons provided by the authority.
- 11.55 We accept that issues relating to consent need to be clarified. In our view, the request mechanism should operate by first providing that any young person can make a request, irrespective of their capacity to consent to an assessment, and second a parent can make a request on behalf of the young person, if the young person has capacity and gives consent or if the young person lacks capacity and it is in their “best interests” under the Mental Capacity Act 2005 to be assessed

under adult legislation. In order to provide clarity, both of these provisions should be stated clearly on the face of the statute. We agree that the request mechanism should be extended to a carer who does not have parental responsibility for the person. Again, we envisage that a carer could make a request on behalf of the young person if the person lacks capacity and it is in their *best interests* to be assessed under adult legislation, or if the young person has capacity and gives consent.

- 11.56 A further issue relating to consent arises where a local authority wishes to exercise its power to assess and provide services under adult legislation but the young person does not consent. We would expect that in the vast majority of cases this power would only be exercised where the young person consented, or if they lack capacity where this is in their “best interests” under the Mental Capacity Act. Some consultees argued that this power should *only* be exercised if the young person consents. We consider that local authorities should retain the ability to assess without the consent of the person concerned (as they do under the Children Act and community care legislation) because there may be a small number of cases where this is necessary; for example, where the young person is at risk of harm because there may be a gap in service provision unless they are provided with services under adult legislation. We suggest the code of practice should provide concrete examples of when this would be appropriate.
- 11.57 Some consultees argued there should be a duty to assess under adult social care legislation, rather than a power. We agree this would give greater legal certainty about when a young person can expect to be assessed under adult legislation, but we are unable to recommend such a change. In the first place, the question involves a borderline issue between children and adult services, and our remit is confined to one side of that border. Second, it may well have resource implications which, for the same reason, we are not in a position to assess. However, it may be that both Governments would want to develop policy in that direction at some time in the future. We therefore conclude that the statute should allow the creation of such a duty by secondary legislation.
- 11.58 Crucially, it will be important to co-ordinate any new legal duty with other areas of law that provide for transition planning. In making our recommendations, we envisage that all existing legal provisions that provide for transition would continue to operate, including the duty to assess certain school leavers under the Disabled Persons (Services, Consultation and Recognition) Act 1986. Both Governments should consider incorporating the relevant provisions of the 1986 Act into the Children Act, rather than retaining and amending the 1986 Act so that it would apply only to those under 18. The code of practice should clarify the interaction of the various legal provisions that apply when a young person is moving from children’s to adults’ services.
- 11.59 At consultation, it was suggested that our proposals should include the transition to adult healthcare within the NHS and the transition responsibilities of the NHS. We recognise that for transition to be effective, links must be made between children and health services, as well as social services. Our recommended duties to co-operate (discussed later in this Part) should assist in these areas.
- 11.60 Finally, some consultees argued that, in order to be consistent with special educational needs law, the ability to provide services under adult legislation

should be extended to those aged 14 and over. In our view, however, special educational needs law is the exception rather than the rule. It is important for our recommendations to be consistent with most other areas of law which treats 16 and 17 years differently to those under 16.

Recommendation 58: The statute should:

- (1) introduce an enhanced duty to co-operate, which should include specific provision to promote co-operation between relevant organisations when a young person is moving from children’s to adults’ services;**
- (2) give local authorities a general power to assess and provide services to 16 and 17 year olds under the adult social care statute;**
- (3) require the local authority to give written reasons if a young person aged 16 and 17 (and their parents or carers on their behalf) requests to be assessed under the adult social care statute, and the authority decides not to carry out the assessment;**
- (4) state that any young person may make the request irrespective of their capacity and a parent or carer can make a request on behalf of the young person, if the young person has capacity and gives consent or if the young person lacks capacity and it is in their “best interests” as defined under the Mental Capacity Act 2005 to be assessed under the adult social care statute; and**
- (5) create a duty, to be implemented via regulations issued by the Secretary of State and the Welsh Ministers, on local authorities to assess certain young people under the adult social care statute and to specify groups to whom this duty is owed.**

Young carers

11.61 The consultation paper noted that a consequence of our scheme applying to those aged 18 and above would be that young carers would no longer be entitled to a carer’s assessment under adult legislation. To ensure that young carers did not lose their existing rights, we proposed to retain and amend both the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000 – including the amendments made to both by the Carers (Equal Opportunities) Act 2004 – so that they would apply only to carers under 18. This would mean that all young carers who are providing a substantial amount of care on a regular basis would have a right to request a carer’s assessment if the person they were caring for was being assessed under adult social care legislation. Young carers aged 16 and 17 would continue to be eligible for a free-standing assessment which did not depend on the cared-for person being simultaneously assessed under the adult legislation and would also continue to be eligible for carers’ services. We also suggested that in order to ensure legal clarity there may be advantages to consolidating these statutes so that there is a single statute for young carers, rather than two separate statutes that must be read in conjunction with each other.

11.62 The consultation paper also noted that the purpose of a carer’s assessment under 1995 Act is to inform the outcome of a community care assessment for the

cared-for person. In order to retain this link, we proposed that the statute should contain a requirement that any community care assessment must have regard to the results of any assessment of a young carer under the 1995 Act, as well as any assessment of a young carer under the 2000 Act and the Children Act 1989.

- 11.63 Finally, the consultation paper proposed that the power for local authorities to assess and provide services to young people aged 16 and 17 would apply to young carers of that age who are caring for an individual aged 18 and over. The request mechanism, as described above, would also apply to young carers (and their parents on their behalf) seeking an assessment under adult legislation.³¹

Consultation responses

- 11.64 A majority of consultees who expressed a view agreed with the proposal.³² However, some expressed concern about retaining the 1995 Act and 2000 Act as rump legislation giving different levels of entry and entitlement depending on the age and circumstances of the particular carer. Others argued our proposals should go further to establish a duty to inform adult services where a child becomes a carer due to the unmet needs of their parent, and a duty for adults' and children's services to work together to meet unmet community care needs.

Discussion

- 11.65 Consultation has confirmed our view that the 1995 Act and 2000 Act should be retained and amended to apply only to carers under 18. We recognise the concern that our proposal would establish a higher threshold for a young carer's assessment, than for an adult carer. In our view, there is no reason why young carers should be treated differently in this respect. The arguments put forward in Part 7 (Carers' Assessments and Eligibility) for lowering the legal threshold for a carer's assessment apply to all carers irrespective of age and therefore, the duties to assess a young carer in the 1995 Act and 2000 Act should be amended to make them consistent with the threshold for a carer's assessment under our scheme. However, in making this recommendation we are not seeking to alter the policy of both Governments that young carers should be seen first and foremost as *children in need* under the Children Act and only in exceptional circumstances should be assessed under carers' legislation. Although the question of how our proposals for young carers are taken forward is strictly speaking beyond our remit, we recommend that both Governments should either consolidate the 1995 Act and the 2000 Act so that there is a single young carer's statute or repeal this legislation and incorporate the provisions in an amended Children Act.
- 11.66 We agree that our scheme should encourage links between adult social care and young carers' legislation. In Part 5 (Assessments), we recommend that the assessment regulations must require that local authorities take into account the care being provided by a carer when undertaking an assessment of the cared-for person and making the decision as to whether the cared-for person's needs call for the provision of services. We consider that this should be extended to include any young carer's assessment undertaken under the young carers' legislation.

³¹ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 11.10 to 11.17.

³² See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 229.

Furthermore, our recommendations for joined-up assessments in Part 5 would enable joint community care and young carers' assessments to take place, if this is considered appropriate. In addition, we recommend in Part 4 (Statutory Principles) a statutory principle to achieve a balance with the well-being of others in determining the well-being of an individual. This would include young carers, where appropriate. Finally, the code of practice should clarify how the different legislation interacts when carrying out a young carer's assessment and give concrete examples of how children's and adults' services should work together in such cases.

- 11.67 There are two further aspects of our recommendations that are relevant to young carers. First, our recommendation that local authorities should be given a power to assess and provide services to young people aged 16 and 17 would apply to young carers of that age who are caring for an individual aged 18 and over. The request mechanism, as described above, would apply to young carers (and their parents on their behalf). Furthermore, a young carer would be able to make a formal request using this mechanism on behalf of the person they are caring for.
- 11.68 Second, later in this Part we recommend the introduction of an enhanced duty to co-operate to apply when a young person is moving from children's to adults' services. This would apply to young carers and would ensure, for example, that when a community care assessment identifies a young carer or the potential for a child to become a young carer because of unmet needs of the parents, the local authority can request assistance from children's services to undertake an assessment under the Children Act or a young carers' assessment, and work together to address the unmet community care needs.

Recommendation 59: The Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000 should be retained and amended so that they would apply only to carers aged under 18.

The duties to assess a young carer in the 1995 and 2000 Acts should be amended to make them consistent with the threshold for a carer's assessment under the adult social care statute.

The Government and the Welsh Assembly Government should either consolidate the 1995 and 2000 Acts so that there is a single young carer's statute or repeal this legislation and incorporate the provisions into the Children Act 1989.

Local authorities should have a general power to assess and provide services to 16 and 17 year old young carers under the adult social care statute. The statute would require the local authority to give written reasons if a young carer aged 16 and 17 (and their parents on their behalf) requests to be assessed under the adult social care statute, and the authority decides not to carry out the assessment. A young carer would be able to make a formal request using this mechanism on behalf of the person they are caring for.

The assessment regulations made under the adult social care statute should contain a requirement that any community care assessment must have regard to the results of any assessment of a young carer.

The enhanced duty to co-operate should include specific provision to promote co-operation between relevant organisations when a person is moving from children's to adults' services.

Parent carers

- 11.69 The consultation paper proposed that people with parental responsibility for disabled children would continue to have a right to a separate carer's assessment under the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000. The results of this assessment must be taken into account when deciding what services, if any, will be provided under the Children Act 1989. Parent carers would also retain the right to have their needs addressed as part of an assessment carried out under section 17 of the Children Act. We also proposed that where a young person aged 16 and 17 is being assessed under the adult social care statute, the parent carer should be given a carer's assessment under the statute.³³
- 11.70 While the majority of consultees who expressed a view supported our proposal, concerns were again expressed – as with young carers – that it would mean retaining rump legislation for parent carers and a higher threshold for the provision of a carer's assessment for a parent carer, compared with carers who are being assessed under our scheme.³⁴

Recommendation 60: Parent carers should continue to have a right to a carer's assessment under the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000.

The duties to assess a parent carer in the 1995 and 2000 Acts should be amended to make them consistent with the threshold for a carer's assessment under the adult social care statute.

The Government and Welsh Assembly Government should either consolidate parent carers' assessments into a single young carers' statute, as described in Recommendation 59, or incorporate them into the Children Act 1989.

If a parent carer who is looking after a young person aged 16 and 17 initiates a formal request that the young person is assessed under the adult social care statute and the local authority agrees to this request, then the parent carer should also be given a carer's assessment under the same statute.

SECTION 117 OF THE MENTAL HEALTH ACT 1983

- 11.71 Section 117 of the Mental Health Act 1983 requires health authorities and local social services authorities, in co-operation with voluntary agencies, to provide after-care to patients detained in hospital for treatment under section 3, 37, 45A, 47 or 48 of the 1983 Act, who then cease to be detained and leave hospital. Case law has confirmed that section 117 is an enforceable joint duty on health bodies and local social services authorities to consider the after-care needs of each

³³ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 11.18 to 11.21.

³⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 232.

individual to whom it relates.³⁵ Furthermore, responsible authorities cannot charge for services provided under section 117.³⁶

- 11.72 As stated in our scoping report, in our scheme section 117 will remain as a separate duty to provide after-care services in the 1983 Act and will not be consolidated into the adult social care statute.³⁷ The main reason is that section 117 applies to a specific group of former mental health patients whose needs are linked directly to the 1983 Act, since services are required in order to reduce their chance of being readmitted to hospital. Furthermore, section 117 cannot be described as a *pure* social care enactment, since it establishes a joint duty on social services *and* the NHS, and would not fit easily into our scheme.
- 11.73 However, the consultation paper considered whether section 117 could or should be more fully integrated within the legal framework for the provision of adult social care services. Specifically, it considered the choice of accommodation directions; the additional payments regulations; ordinary residence; dividing the section 117 duty between the health and social services; the commissioning of after-care services; and recasting section 117 as a gateway duty. The discussion below considers these areas and also the following issues which were raised at consultation: charging for section 117 services; the definition of after-care services; and the termination of section 117.

The choice of accommodation directions

- 11.74 When a local authority has decided that residential accommodation should be provided, the *choice of accommodation directions* require the authority to accommodate that person at the place of his or her choice within England and Wales. These directions apply only to accommodation provided under section 21 of the National Assistance Act 1948. In *R (Stennett) v Manchester City Council*, it was held that section 117 imposes a free-standing duty to provide after-care services and is not a gateway provision that leads to services being provided under other statutes, such as the 1948 Act.³⁸ It follows that the *choice of accommodation directions* do not apply to residential accommodation provided under section 117.
- 11.75 The consultation paper argued that it is anomalous that people accommodated by social services under section 21 of the 1948 Act should have a legal right to choose their accommodation, while those receiving equivalent accommodation under section 117 do not. We proposed that the *choice of accommodation directions* be extended to cover accommodation provided under section 117.³⁹

³⁵ *R v Ealing District Health Authority ex p Fox* [1993] 1 WLR 373.

³⁶ *R (Stennett) v Manchester City Council* [2002] UKHL 34, [2002] 2 AC 1127.

³⁷ Law Commission, *Adult Social Care: Scoping Report* (2008) para 4.192.

³⁸ [2002] UKHL 34, [2002] 2 AC 1127.

³⁹ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 11.58 to 11.60.

Consultation responses

- 11.76 A significant majority of consultees who expressed a view agreed with the proposal.⁴⁰ Several consultees, while agreeing with our proposal, pointed out that certain people in receipt of section 117 after-care are not free to choose their own accommodation. It was also argued the extension of the directions might cause delays to placements which would secure the discharge of hospital patients.

Discussion

- 11.77 Consultation has confirmed our view that in principle, service users should be given a right to choose the accommodation that is being provided by a local authority, irrespective of whether or not section 117 applies.
- 11.78 We accept the point that some section 117 service users are not free to choose their accommodation, such as those subject to supervised community treatment or conditional discharge under the 1983 Act. However, the directions already cater for these situations by specifying that the local authority must be satisfied that the preferred accommodation is “suitable” in relation to the person’s needs.⁴¹ This ensures that, in the main, the directions do not apply in existing cases where accommodation is being provided under the 1948 Act but in conjunction with other legislation that allows for some degree of coercion, such as Guardianship under the 1983 Act, the deprivation of liberty safeguards under the Mental Capacity Act 2005 and criminal justice legislation. However, there may be a small number of cases where the directions can apply even though a degree of coercion may be necessary; for example, Guardianship may be used where a person is moving into their preferred accommodation but there is concern that their mental health may deteriorate and they may try to leave the accommodation. In Part 8 (The Provision of Services), we recommend that the conditions for the provision of preferred accommodation – including that the accommodation must be “suitable” – should be retained and placed in regulations. The code of practice should provide concrete examples on how the choice of accommodation provisions apply where service users are not free to choose their accommodation.
- 11.79 We do not agree that extending the choice of accommodation provisions to include section 117 service users would necessarily cause delays to hospital discharge. This situation is already catered for by the requirement that the preferred accommodation must be “available”, which ensures that, in the main, the directions do not apply in existing cases where accommodation is being provided under the 1948 Act to secure the discharge of a non-section 117 patient from hospital but the individual’s preferred accommodation is not available.⁴² We accept, however, that cases involving service users being discharged from hospital may raise difficult practice issues; for example, it may not be clear whether the directions apply where the patient’s preferred accommodation is not available but likely to become available in the near future. The code of practice

⁴⁰ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 255.

⁴¹ National Assistance Act 1948 (Choice of Accommodation) Directions 1992, dir 3(a) and in Wales, the National Assistance Act 1948 (Choice of Accommodation) Directions 1993, dir 3(a).

⁴² As above, dir 3(c) (England) and dir 3(c) (Wales).

should provide concrete examples on how the choice of accommodation provisions apply to hospital in-patients.

Recommendation 61: The power to make regulations requiring or authorising local authorities to accommodate a person at the place of their choice within England and Wales, set out in Recommendation 36, should apply to those receiving after-care under section 117 of the Mental Health Act 1983.

The additional payments regulations

- 11.80 The *additional payment regulations* provide that, where a resident chooses accommodation that is more expensive than the local authority would usually expect to pay, the resident can be placed in the more expensive accommodation, provided that a third party, such as a relative or friend, is able and willing to top-up the difference.⁴³ These regulations apply to accommodation provided under section 21 of the National Assistance Act 1948 and, again as a consequence of the decision in *Stennett*, do not extend to accommodation provided under section 117. In the consultation paper, we argued that, outside of the regulations, a section 117 service user or a third party can make payments in order to procure more expensive accommodation than the local authority would normally expect to pay. However, we accepted there was uncertainty on this point and therefore, proposed that *the additional payments regulations* should enable section 117 service users and third parties on their behalf to make top-up payments.⁴⁴

Consultation responses

- 11.81 A large majority of consultees who expressed a view agreed with this proposal, with many seeing it as a logical consequence of the extension of the choice of accommodation directions to include section 117.⁴⁵ The main concerns related to how this proposal may be misapplied in practice or ignored by local authorities.

Discussion

- 11.82 We consider that the *additional payments regulations* should enable section 117 service users and third parties on their behalf to make top-up payments for residential accommodation provision. This would introduce greater clarity and certainty regarding the ability to make additional payments. Whilst a small number of consultees have suggested this might be misapplied by local authorities, this concern – if it is a valid one – would be best addressed by providing clear guidance in the code of practice on how the regulations should be interpreted and applied by authorities.

⁴³ National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Amendment) (England) Regulations 2001, SI 2001 No 3441 and the National Assistance (Residential Accommodation) (Additional Payments and Assessment of Resources) (Wales) Regulations 2003, WSI 2003 No 931.

⁴⁴ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 11.61 to 11.64.

⁴⁵ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 258.

Recommendation 62: The power to make regulations to allow for the making of additional payments, set out in Recommendation 36, should apply to those receiving after-care under section 117 of the Mental Health Act 1983.

Ordinary residence

- 11.83 The concept of *ordinary residence* does not apply to section 117 services. Instead, section 117(3) states that the duty to provide after-care services falls on the authorities “for the area in which the person concerned is resident or to which he is sent on discharge by the hospital in which he was detained”. Lord Justice Scott Baker, when he was a High Court judge, held that the relevant after-care bodies for the purposes of section 117(3) are those for the area in which the patient was resident before being detained in hospital, notwithstanding that the patient can be discharged to a different part of the country and is not likely to return. Where a patient has no place of residence, the relevant bodies will be those to which the patient is sent on discharge by the hospital.⁴⁶ This position has subsequently been reflected in Government guidance.⁴⁷
- 11.84 The consultation paper proposed that the concept of ordinary residence should be extended to apply to section 117 after-care services and that the effect of the existing rules under section 117(3) should be retained whereby the patient would remain the responsibility of the local authority in which they were resident at the time of admission. In order to achieve this we put forward two options for discussion: separate rules could be applied to all section 117 services, or only in circumstances where a section 117 patient is being discharged to a new local authority and residential care is not being provided.⁴⁸

Consultation responses

- 11.85 The majority of responses to this proposal agreed that in principle the concept of ordinary residence should be extended to section 117 services and that the current effect of section 117 should be retained.⁴⁹ However, there was disagreement about the best way to achieve this. Some consultees argued that in order to keep the ordinary residence rules as clear and straightforward as possible, separate rules should apply to all section 117 services. Others argued that it would be more straightforward if the current ordinary residence rules covered all section 117 services but were disapplied in specific cases where the effect of the current rules are different.
- 11.86 In the consultation paper, we identified one potential situation where the fit between section 117 and the ordinary residence rules as they operate under the National Assistance Act 1948 would be different: where a section 117 patient is being discharged to a new local authority and residential care is not being provided. The Government helpfully pointed out two further scenarios where the

⁴⁶ *R v Mental Health Review Tribunal ex p Hall* [1999] 2 CCLR 361, 371(J).

⁴⁷ HSC 2000/003 and LAC(2000)3, *After-Care Under the Mental Health Act 1983*, paras 5 to 7.

⁴⁸ *Adult Social Care (2010) Law Commission Consultation Paper No 192*, paras 11.65 to 11.72.

⁴⁹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 260.

application of the ordinary residence rules would produce a different result to section 117 as it stands. The first is where someone has been placed in a care home in a different local authority area and is subsequently detained under section 3 of the 1983 Act. The second is where a section 117 service user moves voluntarily from one local authority area to another. Under the ordinary residence rules, that move would normally change the local authority responsible but under section 117 it does not.

- 11.87 The first scenario reflects the facts in *R (M) v London Borough of Hammersmith and Fulham*, which was published during our consultation and raised as a matter of concern by several consultees.⁵⁰ The applicant, who had a history of Korsakoff's syndrome, had lived in Hammersmith and Fulham for 15 years. Following a serious traffic accident, he was admitted to hospital and upon discharge was placed by Hammersmith and Fulham in a hostel in Sutton under section 21 of the 1948 Act. Under the *deeming rules* Hammersmith and Fulham retained funding responsibility.⁵¹ However, after nine months the applicant's mental health deteriorated and he was detained under section 3 of the 1983 Act for 11 months before being discharged to a residential placement in Ealing. It was held that the *deeming rules* under 1948 Act no longer applied because the applicant was now subject to section 117 by virtue of his section 3 detention. The period spent living in Sutton prior to his hospital admission was sufficient to satisfy the residence test under section 117(3) and therefore the court imposed a duty on Sutton to provide and fund his after-care. This was upheld on appeal.⁵² At first instance, Mr Justice Mitting noted the fact that the construction creates considerable practical problems for the management of discharged patients but this "cannot lead to a construction of primary legislation that the wording of the legislation does not bear".⁵³
- 11.88 Several local authorities expressed concern about the implications of this judgment and argued that under our scheme, responsibility for funding section 21 accommodation should remain with the placing authority as it would do under the ordinary residence rules. However, some consultees argued that the effect of this judgment should be retained since it means that service users will receive support from social workers who work in the local area and are aware of locally available services. Others argued that the specific and cyclical nature of mental illness meant that the last authority in which the patient was living should only have section 117 responsibility until any further detention occurred.

Discussion

- 11.89 In our view, extending the concept of ordinary residence to apply to section 117 after-care services would bring greater clarity and consistency. As pointed out in the consultation paper, it would also ensure that section 117 service users would benefit from having access to the dispute resolution procedures that apply to

⁵⁰ [2010] EWHC 562 (Admin), (2010) 13 CCLR 217.

⁵¹ The National Assistance Act 1948, s 24(5).

⁵² *R (Hertfordshire County Council) v London Borough of Hammersmith and Fulham* [2011] EWCA Civ 77.

⁵³ *R (M) v London Borough of Hammersmith and Fulham* [2010] EWHC 562 (Admin), (2010) 13 CCLR 217 at [27].

ordinary residence. Whether the effect of the existing rules under section 117(3) should be retained, however, is less clear cut.

- 11.90 The consultation paper attempted to replicate the existing rules for deciding who is responsible for funding services for section 117 service users and argued that to alter these rules was a matter for political policy and beyond the remit of our review. However, the decision in *R (M) v London Borough of Hammersmith and Fulham* raises serious questions about the efficacy of current policy.
- 11.91 In our view, there may be legal advantages to changing current policy and applying the same rules to section 117 service users that currently apply under the 1948 Act. It would ensure greater legal clarity and consistency, and in principle we do not consider that section 117 service users should be treated differently to other service users in this respect. However, we did not consult specifically on this issue. Changing the current rules would alter existing funding responsibilities, in the sense that different local authorities would become liable, but it would not appear to have any overall resource implications.
- 11.92 The Government suggested in its response that it might be better to take the opportunity of a new statutory framework to review, as a matter of policy, whether and to what extent, the distribution of local authority responsibilities under section 117 should be brought in line with those under the main ordinary residence rules. The Welsh Assembly Government also suggested that this issue could be taken forward as a matter of policy jointly with the Government so that a position for England and Wales could be developed. Given these responses, our view is that the issue of how the ordinary residence rules should be applied to section 117 should be taken forward as a general review of political policy.

Recommendation 63: The concept of ordinary residence should be extended to apply to after-care services provided under section 117 of the Mental Health Act 1983. The issue of how the ordinary residence rules should be applied to section 117 should be taken forward as a general review of the policy of the Government and Welsh Assembly Government.

Dividing section 117 between health and social services

- 11.93 Section 117 is a joint duty placed on health and social services authorities but it is not clear from the statute whether the duty falls jointly and severally on health and social services authorities, in that both are responsible for the entire duty, or whether the duty falls primarily on health authorities to provide *healthcare after-care* and social services authorities to provide *social care after-care*. In the consultation paper we argued that it is unlikely that a court would regard a health body as being accountable for the provision of *social care after-care*, or a social services authority as being accountable for *healthcare after-care*. However, the position is not clear in law and this could cause difficulties. We therefore proposed that section 117 should be amended to state expressly that the duty falls on health authorities to provide *healthcare after-care*, and on social services authorities to provide *social care after-care*. We also asked for views on whether, if this proposal were implemented, the termination of the duty should also be split so that, for example, *social care after-care* ceases when the social services

authority is satisfied that the person no longer needs social care after-care; or whether both authorities should be involved in the decision.⁵⁴

- 11.94 Since consultation, the Health and Social Care Bill 2011 has been introduced in Parliament and, amongst other matters, proposes to amend section 117 to make clear that in England the commissioning consortia are responsible only for the health (rather than social) services provided under section 117. It also proposes to split the termination of the section 117 duty. The section 117 duty on the consortia in question continues until it (rather than it and the local social services authority together) is satisfied that after-care is no longer required. Likewise, the duty on the local social services authority continues until it (rather than it and the consortia) is satisfied that after-care is no longer required. These amendments would apply in England but not in Wales.⁵⁵

Consultation responses

- 11.95 A majority of responses that expressed a view supported the proposal.⁵⁶ However, a significant minority disagreed on the basis that dividing the section 117 duty would not promote, and may in many cases undermine, multi-agency working. Some consultees argued that our proposal was unnecessary but accepted that there may be merit in making the position clear on the face of the 1983 Act. A small majority of responses to the question argued that the termination of the duty should not be split.⁵⁷

Discussion

- 11.96 Although a significant minority of consultees argued that section 117 should be retained as a joint duty, we remain concerned that the wording of section 117 fails to reflect sufficiently the general point that we would expect health services to be accountable for providing *healthcare after-care* and the local authority for *social care after-care*. We are not entirely persuaded that to clarify this in statute law would undermine joint working because the key issue is the quality of the underlying relationship. In areas where there are good partnership arrangements any change should make little difference. A joint duty is no guarantee of effective joint working, since social services and the NHS have exactly the same incentive to argue about who is responsible for services, as they do in any other situation.
- 11.97 Nonetheless, we recognise the view expressed by Lord Justice Otton that as a joint duty, section 117 may help to prevent people from falling between the gaps between services and encourage cross funding.⁵⁸ If this is the case, on balance there may be stronger reasons for retaining section 117 as a joint duty and providing clarification on the individual responsibilities of health and social services in guidance.

⁵⁴ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 11.73 to 11.77.

⁵⁵ Health and Social Care Bill 2011, cl 32.

⁵⁶ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 263.

⁵⁷ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 267.

⁵⁸ *R (Watson) v Richmond upon Thames London Borough Council* (2000) 3 CCLR 276, 285(A).

11.98 However, part of the answer to whether the section 117 duty should be divided, rests on whether section 117 should be a gateway duty or a free-standing duty. If section 117 is established as a gateway duty it would be implausible to maintain section 117 as a joint duty. This issue is discussed in more detail below. In our view, there are compelling reasons for establishing section 117 as a gateway duty which outweigh our reservations in relation to dividing the section 117 duty. On this basis, the section 117 duty should be divided between health and social care. If the section 117 duty is divided, then the termination of the duty should also be divided between health and social care, so that either the NHS or social services authority can terminate its duty to provide section 117 services but not the other authority's duty. Changes to the termination of the section 117 duty are discussed below.

11.99 In our view, the amendments proposed in the Health and Social Care Bill 2011 strengthen the case for dividing the section 117 duty. It would be confusing and inconsistent to retain section 117 as a joint duty as it relates to social services authorities, when health authorities are responsible only for *healthcare after-care*.

Recommendation 64: The joint duty in section 117 of the Mental Health Act 1983 should be divided between health and social care. In addition, the section 117 duty on the NHS should continue until it is satisfied that after-care is no longer required, and likewise the duty on the local social services authority should continue until it is satisfied that after-care is no longer required.

Commissioning after-care services

11.100 The section 117 duty is to “provide” after-care but apart from the reference to doing so “in co-operation with relevant voluntary agencies”, there is nothing stating that health and social services authorities may commission services from other providers. In practice, most authorities commission section 117 services and it is likely that a court would agree that *provide* must imply *commission*. However, section 117 leaves room for doubt, in contrast to most health and social care statutes, where the power to commission is explicit. Our consultation paper, therefore, proposed that section 117 should be amended to clarify that health and social services authorities can commission after-care services.⁵⁹

11.101 All consultees who expressed a view agreed with this proposal.⁶⁰ The Health and Social Care Bill 2011 proposes to amend section 117 to make clear that the duty on commissioning consortia is to “commission”, rather than “provide”, healthcare after-care. This applies in England only.

Recommendation 65: Section 117 of the Mental Health Act 1983 should be amended to clarify that social services authorities may commission services from other providers.

⁵⁹ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 11.74 and 11.77.

⁶⁰ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) para 11.232.

Recasting section 117 as a gateway provision

- 11.102 In the consultation paper we asked for views on whether section 117 should be recast as a gateway duty. In effect, section 117 would operate as an enforceable individual duty that is carried out through the provision of services under other legislation, such as the NHS Acts 2006, the Children Act 1989 and adult social care legislation. However, to preserve the existing position in relation to charging, the power to charge for community care services would be disapplied in the case of section 117 after-care services.⁶¹
- 11.103 As noted above, since consultation the Health and Social Care Bill 2011 has been introduced. This would, if passed, have the effect that any health services commissioned by the GP consortia (or the NHS Commissioning Board) under section 117 must be regarded as services provided under section 3 of the NHS Act 2006 and consequently all the rules that apply under the 2006 Act, such as prescription charges and duties to co-operate, will apply.⁶² This would establish section 117 as a form of gateway duty for NHS services.

Consultation responses

- 11.104 A majority of responses to this question argued that section 117 should become a gateway provision.⁶³ Some consultees were, however, concerned to ensure that children would not lose their existing entitlements to after-care services. Others pointed out that section 117 applies to people irrespective of their country of origin; whereas the destitution-plus test applies to most community care legislation, it does not apply to section 117 after-care.⁶⁴ It was argued this aspect of section 117 must be retained if the duty is to become a gateway provision.

Discussion

- 11.105 The main advantage of recasting section 117 from a free-standing duty to a gateway provision would be that the rules that apply to a person's care package would be the same, irrespective of whether the service user was eligible for section 117 after-care or whether they were a non-section 117 service user. In effect, the current uncertainties, complications and anomalies would be removed.
- 11.106 However, we recognise the concerns that this change could make it easier for future Governments to introduce charges for section 117 services. It is, therefore, important to emphasise that our recommendation is made *only* on the basis that the power to charge for section 117 services would be disapplied.
- 11.107 We do not consider that children or any other groups would be affected adversely by this change. There would continue to be an enforceable individual duty to provide after-care services to all groups, irrespective of whether the services are being provided under other legislation such as the Children Act 1989 or the NHS

⁶¹ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 11.78 to 11.80.

⁶² Health and Social Care Bill 2011, cl 32.

⁶³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 270.

⁶⁴ Schedule 3 to the Nationality, Immigration and Asylum Act 2002 does not apply to section 117 services.

Acts 2006, which do not in themselves contain such duties. This is because section 117 would continue to operate as an enforceable individual duty but would be carried out through the provision of services under other legislation.

- 11.108 It is also important to emphasise that this recommendation is made *only* on the basis that the existing rules which enable after-care services to be provided to those subject to immigration control must be retained.
- 11.109 As noted above, however, the consequence of establishing section 117 as a gateway duty is that it cannot remain as a joint duty and would need to be split between health and social care. While many consultees opposed the division of the section 117 duty, in our view these concerns are outweighed by the benefits of establishing section 117 as a gateway duty.
- 11.110 As noted above, the Health and Social Care Bill proposes to introduce a form of gateway for the provision of section 117 healthcare after-care services. If similar changes were made to the social care side of section 117, then any *social care after-care services* would in law be regarded as services provided under adult social care legislation. Although this is not the type of gateway we had envisaged in the consultation paper, we consider that the effect would generally be the same. However, one of the outcomes that we had hoped to achieve by creating a gateway was to make clearer the relationship between section 117 and local authority eligibility criteria. If the gateway provision had established that section 117 is an enforceable duty carried out through the provision of services *under* other legislation such as adult social care legislation (as argued in the consultation paper), then it would be clear that eligibility criteria apply. Applying the Health and Social Care Bill approach, the use of eligibility criteria would have to be read into the terms of the section 117 criteria.⁶⁵ However, our original intention could still be achieved by tightening the definition of after-care services (discussed below) and guidance in the code of practice clarifying the relationship between section 117 and eligibility criteria.
- 11.111 We also consider that in order to promote legal clarity and consistency, section 117 should be recast as a gateway duty in both England and Wales.

Recommendation 66: Section 117 of the Mental Health Act 1983 should be recast from a free-standing duty to a gateway provision in both England and Wales. The code of practice should clarify the relationship between section 117 and local authority eligibility criteria.

Other issues raised at consultation

NHS continuing healthcare

- 11.112 Several responses argued that greater clarity is needed on the relationship between eligibility for after-care services provided under section 117 of the Mental Health Act 1983 and eligibility for NHS continuing healthcare.⁶⁶ The

⁶⁵ This is on the basis that section 117 allows an authority to have regard to resources and other factors in performing its duty. This general point is discussed in Part 6 (Eligibility).

⁶⁶ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) paras 11.228 to 11.230.

relevant guidance states that because there is no power to charge for section 117 services, it is not necessary to assess for NHS continuing healthcare if all of the services that the person will receive are section 117 services; only needs that are not section 117 after-care needs should be considered for NHS continuing healthcare.⁶⁷ Local authorities and the NHS are advised to have agreements in place detailing how they will carry out their section 117 responsibilities, and these agreements should clarify which services fall under section 117 and which authority should fund them.⁶⁸ Different regions have different ways of working out how section 117 funding costs should be apportioned; however, where this results in the NHS fully funding a section 117 package this does not constitute NHS continuing healthcare. Health authorities should have separate budgets for section 117 and NHS continuing healthcare, and where they are funded from the same budget they still continue to be distinct and separate entitlements.⁶⁹

11.113 In our view, the legal relationship between NHS continuing healthcare and section 117 as set out in the relevant guidance is relatively clear. Most of the difficulties raised at consultation appear to relate to a lack of knowledge or a misreading of this position, and accordingly, should be clarified in the existing NHS guidance.

11.114 As noted above, since consultation the Health and Social Care Bill 2011 has been introduced, which would, if passed, have the effect that, in England, commissioning consortia are responsible only for the health (rather than social) services provided under section 117, and that any health services commissioned by the GP consortia (or the NHS Commissioning Board) provided under section 117 must be regarded as services provided under section 3 of the NHS Act 2006 (and all the rules that apply under the 2006 Act, such as prescription charges and duties to co-operate, will apply to section 117).⁷⁰ In our view, this change does not mean necessarily that the guidance on NHS continuing healthcare needs to be altered, insofar that it would still be possible to expect local authorities and NHS bodies to have agreements in place detailing how they will carry out their section 117 responsibilities. However, some of the explanation in the guidance will need to change to address the changed relationship between health and social services when negotiating funding agreements for section 117 services.

11.115 However, we also recommend earlier in this Part that section 117 should be amended to introduce similar changes to the social care side of the duty. In effect, local authorities would only be required to provide social services under section 117, and any social care services provided under section 117 must be regarded as services under adult social care legislation (and the same rules under that legislation would apply – including the prohibitions on health services that can be provided by local authorities). In our view, this change would mean that the current relationship between NHS continuing healthcare and section 117 could not be maintained. Local authorities would be prohibited from funding NHS

⁶⁷ Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care: July 2009 Revised* (2009) paras 115 to 116 and Department of Health, *NHS Continuing Healthcare: Practice Guidance* (2010) para 4.13.

⁶⁸ HSC 2000/003 and LAC(2000)3, *After-Care Under the Mental Health Act 1983*.

⁶⁹ Department of Health, *NHS Continuing Healthcare: Practice Guidance* (2010) para 4.13.

⁷⁰ Health and Social Care Bill 2011, cl 32.

continuing healthcare under section 117 and in effect, the NHS would be solely responsible for NHS continuing healthcare provision to section 117 service users. It is likely that such individuals would need to establish eligibility for NHS continuing healthcare on the same basis as any other person. This should be clarified in the existing NHS guidance.

Charging for section 117 services

- 11.116 The inability to charge for section 117 services produced a range of views at consultation.⁷¹ Some argued it was inequitable that informal patients or those detained under section 2 of the 1983 Act are not eligible for free section 117 services, while those detained under section 3 are eligible even though their needs are often not objectively different. In *R (Stennett) v Manchester City Council* counsel for the local authority described this scenario as “the anomaly of the compliant and non-compliant patients in adjacent beds”; although the point was rejected by Lord Steyn as being “too simplistic” on the basis that there “may well be a reasonable view that generally patients admitted under sections 3 and 37 pose greater risks ... than compliant patients” and moreover “Parliament necessarily legislates for the generality of cases”.⁷²
- 11.117 The *adjacent beds argument* was used by some consultees as being a reason for abolishing free section 117 services, whilst for others it was a reason for extending the provision of free after-care services to all formal and informal patients under the 1983 Act. Some local authorities, many of whom fell into the former group, called for a general review of charging in relation to section 117. We have some doubts as to the form of this argument in any event. It could reasonably be argued that an enhanced right to after-care was an appropriate response by the state towards those whose liberty it had curtailed.
- 11.118 Any extension of the prohibition on charging would have significant resource implications and is clearly beyond the scope of our review. Conversely, we do not consider it right to recommend a reduction in rights of this significance by allowing charging.

The definition of after-care services

- 11.119 Some consultees argued that the definition of after-care services should be clarified.⁷³ After-care services are not defined in the Mental Health Act 1983. The Mental Health Act Code of Practice in England does not give any specific examples but states such services include those provided directly and commissioned by health and social services authorities, and it lists a broad range of needs that after-care could address.⁷⁴ The *National Framework for NHS Continuing Healthcare* suggests that after-care services must be provided for a reason related to mental disorder and may not include services to meet physical

⁷¹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) paras 11.267 to 11.269.

⁷² *R (Stennett) v Manchester City Council* [2002] UKHL 34, [2002] 2 AC 1127 at [13].

⁷³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) paras 11.270 to 11.272.

⁷⁴ Department of Health, *Code of Practice: Mental Health Act 1983* (2008) paras 27.4 and 27.13.

health problems.⁷⁵ The Code of Practice in Wales defines after-care as services provided to meet an assessed need “arising from the patient’s mental disorder” and are aimed at “reducing the likelihood of the patient being readmitted to hospital for treatment for that disorder”; the examples given include social work and the administration and monitoring of medication.⁷⁶ The definition of after-care services has also been developed through case law, which has established a broad definition that includes social work, assistance with problems of employment, accommodation or family relationships, domiciliary services, and day centre and residential facilities.⁷⁷

- 11.120 In *R (Mwanza) v London Borough of Greenwich*, handed down during our consultation, it was held that a local authority’s responsibility to provide after-care services under section 117 is restricted to those services necessary to meet a need arising from the former patient’s mental disorder and aimed at reducing that person’s chance of being readmitted to hospital for treatment for that disorder.⁷⁸ Consequently, the section 117 duty does not extend to providing *normal accommodation* simply on the basis that there is an increased risk to the person if accommodation is not provided, rather than because of their mental disorder. If the person is in need of care and attention then section 21 of the National Assistance Act 1948 is the more appropriate provision for seeking assistance.
- 11.121 Several consultees were concerned by the implication that *bare accommodation* may rarely fall within section 117, arguing that without such accommodation it may be impossible to provide the other elements of the care package effectively. Others were concerned that the judgment had failed to clarify the purpose of section 117 services. One interpretation could be that section 117 services are limited to those aimed at preventing re-admission to hospital based on the specific circumstances of the last compulsory hospital admission under section 3. In practice, however, it would be extremely difficult to distinguish between services aimed at preventing section 3 admissions and those aimed at preventing admission under other sections of the 1983 Act. The alternative interpretation that section 117 could include services aimed generally at preventing any future re-admission to a psychiatric hospital – including an informal admission or an admission for a new condition not related to the previous illness.
- 11.122 Defining after-care services in the 1983 Act will help to clarify the purpose of such services, rather than leaving this matter entirely to case law. It would also help local authorities to determine which needs fall within the scope of section 117 and those needs that fall outside. As is currently the case, local authorities can apply eligibility criteria to decide which levels of social care after-care needs it will provide services to meet.⁷⁹ In order to make clear the legal position confirmed in *Mwanza*, section 117 services should be defined as those services necessary to

⁷⁵ Department of Health, *The National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care: July 2009 Revised* (2009) paras 115 to 116.

⁷⁶ Welsh Assembly Government, *Mental Health Act 1983: Code of Practice for Wales* (2008) para 31.2.

⁷⁷ *Clunis v Camden and Islington Health Authority* [1998] QB 978, 992.

⁷⁸ [2010] EWHC 1462 (Admin), (2010) 13 CCLR 454 at [67] and [75] to [76].

⁷⁹ See Part 6 (Eligibility), which discusses the relationship between the eligibility criteria and statutory duties (including section 117).

meet a need arising from the person's mental disorder for which the person was being treated while in hospital; and aimed at reducing that person's chance of being readmitted to hospital for treatment for that disorder.

- 11.123 Moreover, the definition should clarify that the aim of section 117 services is to prevent any re-admission to hospital (including voluntary admissions). Although we recognise concerns that this may lead to lifelong funding responsibilities for some former mental health patients, this makes a strong case for robust review procedures in individual cases of the ongoing need for section 117 after-care and the discharge of people where it is no longer appropriate.
- 11.124 This definition would, however, continue to exclude *bare accommodation* from section 117 status. We take the view that it is correct legally that section 117 does not include services that are not necessary to meet the needs arising from a person's mental disorder. However, we suggest that the code of practice should provide guidance on distinguishing between accommodation which is and is not related to a mental disorder.

Recommendation 67: After-care services provided under section 117 of the Mental Health Act 1983 should be defined on the face of the 1983 Act as those services necessary to meet a need arising from the person's mental disorder; and aimed at reducing that person's chance of being readmitted to hospital for treatment for that disorder. The code of practice should provide guidance on distinguishing between accommodation which is and is not related to a mental disorder.

Termination of section 117

- 11.125 Some consultees argued that the current guidance on the termination of the section 117 duty leaves a good deal of room for interpretation and should be clarified in legislation. Section 117(2) states that the duty to provide after-care services will cease if the health body and social services authority are satisfied "that the person concerned is no longer in need of such services" and that they shall not be so satisfied in the case of patients subject to a Community Treatment Order. The joint health services and local authority circular provides that:

It is for the authority responsible for providing particular services to take the lead in deciding whether those services are no longer required. The patient, his/her carer and other agencies should always be consulted.⁸⁰

- 11.126 The Code of Practice in England advises that after-care services should not be withdrawn solely on the grounds that the patient has been discharged from specialist mental health services; an arbitrary period has passed since the care was first provided; the patient is deprived of their liberty under the Mental Capacity Act 2005; the patient returns to hospital informally or under section 2; or the patient is no longer on a Community Treatment Order or section 17 leave.⁸¹

⁸⁰ HSC 2000/003 and LAC(2000)3, *After-Care Under the Mental Health Act 1983*, para 4.

⁸¹ Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 27.20.

- 11.127 Some consultees argued that additional safeguards should be added to ensure that the section 117 duty is not terminated prematurely, such as consultation with the service user, carer and any relevant support agencies.
- 11.128 We recommend, above, that as a consequence of our recommendation to divide the section 117 duty between health and social care, the termination of the duty should also be divided between health and social care. There is, therefore, a danger that any decision to bring the section 117 duty to an end could be made in isolation and without appropriate discussions between health and social services. However, since we recommend that section 117 should become a gateway duty, we consider that this concern would be addressed by the introduction of new duties to co-operate in our scheme (and those that already exist in the NHS Acts 2006). These duties are discussed in more detail later in this Part.
- 11.129 We agree with consultees that, wherever possible, all relevant people should be consulted – most importantly the service user themselves – before section 117 is terminated. We do not, however, agree that section 117 should be amended to provide for this expressly. As a general rule, guidance is the most appropriate place for providing clarity about the termination of section 117. This allows a flexible approach to be taken, which is particularly important because the circumstances in which it is appropriate to end section 117 after-care will vary from person to person and according to the nature of the services being provided. Indeed, the *Mental Health Act Code of Practice* already advises to fully involve the patient in the decision to end section 117 after-care.⁸² Furthermore, as a consequence of our recommendation that section 117 should become a gateway duty, this concern would be addressed by the application of the statutory principles we recommend in Part 4 (Statutory Principles), which would require the local authority to give individuals the opportunity to be involved, as far as is practicable in the circumstances, in any decisions made under the statute. This would include any decision by a local authority to terminate section 117 services. Accordingly, we make no further recommendation regarding the termination of section 117 after-care (other than Recommendation 64).

HOSPITAL DISCHARGE

- 11.130 The Community Care (Delayed Discharges) Act 2003 establishes separate procedures for community care and carers' assessments when NHS patients are discharged from hospital. The consultation paper did not propose to amend the content of the 2003 Act nor the relevant regulations, but rather proposed that the provisions should be incorporated in their existing form into our scheme, rather than remaining a standalone statute. This would mean that the Welsh Ministers would continue to have the option, but would not be required, to implement these provisions (as the Act has not been implemented in Wales).⁸³
- 11.131 A small majority of those who expressed a view agreed with the proposal.⁸⁴ However, many consultees disagreed or were equivocal, mainly on the basis that

⁸² Department of Health, *Code of Practice: Mental Health Act 1983* (2008) para 27.19.

⁸³ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 11.33 to 11.38.

⁸⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 238.

they did not agree with the delayed discharge legislation itself, and pointed to what they saw as the consequences of the delayed discharge provisions, including more emergency re-admissions and a lack of choice for service users.

- 11.132 In our view, the delayed discharge provisions should be incorporated into our scheme. We note that if the delayed discharge provisions are brought across to the statute, the well-being principle (as set out in Part 4 (Statutory Principles)) would apply to these provisions and would require decision-makers to, amongst other things, assume that the person is the best judge of their own well-being (if they have capacity), and follow the person's views, wishes and feelings wherever practicable and appropriate. We envisage that this would help address concerns about the current lack of choice in the process.

Recommendation 68: The delayed discharge provisions should be incorporated into our scheme.

PRISONS

- 11.133 The consultation paper considered that the legal framework does not exclude prisoners from the standard social care functions of local authorities, but that this situation arose by oversight rather than any deliberate design. For instance, there is no prohibition in law which excludes prisoners expressly from the class of persons to whom services can be provided. We noted, however, that in practice the barriers to the provision of services to prisoners include the ordinary residence rules, eligibility framework and overlap with services that can be provided by the prison and health authorities. We argued that the law cannot operate effectively unless a policy decision is made by the Government and the Welsh Assembly Government about whether prisons should be included or excluded from adult social care, and that whatever decision is taken by both Governments should be reflected in our scheme.⁸⁵
- 11.134 Consultees expressed a range of views on whether prisoners should be included or excluded from adult social care, as set out in the full analysis.⁸⁶ No consultee disputed our assertion that, as a matter of law, prisoners are not excluded from adult social care, although a number argued more clarity is needed on this issue. We have provided the Government and Welsh Assembly Government with the analysis of the consultation responses in this area, to inform their ongoing policy work. The fundamental decision must remain one for both Governments, but whatever decision is taken should be reflected in the statute.

Recommendation 69: If the policy decision is that prisoners should not be excluded from adult social care, then the legal framework must facilitate this policy, for example through the ordinary residence rules and eligibility framework. If the policy decision is that prisoners should be excluded, then the statute must make this position clear.

⁸⁵ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 11.40 to 11.54.

⁸⁶ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 243.

DUTIES TO CO-OPERATE

- 11.135 The consultation paper reviewed the different ways in which statute law can and has been used to encourage co-operation between social services and other organisations, such as the NHS. We proposed the introduction of a general duty to co-operate which would be imposed on each social services authority to make arrangements to promote co-operation with other relevant organisations. It was suggested that the statute could provide a list of relevant organisations, such as housing, education and health authorities, and provide examples of arrangements that could be made under this duty, such as sharing information, pooling budgets or staff, or providing types of goods or services.⁸⁷
- 11.136 The consultation paper also proposed the introduction of an enhanced duty to co-operate, which would allow local authorities to request certain authorities to assist in a number of circumstances, including when an assessment is taking place, in providing services to an individual, where a service user is moving from one local authority area to another and adult protection investigations. We proposed that the duty would apply to education, housing, health and other local authorities, who would be required to give due consideration to the request.⁸⁸

Consultation responses

- 11.137 The overwhelming majority of responses to these proposals agreed with the introduction of a general and an enhanced duty to co-operate in the statute.⁸⁹ Most argued that both duties should include a list of relevant bodies and provided suggestions on who should be included, although there was some support for a general catch-all category such as all *statutory services*. Some consultees argued that the general duty should be strengthened, for example by ensuring effective information sharing. None of the written responses expressed support for extending the circumstances in which the enhanced duty would apply beyond those suggested in the consultation paper. There was also broad agreement that the duty should apply to education, housing, health and other local authorities. Some argued that social services authorities should be placed under a duty to give due regard to requests to co-operate from other bodies such as health services.

Discussion

- 11.138 Consultation has confirmed our view that the statute should include a general and enhanced duty to co-operate. It is important for the statute to be precise about which bodies are included in these duties. As a minimum, we consider the duty should cover health services, the police, other local authorities and any other persons or bodies the authority consider appropriate. In addition, the duty should also promote co-operation internally between social services and other departments such as children's services and, in unitary authorities and London Boroughs, housing departments. In our view, the list of authorities must be limited to public bodies in England and Wales, including hybrid public bodies. The duty

⁸⁷ Adult Social Care (2010) Law Commission Consultation Paper No 192, para 11.91.

⁸⁸ Adult Social Care (2010) Law Commission Consultation Paper No 192, para 11.92.

⁸⁹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 274 and p 279.

operates at the level of public law and cannot be made enforceable against purely private bodies. We set out our list below.

- 11.139 In relation to information sharing, we acknowledge that many consultees reported that this causes difficulties in practice and we therefore suggest that the code of practice provide guidance on how the duty should be implemented to ensure effective and lawful information sharing. Some consultees argued that as well as local authorities, other agencies should be placed under an obligation to promote co-operation. However, this would require amendments to the statutory functions of non-social care agencies and is accordingly outside the scope of our review. Furthermore, in relation to health services a similar duty to co-operate is set out in section 82 of the NHS Act 2006. We accept the views of consultees that the proposed enhanced duty could be strengthened by the inclusion of a requirement to give written reasons if the requested authority refuses to co-operate. We are also persuaded that the enhanced duty should be reciprocal and require social services to give due regard to requests to co-operate from other bodies and give written reasons if it decides not to co-operate.

Recommendation 70: The statute should include a general duty to co-operate which would be imposed on each social services authority to make arrangements to promote co-operation with:

- (1) other adult social services authorities;**
- (2) NHS public bodies;**
- (3) housing authorities, and bodies which provide housing on the nomination of housing authorities;**
- (4) education authorities;**
- (5) children's social services;**
- (6) the police; and**
- (7) subject to Government policy on prisons, the National Offender Management Service.**

The statute should also give examples, in the form of a non-exhaustive list, of arrangements that can be made under this duty, such as sharing information, pooling budgets or staff, or providing types of goods or services.

Recommendation 71: The statute should include an enhanced duty to co-operate. This duty would apply when:

- (1) an assessment of a service user or carer is taking place;**
- (2) providing services to a service user or carer;**
- (3) a service user is moving from one local authority area to another;**
- (4) an adult protection investigation is taking place;**
- (5) a request is made by a local authority for an NHS continuing healthcare assessment;**
- (6) someone moves from local authority care into NHS continuing healthcare; and**
- (7) a young person (including a young carer) is moving from children's to adults' services.**

This duty would apply to the same list of organisations above. The requested agency would be required to give due consideration to the request, and if it refuses to co-operate would be required to give written reasons. The duty would also require the social services authority to give consideration to requests to co-operate from other bodies and give written reasons if it decides not to co-operate.

PART 12

OTHER ISSUES

INTRODUCTION

- 12.1 This Part considers the remaining areas discussed in our consultation paper, as well as other issues that emerged during consultation. Specifically, it considers advocacy, the disability register, urgent service provision, re-ablement services, strategic planning, Shared Lives, the definition of a disabled person, the well-being power, and complaints and redress.

ADVOCACY

- 12.2 There has long been recognition by disability groups, professionals, service providers and service users of the importance of advocacy and the valuable role it can play in supporting service users and carers. Even though this issue was not addressed in our consultation paper, the need for and importance of advocacy services in adult social care was reflected in the evidence we received. Advocacy in social care refers to a particular role, distinct from advocacy in formal proceedings as understood by lawyers. The role of the advocate is to assist disabled people to speak up for themselves, or if the disabled person is unable to do so, to communicate and represent the disabled person's needs and wishes. Advocacy is, therefore, seen as a vital component of achieving independent living and full citizenship for disabled people.¹
- 12.3 Both Governments' support for advocacy is set out in a range of policy documents. For example, *Improving the Life Chances of Disabled People* recommends "improvements to the availability of independent advocacy" as part of a more general commitment to full and equal citizenship for all disabled people.² The *Valuing People Now* three-year strategy for people with learning disabilities sets out a programme of regional and national action to support the development of advocacy.³ Similar policy statements appear in the national strategies on autism and dementia.⁴ The Coalition Government has also given support for the development of advocacy services as part of the policy of personalisation.⁵ Finally, the Welsh Assembly Government is intending to develop a business case to introduce a comprehensive advocacy service for older people.⁶
- 12.4 Although the provision of advocacy has been developed largely through political policy, there are a number of existing legal rights to advocacy. These include:

¹ Prime Minister's Strategy Unit, *Improving the Life Chances of Disabled People* (2005) p 58.

² As above, pp 10 and 14.

³ HM Government, *Valuing People Now: A New Three-Year Strategy for People With Learning Disabilities* (2009) para 4.5.

⁴ HM Government, *Fulfilling and Rewarding Lives: The Strategy for Adults with Autism in England* (2010) p 45 and Department of Health, *Living Well With Dementia: A National Dementia Strategy* (2009) p 48.

⁵ Department of Health, *A Vision for Adult Social Care* (2010) para 4.9.

⁶ Welsh Assembly Government, *Sustainable Social Services for Wales* (2011) para 3.46.

- (1) the duty to appoint an Independent Mental Capacity Advocate under the Mental Capacity Act 2005 if a local authority intends to arrange long-term residential accommodation for a person who lacks capacity and there is no-one to represent their *best interests*;⁷
- (2) powers to appoint an Independent Mental Capacity Advocate where a review of residential care is taking place and in adult protection cases;⁸
- (3) the duty to appoint an Independent Mental Health Advocate for detained patients and those living in the community under certain powers of the Mental Health Act 1983;⁹
- (4) target duties placed on local authorities to provide “support and advice services” such as advocacy,¹⁰ which will crystallise into a specific individual duty if a service user is assessed as having an eligible need that requires the provision of an advocate;¹¹ and
- (5) in certain circumstances, a right to advocacy can be derived from the State’s positive procedural obligations under Article 8 of the European Convention on Human Rights.¹²

12.5 In addition, the Disabled Person (Services, Consultation and Representation) Act 1986 enables the Secretary of State and the Welsh Ministers to make regulations to make provision for the appointment of “authorised representatives of disabled persons”. The 1986 Act goes on to require local authorities to permit representatives to, amongst other matters, make representations following a community care assessment and if services are not being provided.¹³ These provisions, however, have never been enacted.

Consultation responses

12.6 The evidence presented by consultees makes clear that advocacy services play an essential role in assisting people to make and communicate decisions, safeguarding people from abuse and neglect and helping people to enforce their rights, secure access to justice and obtain an effective remedy.¹⁴

⁷ Mental Capacity Act 2005, s 39.

⁸ Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations 2006, SI 2006 No 2883 and the Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Wales) Regulations 2007, WSI 2007 No 852.

⁹ Mental Health Act 1983, ss 130A and 130C.

¹⁰ For example, National Assistance Act 1948, s 29 and LAC(93)10, appendix 2, para 2(1)(a). See also Department of Health, *Prioritising Need in the Context of Putting People First* (2010) paras 36 and 126.

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

¹² *CF v Secretary of State for the Home Department* [2004] EWHC 111 (Fam) at [166] and [167] and *S v Local Authority X* [2003] EWHC 551 (Fam) at [45] and [59]. See also Munby LJ, “Making Sure the Child is Heard: Part 2 – Representation” (2004) 34 *Family Law* 427.

¹³ Disabled Person (Services, Consultation and Representation) Act 1986, ss 1 to 3.

¹⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) paras 14.2 to 14.19.

- 12.7 Some consultees developed this point and argued that a new legal right to advocacy was needed. It was argued that without the express backing of the law, access to advocacy would remain patchy and would not be seen as an important service or form of support for service users. Moreover, consultees argued that a legal right to advocacy would prevent local authorities withdrawing funding from advocacy services critical of them. One consultee pointed to a discrepancy that would arise without a formal right to advocacy in our scheme: a person would be entitled to an Independent Mental Capacity Advocate as of right if they are *unbefriended* and being placed in a care home, but not if the placement is terminated and they are placed in a supported living scheme.
- 12.8 Others argued that the United Nations Convention on the Rights of Persons with Disabilities is supportive of a right to advocacy. The preamble to the Convention sets out that disabled people “should have the opportunity to be actively involved in decision-making processes about policies and programmes including those directly affecting them”.¹⁵ Although Article 29, which deals with involvement in detail, focuses on political rights and public affairs, arguably when read in light of the Convention as a whole, there is implicit support for the right to advocacy.¹⁶

Discussion

- 12.9 There is already a general right to advocacy in adult social care legislation, in the unimplemented provision of the Disabled Persons (Services, Consultation and Representation) Act 1986. It would be contrary to our stated aim of not removing rights not to recreate this right in the statute. However, it would be going beyond law reform into the realm of political policy to recommend its immediate implementation. The provision is also a comparatively old one now, and we therefore consider it would be appropriate to allow the specific requirements of the 1986 Act to be modified by regulation, to allow the scheme to be expanded in the light of the more expansive understanding of advocacy now current.

Recommendation 72: The right to advocacy contained in the Disabled Persons (Services, Consultation and Representation) Act 1986 should be retained in the statute, with a power for the Secretary of State and Welsh Ministers to implement the right and modify it to bring it into line with modern understandings.

DISABILITY REGISTERS

- 12.10 Section 29(4)(g) of the National Assistance Act 1948 and the relevant directions¹⁷ require local authorities to compile and maintain registers of people to whom section 29 of the 1948 Act “relates” and who are ordinarily resident in their area. Section 29 *relates* to disabled people, who are defined as adults who are:

¹⁵ United Nations, *Convention on the Rights of Persons with Disabilities and Optional Protocol* (2006) Preamble o.

¹⁶ E Flynn, “Ireland’s Compliance with the Convention on the Rights of Persons with Disabilities: Towards a Rights-Based Approach for Legal Reform?” (2010) 3 *Dublin University Law Journal* 357, 370.

¹⁷ LAC (93)10, appendix 4.

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

- 12.11 This duty is supplemented by section 1 of the Chronically Sick and Disabled Persons Act 1970, which requires local authorities to “inform themselves” of the number of people in their area to which section 29 of the 1948 Act “applies”. The register should include both those who are receiving section 29 services and those who may require such help in the future.¹⁸ Its purpose is to assist local authorities to plan services and for certain statutory purposes unconnected with section 29 (such as establishing eligibility for certain welfare benefits).¹⁹
- 12.12 In addition to the requirement to maintain a register, there are similar but not identical requirements to collect information about service users and carers. For example, statutory guidance obliges local authorities in England to collect and analyse data on a number of issues, including which service user groups are referred for assessment and receive services, and to “identify, make contact with and keep a record of deafblind people in their catchment area”.²⁰ Furthermore, joint strategic needs assessments and local commissioning strategies require information on social care profiles and levels of need within an area.²¹
- 12.13 The consultation paper proposed that the disability register should be abolished on the basis that few disabled people choose to register and it therefore fails to provide an accurate record, and the register’s accuracy is further undermined by the restrictive definition of disabled people provided in section 29 of the 1948 Act. Moreover, there is no evidence that the registers are used in strategic planning, and even an accurate register would be of little use for effective strategic planning which requires a needs-based approach. Finally, the majority of services, welfare benefits or concessions do not rely on registration. The consultation paper did, however, recognise that the register is more accurate in relation to blind and partially sighted people and most of the benefits linked to registration are directed at this group. We therefore asked for views on whether the register should be retained but only in respect of such people.²²

Consultation responses

- 12.14 A majority of responses to this proposal agreed that the disability register should be abolished.²³ Some described registers as stigmatising, and suggested that local authorities fail to maintain their register properly or even at all. However, a significant minority of consultees disagreed with our proposal. Some argued that

¹⁸ LAC (93)10, appendix 4, para 2.

¹⁹ LAC (93)10, appendix 4, para 2 and DHSS Circular 12/70, *Chronically Sick and Disabled Persons Act 1970*, para 5.

²⁰ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) paras 156 to 161 and LAC(DH)(2009)6, *Social Care for Deafblind Children and Adults*, para 14. See also NAFWC 10/2001, *Social Care for Deafblind Children and Adults*, para 16.

²¹ Local Government and Public Involvement in Health Act 2007, s 116.

²² Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 13.2 to 13.13.

²³ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 325.

disability registers need to be reformed rather than abolished, and that in areas where the duty to maintain a register is taken seriously and allocated sufficient resources, registers *are* effective tools for strategic planning and other purposes. Furthermore, several responses stated that the registers are valuable for blind and partially sighted people, including responses from organisations that represent these groups and individual service users who fall within these categories.

Discussion

- 12.15 In most cases disability registers fail to fulfil the two main purposes for which they were established: assisting local authorities to plan services and proving eligibility for certain benefits. However, there are important exceptions. The register is significantly more accurate in relation to blind and partially sighted people and most of the benefits linked to registration are directed at these groups. Furthermore, it appears that where there is a strong local commitment to make the registers work they can be an effective tool for planning and other purposes.
- 12.16 We therefore consider that the duty to establish and maintain a register should be maintained but only in relation to blind and partially sighted people. In all other cases, local authorities should be given a power to establish registers. This would allow local authorities who are strongly committed to the development of registers to continue to use them effectively.
- 12.17 We also note that statutory guidance is being used increasingly as a way of requiring local authorities to collect data about service users without having to maintain a formal register. For example, the *Prioritising Need* statutory guidance requires local authorities to collate a range of data about referrals and assessments.²⁴ It is possible that, if properly maintained, the register could feed into this data collection requirement.
- 12.18 Moreover, the guidance for deafblind people suggests a more proactive role for local authorities in that they are not only required to keep a record but also “make contact” with service users.²⁵ On consultation, this was viewed as a useful and welcome innovation. We, therefore, consider that these requirements should be maintained in the code of practice. We also suggest that both Governments should consider extending the latter requirement (*to make contact with*) to other service user groups.

Recommendation 73: Local authorities should be required to establish and maintain a register of blind and partially sighted people. In all other cases, local authorities should be given a power to establish and maintain registers.

The code of practice should maintain the existing requirements for local authorities to analyse data on a number of issues including which groups are referred for assessment and receive services; and identify, make contact with and keep a record of deafblind people in their catchment area.

²⁴ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 156.

²⁵ LAC(DH)(2009)6, *Social Care for Deafblind Children and Adults*, para 14 and NAFWC 10/2001, *Social Care for Deafblind Children and Adults*, para 16.

URGENT SERVICE PROVISION

- 12.19 Section 47(5) of the NHS and Community Care Act 1990 allows a local authority to provide temporary community care services without having undertaken an assessment where in the opinion of the authority the person requires those services as a matter of urgency. Subsection 47(6) provides that if, by virtue of subsection (5), services have been provided temporarily, then as soon as practicable thereafter an assessment of the person's needs must be made in accordance with section 47(1). The consultation paper proposed that both these provisions should be retained in the statute.²⁶
- 12.20 All responses who expressed a view agreed with this proposal.²⁷ It was argued that this power is an essential means of allowing local authorities to assist people at times of emergency and crisis. However, several people suggested that greater clarity was needed about what was meant by *urgent cases* and when emergency intervention is appropriate. It was also suggested that this power should be recast as a duty since local authorities can be reluctant to exercise the power without substantial advocacy on the behalf of the person concerned.
- 12.21 We agree that the power to provide emergency services is a useful mechanism to deal with situations of crisis. However, it is not desirable to express this as a duty rather than a power. We did not receive evidence that the current power was not working or insufficient, and changing this into a duty would have resource implications. We suggest the code of practice should provide concrete examples of the circumstances where a local authority should exercise the power.

Recommendation 74: The statute should retain local authority powers to provide temporary urgent services before an assessment is carried out.

RE-ABLEMENT SERVICES

- 12.22 The previous Government in England and the Welsh Assembly Government had signalled an intention to provide individuals with a right to re-ablement services for a set period of time. Such services might include care and support for people who are leaving hospital for the first time; however no further details were published on whether such services would be subject to the same eligibility criteria as other services.²⁸ Our consultation paper proposed that if a right to re-ablement services is introduced, this should be accommodated in the statute.²⁹
- 12.23 A majority of consultees who expressed a view agreed with the proposal.³⁰ However, queries were raised about the meaning of *re-ablement* and the relationship between a right to re-ablement and our proposed eligibility framework. Many consultees expressed concern about the resources implications if such services had to be provided free of charge. The Government stated that

²⁶ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 4.58 to 4.60.

²⁷ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 92.

²⁸ Shaping the Future of Care Together (2009) Cm 7673, p 51 and Welsh Assembly Government, *A Strategy for Social Services in Wales Over the Next Decade* (2007) p 38.

²⁹ Adult Social Care (2010) Law Commission Consultation Paper No 192, para 6.26.

³⁰ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 123.

“we do not anticipate that there will be rights to specific services stated in the statute”. Similarly, the Welsh Assembly Government stated that while a right to re-ablement services remains a “policy priority” it is unlikely that such a right would be introduced in advance of a new adult social care statute.

- 12.24 Since consultation, the Welsh Assembly Government has stated it will “introduce a requirement for re-ablement services to be provided across Wales”.³¹ In our view, if the policy intention is to introduce a specific right to re-ablement services, then this right should be set out in the statute, and its relationship with the eligibility framework should be made clear. Otherwise, re-ablement would be accommodated in our scheme through the retention of the existing right to re-ablement services (known as “intermediate care”) free of charge, which we recommend in Part 8 (The Provision of Services).³² Furthermore, our scheme would continue to allow local authorities, before proceeding to determine eligible needs, to consider whether an individual might benefit from “a short period of re-ablement or intermediate care to increase what they are able to do for themselves before an assessment of longer-term need is undertaken”.³³ This is discussed in Part 5 (Assessments). Due to the uncertainty of the policy position in Wales we do not make a specific recommendation on re-ablement services.

STRATEGIC PLANNING

- 12.25 The legal framework for strategic planning is complex and often confusing, as discussed in detail in the consultation paper. There is continuing lack of clarity about what obligations are currently in force and how they work. Furthermore, the strategic planning responsibilities of local authorities are much wider than the planning of adult social care services and include, for example, housing, children’s services, the NHS, emergency services and voluntary groups. Accordingly, we argued that it made little sense and goes beyond the remit of our review to try and address this complexity by proposing a duty on local social services departments alone to provide strategic plans. We therefore proposed not to include any strategic planning requirements in our scheme.³⁴
- 12.26 A majority of consultees who expressed a view agreed with the proposal.³⁵ Most recognised that strategic planning is a confused and complicated area and to add further provisions would only exacerbate these problems. Nevertheless, there were a small number of consultees that argued that our scheme should include strategic planning provisions.
- 12.27 As discussed earlier in this Part, under our scheme local authorities would continue to have a duty to establish and maintain a register in relation to blind

³¹ Welsh Assembly Government, *Sustainable Social Services for Wales* (2011) para 3.39. See also Department of Health, *A Vision for Adult Social Care* (2010) para 3.12.

³² Community Care (Delayed Discharge etc) Act (Qualifying Services) (England) Regulations 2003, SI 2003 No 1196.

³³ Department of Health, *Prioritising Need in the Context of Putting People First* (2010) para 41.

³⁴ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 13.16 to 13.25.

³⁵ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 330.

and partially sighted people, as well as a power to compile a disability register more generally. These registers can be used in strategic planning for adult social care and other services. However, in our view, it would not be effective or appropriate to include further strategic planning provisions in our scheme. We therefore do not make a specific recommendation on this issue.

SHARED LIVES

- 12.28 Shared Lives, formerly known as *adult placements*, is a service that generally involves the placement of service users in family homes where they have the opportunity to be part of the carer's family and support networks. However, the Shared Lives scheme does not sit easily in the community care legal framework and there is some confusion about whether it is a residential or non-residential service. How Shared Lives is categorised has consequences for charging, whether direct payments are available to fund it, and the application of the ordinary residence rules. The consultation paper proposed that the statute should enable regulations to be issued by the Secretary of State and Welsh Ministers prescribing whether Shared Lives schemes should be considered to be a residential or non-residential service. It was argued this would allow flexibility in the law and enable any changes or developments of policy.³⁶
- 12.29 A majority of consultees who expressed a view agreed with the proposal including organisations representing Shared Lives schemes and individual service users and carers who participate in such schemes.³⁷ However, a small number of consultees disagreed with the proposal, arguing that Shared Lives should be considered to be residential care in some cases, or to allow for the possibility that these schemes may in the future extend their service provision into what would normally be regarded as residential care.
- 12.30 We consider that it is important that the law should provide certainty on this issue, although we express no view on whether Shared Lives should be viewed as a residential or non-residential service. We accept, however, the view that the law should be sufficiently flexible to allow Shared Lives schemes to develop in the future. We therefore consider that the regulation-making power should be sufficiently broad to allow the Secretary of State and the Welsh Ministers to apply the regulations differentially in relation to specific Shared Lives schemes.

Recommendation 75: The statute should give the Secretary of State and Welsh Ministers a regulation-making power to prescribe whether Shared Lives schemes should be considered to be residential or non-residential services. This power should allow the regulations to apply differentially to specific Shared Lives schemes.

DEFINITION OF A DISABLED PERSON

- 12.31 Most community care statutes only allow services to be provided to certain categories of user groups. However, some of the descriptions of these categories are outdated and stigmatising and furthermore, many of the categories are too

³⁶ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 9.54 to 9.60.

³⁷ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 187.

broad to serve any useful legal purpose. The consultation paper argued that it would also be difficult to consolidate the existing categories without the definition becoming so broad as to be almost meaningless. Furthermore, we argued that in principle a person should be eligible for services if they have an assessed eligible need and that to provide an additional hurdle based on a legal category, such as “a disabled person”, is unnecessary. We, therefore, proposed that the statute should not include a central definition of a *disabled person* or *service user*.³⁸

- 12.32 A majority of consultees who expressed a view agreed with the proposal.³⁹ Many argued that this proposal would modernise statute law and ensure that community care law moves away from the stigmatising language and assumptions of dependency and deficiency that pervade it. However, some consultees disagreed with the proposal, arguing there should be a *social model* of disability in the statute or a list of categories of service user groups.
- 12.33 In our view, the requirement that a person must fall within a legal category (such as a disabled person) in addition to having an assessed eligible need is unnecessary and would undermine our primary goal of reducing the confusion and complexity that pervades adult social care. We therefore do not make any recommendation for a legal definition of a *disabled person* or *service user*.

WELL-BEING POWER

- 12.34 Section 2(1) of the Local Government Act 2000 gives local authorities in England and Wales a wide-ranging power to do anything that is likely to promote the well-being of their area. This includes giving financial assistance and providing staff, goods, services or accommodation to any person.⁴⁰ The consultation paper noted that there is potentially a good deal of overlap between the provision of adult social care services and the use of the well-being power, and explored the idea of whether the well-being power could become the vehicle for the provision of services under the adult social care statute. While concluding that there are no clear advantages to such a structure, the paper asked for further comments on how the well-being power is being or should be used in practice.⁴¹
- 12.35 At consultation, a number of local authorities stated that they rarely use the well-being power, while other consultees highlighted a number of ways in which the well-being power is currently being used in the area of adult social care, such as meeting needs that fall below the eligibility threshold.⁴²
- 12.36 Since consultation, the Localism Bill 2011 has been introduced in Parliament, which includes a general power of competence for local government in England that is far wider than (and in England it will replace) the well-being power. It is therefore not necessary to make any recommendations for the well-being power in this report. While the general power of competence does have some

³⁸ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 9.35 to 9.51.

³⁹ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 180.

⁴⁰ Local Government Act 2000, s 2(4).

⁴¹ Adult Social Care (2010) Law Commission Consultation Paper No 192, paras 11.22 to 11.32.

⁴² See Law Commission, *Adult Social Care: Consultation Analysis* (2011) p 234.

implications for the necessity to draft specific *powers* for local authorities, the *duties* that apply in our scheme will still have to be clearly stated. The relationship between the general powers of a local authority and its specific duties is discussed in more detail in Part 5 (Assessments).

COMPLAINTS AND REDRESS

- 12.37 In the scoping report, we put forward the view that one aspect of the adult social care project 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.⁴³ While the Department of Health approved the scoping report as providing the agenda for our substantive law reform project, the one area they did not wish us to cover was the system for service user redress. Accordingly, our consultation paper did not examine the efficacy of the complaints and redress system, nor did it make any proposals on this issue.
- 12.38 Notwithstanding the decision not to take this area forward in the substantive project, the issue of complaints and redress came up at the majority of consultation events we attended, and was raised in several submissions.⁴⁴ In particular, many consultees argued that a community care tribunal was needed to provide a merits review of local authority decisions in this area. Although this issue is outside of our remit, in our view both Governments should consider reviewing this area in the future.

Recommendation 76: The Government and Welsh Assembly Government should consider reviewing the complaints and redress system and whether a community care tribunal should be established.

(Signed) JAMES MUNBY, *Chairman*
ELIZABETH COOKE
DAVID HERTZELL
DAVID ORMEROD
FRANCES PATTERSON

MARK ORMEROD, *Chief Executive*
6 April 2011

⁴³ See Law Commission, *Adult Social Care: Scoping Report* (2008) paras 4.331 to 4.350.

⁴⁴ See Law Commission, *Adult Social Care: Consultation Analysis* (2011) paras 14.20 to 14.31.

APPENDIX A

LIST OF RECOMMENDATIONS

Recommendation 1: There should be single statutes for adult social care for each of England and Wales. In Wales this should be implemented by an Act of the National Assembly for Wales.

Recommendation 2: Adult social care should be regulated through a three-level structure of statute, regulations and guidance issued under the statute. The general power to issue directions under section 7A of the Local Authority Social Services Act 1970 should be repealed as it relates to our scheme.

Recommendation 3: The statute should:

- (1) require the Secretary of State and Welsh Ministers to prepare and from time to time revise a code of practice to provide guidance for social services authorities on the exercise of their functions under the statute;
- (2) require consultation with concerned bodies and other persons before any code is prepared or revised;
- (3) provide that the code of practice, and any revisions made to it are subject to the negative resolution procedure in Parliament or the National Assembly; and
- (4) specify that the code of practice must be followed by decision makers acting under the legislation and can only be deviated from where there are good reasons to do so, but without freedom to take a substantially different course.

Section 7(1) of the Local Authority Social Services Act 1970 should be repealed insofar as it relates to our scheme.

Recommendation 4: If practice guidance is issued in relation to our scheme, it should be kept to a minimum and the legal status of the guidance should be clarified and stated clearly in the guidance itself. Future policy documents should state that they are not legal documents and should be understood as indicating the direction of Government policy.

Recommendation 5: The statute should:

- (1) set out a single overarching principle that adult social care must promote or contribute to the well-being of the individual; and
- (2) state that in deciding how to give effect to this principle in relation to individuals, decision makers must:
 - (a) assume that the person is the best judge of their own well-being, except in cases where they lack capacity to make the relevant decision;
 - (b) follow the individual's views, wishes and feelings wherever

practicable and appropriate;

- (c) ensure that decisions are based upon the individual circumstances of the person and not merely on the person's age or appearance, or a condition or aspect of their behaviour which might lead others to make unjustified assumptions;
- (d) give individuals the opportunity to be involved, as far as is practicable in the circumstances, in assessments, planning, developing and reviewing their care and support;
- (e) achieve a balance with the well-being of others, if this is relevant and practicable;
- (f) safeguard adults wherever practicable from abuse and neglect; and
- (g) use the least restrictive solution where it is necessary to interfere with the individual's rights and freedom of action wherever that is practicable.

Recommendation 6: The statute should place duties on local authorities to provide information, advice and assistance services in their area and to stimulate and shape the market for services.

Recommendation 7: The duty to assess should be triggered where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may have social care needs that can be met by the provision of services.

Recommendation 8: The statute should provide that the local authority duty to assess will be discharged if the person to be assessed refuses the assessment (or if someone else with appropriate authority refuses on their behalf), unless the person lacks capacity in some respect relevant to the assessment, or there are safeguarding concerns. If the person subsequently makes a formal request for an assessment, then the authority must carry out the assessment.

Recommendation 9: The focus of the assessment duty should be an assessment of a person's care and support needs and the outcomes they wish to achieve.

Recommendation 10: The statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the assessment process.

Recommendation 11: The statute should require that in undertaking a community care assessment, a local authority must consult with the service user and carer, except if consultation is not realistically possible in the circumstances.

Recommendation 12: The community care assessment regulations must:

- (1) require a proportionate approach to assessment, having regard to the needs of the individual;
- (2) specify the circumstances in which a specialist assessment must be

arranged; and

- (3) require assessors to consider all needs during an assessment, irrespective of whether they can or are being met by a third party and to take into account if a third party is willing and able to meet a need at the care planning stage.

The community care assessment regulations may: require consultation with other persons or agencies; specify timescales; specify who can carry out an assessment; require the provision of information; specify the considerations to which the assessment should have regard; and specify a particular form of self-assessment, if the Secretary of State or Welsh Ministers wish them to do so.

Recommendation 13: The code of practice should provide guidance on how self-assessment should be integrated in the assessment process.

Recommendation 14: The code of practice should provide guidance on when it would be appropriate for a local authority to authorise other individuals or bodies to carry out an assessment, or aspects of an assessment, and what degree of oversight should be provided by the local authority.

Recommendation 15: The statute should include a clear statement to the effect that a local authority can carry out a community care assessment at the same time as any other assessment is carried out.

Recommendation 16: The statute should place a duty on local authorities to:

- (1) determine whether a person's social care needs are eligible needs, using eligibility criteria; and
- (2) provide or arrange community care services to meet all eligible needs.

The wording of the duty must make it clear that the duty is an individual duty enforceable through judicial review.

Recommendation 17: The statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the eligibility framework for the provision of community care services. The code of practice should specify clearly how local authorities should set their eligibility criteria, including the needs that a local authority must, as a minimum, provide services to meet.

Recommendation 18: Section 21 of the National Assistance Act 1948 should be retained in our scheme and, if it is possible to do so, be located in the adult social care statute and not as a separate standalone provision in the 1948 Act. Moreover, it should be retained with only such amendment that will have no consequences on its effect.

The residual section 21 duty should be retained as a long-stop legal duty, available only to those who fall below the local authority eligibility criteria.

Recommendation 19: There should be a single duty to undertake a carer's assessment in the statute, which is triggered where the local authority is satisfied that the cared-for person is someone for whom the local authority has a power to

provide services (subject to the other criteria for an assessment being satisfied).

Recommendation 20: The duty to assess a carer should apply to any carer who is providing care to another person and not be restricted to those carers who are providing a substantial amount of care on a regular basis. Any such assessment undertaken should be proportionate to the needs presented by the carer.

Recommendation 21: The carers' assessment duty should no longer require a carer to request the assessment in order to trigger the duty. Instead, the duty should be triggered where it appears to the local authority that the carer may have, or will have upon commencing the caring role, needs that could be met by the provision of carers' services or services to the cared-for person.

Recommendation 22: The statute should provide that a carer's assessment must:

- (1) be of the carer's ability to provide and to continue to provide care for the person cared for; and
- (2) take into consideration whether the carer works or wishes to work, or is undertaking, or wishes to undertake, education, training or any leisure activity.

Recommendation 23: The statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the process for carers' assessments.

Recommendation 24: A local authority should have discretion to assess a carer who receives payment for the care they provide or is a volunteer worker, where the authority believes the relationship is not principally a commercial or ordinary volunteering one.

Recommendation 25: The carers' assessment regulations must make provision to require local authorities to take into account the results of the cared-for person's community care assessment in determining whether to provide services to a carer.

The carers' assessment regulations may require local authorities to have regard to the family's needs as a whole when undertaking a community care assessment or carer's assessment and in determining whether to provide services, if the Secretary of State or Welsh Ministers wish them to do so.

Recommendation 26: The statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the eligibility framework for the provision of carers' services.

Recommendation 27: Local authorities should be required to:

- (1) determine whether a carer's needs are eligible needs using eligibility criteria; and
- (2) provide or arrange services to meet all eligible needs of carers.

Recommendation 28: *Community care services* (however named) should be defined in the statute as any of the following provided in accordance with the well-being principle:

- (1) residential accommodation;
- (2) community and home-based services;
- (3) advice, social work, counselling and advocacy services; or
- (4) financial or any other assistance.

The statute should set out the following list of outcomes to which the well-being principle must be directed:

- (1) health and emotional well-being;
- (2) protection from harm;
- (3) education, training and recreation;
- (4) the contribution made to society; and
- (5) securing rights and entitlements.

Recommendation 29: Carers' services should be defined in the statute through reference to the same list of services and outcomes that we recommend for service users.

Recommendation 30: The statute should place a duty on a local authority to ensure the production of a care and support plan for people with assessed eligible needs (including carers). If a person falls below the eligibility criteria, then the authority should be required to put the reasons for that decision in writing and make a written record of the assessment available to the individual.

The code of practice should provide guidance on when it would be appropriate for local authorities to authorise others to produce the plan and what degree of oversight should be provided by the local authority, and clarify that self-funders with assessed eligible needs have a right to a care and support plan.

Recommendation 31: The statute should place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the form and content of care and support plans.

Recommendation 32: The care and support plan regulations must:

- (1) require that plans be set out in writing and signed on behalf of the local authority;
- (2) require that plans include a summary of assessed needs, eligible needs, and outcomes to be achieved;
- (3) specify where appropriate that plans must include the amount of the

personal budget and how this sum has been calculated;

- (4) require that plans must include a summary of the services that will be provided, whether a direct payment will be provided and any financial contributions;
- (5) require that plans are reviewed regularly; and
- (6) specify that a copy of the plan should always be made available to the service user.

The care and support plan regulations may specify other requirements for the plan, if the Secretary of State or Welsh Ministers wish them to do so.

The code of practice should provide concrete examples of the form and content of care and support plans, addressing both the requirements in the regulations and other legal requirements.

Recommendation 33: A regulation-making power should be introduced to enable the Secretary of State and Welsh Ministers to require local authorities to allocate a personal budget to service users and carers. The regulations, if made, must prescribe who is eligible for a personal budget and the circumstances in which budgets should not be allocated.

Recommendation 34: The direct payments provisions should be retained in their existing form in our scheme.

Recommendation 35: Direct payments should be extended to cover residential accommodation.

Recommendation 36: A regulation-making power should be introduced to enable the Secretary of State and Welsh Ministers to require or authorise local authorities to accommodate a person at the place of their choice within England and Wales and to allow for the making of additional payments.

Recommendation 37: A regulation-making power should be introduced to enable the Secretary of State and the Welsh Ministers to require or authorise local authorities to charge for residential and non-residential services, or to establish a charging framework for services.

Recommendation 38: The existing regulation-making power, which enables services to be provided free of charge, should be maintained in our scheme. As a minimum the current services that must be provided free of charge should be included in the regulations.

Recommendation 39: The statute should:

- (1) provide clearly that local social services authorities have the lead co-ordinating responsibility for safeguarding;
- (2) place a duty on local social services authorities to investigate adult protection cases, or cause an investigation to be made by other agencies, in individual cases; and

- (3) place a duty on the Secretary of State and Welsh Ministers to make regulations prescribing the process for adult protection investigations.

Recommendation 40: *Adults at risk* should be those who appear to:

- (1) have health or social care needs, including carers (irrespective of whether or not those needs are being met by services);
- (2) be at risk of harm; and
- (3) be unable to safeguard themselves as a result of their health or social care needs.

In addition, the statute should provide that the duty to investigate should apply only in cases where the local authority believes it is necessary.

Harm should be defined as including but not limited to:

- (1) ill treatment (including sexual abuse, exploitation and forms of ill treatment which are not physical);
- (2) the impairment of health (physical or mental) or development (physical, intellectual, emotional, social or behavioural);
- (3) self-harm and neglect; or
- (4) unlawful conduct which adversely affects property, rights or interests (for example, financial abuse).

Recommendation 41: The statute should not include any new compulsory or emergency powers, unless the Government or the Welsh Assembly Government decides that such powers are needed.

Recommendation 42: The compulsory removal power under section 47 of the National Assistance Act 1948 should be repealed. The Government and the Welsh Assembly Government should consider commissioning research into the existing use of section 47, and then decide, on the basis of that research, whether it would be appropriate to reform the section, following public consultation.

Recommendation 43: Local authorities should be required to protect property when a person is admitted to hospital or residential care.

Recommendation 44: Adult safeguarding boards should be placed on a statutory footing. In order to achieve this, the statute should:

- (1) give the local social services authority the lead role in establishing and maintaining adult safeguarding boards;
- (2) specify the following functions for adult safeguarding boards:
 - (a) to keep under review the procedures and practices of public bodies which relate to safeguarding adults;

- (b) to give information or advice, or make proposals, to any public body on the exercise of functions which relate to safeguarding adults;
 - (c) to improve the skills and knowledge of professionals who have responsibilities relating to safeguarding adults; and
 - (d) to produce a report every two years on the exercise of the board's functions;
- (3) give the Secretary of State and the Welsh Ministers a regulation-making power to add to this list;
 - (4) require each of the following to nominate a board member who has the appropriate skills and knowledge:
 - (a) the local social services authority;
 - (b) the NHS; and
 - (c) the police;
 - (5) give the Secretary of State and the Welsh Ministers a regulation-making power to add to this list;
 - (6) give the Care Quality Commission, the Care and Social Services Inspectorate Wales and the Healthcare Inspectorate Wales a power to nominate an appropriate representative to attend meetings;
 - (7) give the local social services authority a power to appoint any other person with the necessary skills and knowledge relevant to the board, and responsibility for appointing the chair; and
 - (8) provide that adult safeguarding boards should commission serious case reviews and establish a duty to contribute to these reviews.

The code of practice should provide guidance on when information can and should be shared with adult safeguarding boards.

Recommendation 45: The enhanced duty to co-operate should include specific provision to promote co-operation between relevant organisations in adult protection cases.

Recommendation 46: The Government and the Welsh Assembly Government should consider reviewing the following issues:

- (1) the application of guardianship under the Mental Health Act 1983 to people with learning disabilities;
- (2) protecting adults at risk who are being ill treated or neglected but who are not subject to the powers of the Mental Health Act 1983 or mentally incapacitated; and
- (3) the powers of local authorities to apply for occupation orders on behalf of a person under the Family Law Act 1996.

Recommendation 47: Under our scheme, a local authority should have:

- (1) a *duty* to provide services where the person is ordinarily resident (subject to the application of the local authority's eligibility criteria);
- (2) a *power* to provide services for people not ordinarily resident or of no settled residence;
- (3) a *duty* to provide residential accommodation where a person is not ordinarily resident but is in urgent need of accommodation;
- (4) a *duty* to carry out an assessment of needs, irrespective of ordinary residence; and
- (5) a *power* to provide temporary urgent services, without carrying out an assessment, irrespective of ordinary residence.

Recommendation 48: The local authority in which the cared-for person lives should be given primary responsibility for providing carers' services. The code of practice should provide guidance on how local authorities are to address the particular needs of carers living at a distance.

Recommendation 49: The enhanced duty to co-operate should include specific provision to promote co-operation between local authorities when individuals are moving areas.

Recommendation 50: The statute should establish that when a service user moves from one local authority to another, or has a clear intention to move, the receiving authority must carry out an assessment. If the new authority decides to give a significantly different support package, it should be required to produce a clear written explanation to the service user and where appropriate their carer.

The Secretary of State and Welsh Ministers should have a power to make regulations requiring that when service users move from one authority to another, the new authority must provide the person with equivalent services or direct payments to those provided by the original authority to cover their support needs until they undergo an assessment in the new authority.

Recommendation 51: The existing statutory prohibitions on the provision of healthcare by local authorities should be retained, and:

- (1) the wording of the prohibitions should be reviewed and where appropriate simplified;
- (2) where possible NHS guidance and directions should always distinguish between legal powers and duties;
- (3) the prohibitions should include a clear statement to the effect that the range of powers and duties given to the NHS are those set out in regulations and guidance issued under the NHS Acts 2006;
- (4) the *quantity and quality test* should be set out in statute law; and

- (5) the Secretary of State and Welsh Ministers should be given a power to establish in regulations an eligibility framework and what combination of needs would make a person eligible for NHS continuing healthcare.

Recommendation 52: The enhanced duty to co-operate should apply when a request is made by a local authority for an NHS continuing healthcare assessment and where someone moves from social care into NHS care.

Recommendation 53: If direct payments are extended to healthcare, the statute should require the NHS to consider reasonable requests to continue to provide direct payments to social care service users who become eligible for NHS continuing healthcare, and where the NHS has decided not to provide direct payments, it would be required to consider whether existing service provider or agency arrangements should be kept in place.

Recommendation 54: The Government and Welsh Assembly Government should consider reviewing whether the courts are the appropriate forum for determining disputes over NHS continuing healthcare.

Recommendation 55: The code of practice should provide concrete examples of how the prohibitions apply in cases involving residential or non-residential services.

Recommendation 56: Our scheme should prohibit social services authorities from providing ordinary housing and connected services, if these services are authorised or required to be provided under other legislation.

Recommendation 57: The adult social care statute should apply to those aged 18 and above (subject to a power to provide transitional services).

The Government and the Welsh Assembly Government should consider amending the Children Act 1989 to incorporate the same rights to services for children that are currently contained in the Chronically Sick and Disabled Persons Act 1970, the Disabled Persons (Services, Consultation and Representation) Act 1986 and the NHS Acts 2006.

Recommendation 58: The statute should:

- (1) introduce an enhanced duty to co-operate, which should include specific provision to promote co-operation between relevant organisations when a young person is moving from children's to adults' services;
- (2) give local authorities a general power to assess and provide services to 16 and 17 year olds under the adult social care statute;
- (3) require the local authority to give written reasons if a young person aged 16 and 17 (and their parents or carers on their behalf) requests to be assessed under the adult social care statute, and the authority decides not to carry out the assessment;
- (4) state that any young person may make the request irrespective of their capacity and a parent or carer can make a request on behalf of the young person, if the young person has capacity and gives consent or if the young

person lacks capacity and it is in their “best interests” as defined under the Mental Capacity Act 2005 to be assessed under the adult social care statute; and

- (5) create a duty, to be implemented via regulations issued by the Secretary of State and the Welsh Ministers, on local authorities to assess certain young people under the adult social care statute and to specify groups to whom this duty is owed.

Recommendation 59: The Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000 should be retained and amended so that they would apply only to carers aged under 18.

The duties to assess a young carer in the 1995 and 2000 Acts should be amended to make them consistent with the threshold for a carer’s assessment under the adult social care statute.

The Government and the Welsh Assembly Government should either consolidate the 1995 and 2000 Acts so that there is a single young carer’s statute or repeal this legislation and incorporate the provisions into the Children Act 1989.

Local authorities should have a general power to assess and provide services to 16 and 17 year old young carers under the adult social care statute. The statute would require the local authority to give written reasons if a young carer aged 16 and 17 (and their parents on their behalf) requests to be assessed under the adult social care statute, and the authority decides not to carry out the assessment. A young carer would be able to make a formal request using this mechanism on behalf of the person they are caring for.

The assessment regulations made under the adult social care statute should contain a requirement that any community care assessment must have regard to the results of any assessment of a young carer.

The enhanced duty to co-operate should include specific provision to promote co-operation between relevant organisations when a person is moving from children’s to adults’ services.

Recommendation 60: Parent carers should continue to have a right to a carer’s assessment under the Carers (Recognition and Services) Act 1995 and the Carers and Disabled Children Act 2000.

The duties to assess a parent carer in the 1995 and 2000 Acts should be amended to make them consistent with the threshold for a carer’s assessment under the adult social care statute.

The Government and Welsh Assembly Government should either consolidate parent carers’ assessments into a single young carers’ statute, as described in Recommendation 59, or incorporate them into the Children Act 1989.

If a parent carer who is looking after a young person aged 16 and 17 initiates a formal request that the young person is assessed under the adult social care statute and the local authority agrees to this request, then the parent carer

should also be given a carer's assessment under the same statute.

Recommendation 61: The power to make regulations requiring or authorising local authorities to accommodate a person at the place of their choice within England and Wales, set out in Recommendation 36, should apply to those receiving after-care under section 117 of the Mental Health Act 1983.

Recommendation 62: The power to make regulations to allow for the making of additional payments, set out in Recommendation 36, should apply to those receiving after-care under section 117 of the Mental Health Act 1983.

Recommendation 63: The concept of ordinary residence should be extended to apply to after-care services provided under section 117 of the Mental Health Act 1983. The issue of how the ordinary residence rules should be applied to section 117 should be taken forward as a general review of the policy of the Government and Welsh Assembly Government.

Recommendation 64: The joint duty in section 117 of the Mental Health Act 1983 should be divided between health and social care. In addition, the section 117 duty on the NHS should continue until it is satisfied that after-care is no longer required, and likewise the duty on the local social services authority should continue until it is satisfied that after-care is no longer required.

Recommendation 65: Section 117 of the Mental Health Act 1983 should be amended to clarify that social services authorities may commission services from other providers.

Recommendation 66: Section 117 of the Mental Health Act 1983 should be recast from a free-standing duty to a gateway provision in both England and Wales. The code of practice should clarify the relationship between section 117 and local authority eligibility criteria.

Recommendation 67: After-care services provided under section 117 of the Mental Health Act 1983 should be defined on the face of the 1983 Act as those services necessary to meet a need arising from the person's mental disorder; and aimed at reducing that person's chance of being readmitted to hospital for treatment for that disorder. The code of practice should provide guidance on distinguishing between accommodation which is and is not related to a mental disorder.

Recommendation 68: The delayed discharge provisions should be incorporated into our scheme.

Recommendation 69: If the policy decision is that prisoners should not be excluded from adult social care, then the legal framework must facilitate this policy, for example through the ordinary residence rules and eligibility framework. If the policy decision is that prisoners should be excluded, then the statute must make this position clear.

Recommendation 70: The statute should include a general duty to co-operate which would be imposed on each social services authority to make arrangements to promote co-operation with:

- (1) other adult social services authorities;
- (2) NHS public bodies;
- (3) housing authorities, and bodies which provide housing on the nomination of housing authorities;
- (4) education authorities;
- (5) children's social services;
- (6) the police; and
- (7) subject to Government policy on prisons, the National Offender Management Service.

The statute should also give examples, in the form of a non-exhaustive list, of arrangements that can be made under this duty, such as sharing information, pooling budgets or staff, or providing types of goods or services.

Recommendation 71: The statute should include an enhanced duty to co-operate. This duty would apply when:

- (1) an assessment of a service user or carer is taking place;
- (2) providing services to a service user or carer;
- (3) a service user is moving from one local authority area to another;
- (4) an adult protection investigation is taking place;
- (5) a request is made by a local authority for an NHS continuing healthcare assessment;
- (6) someone moves from local authority care into NHS continuing healthcare; and
- (7) a young person (including a young carer) is moving from children's to adults' services.

This duty would apply to the same list of organisations above. The requested agency would be required to give due consideration to the request, and if it refuses to co-operate would be required to give written reasons. The duty would also require the social services authority to give consideration to requests to co-operate from other bodies and give written reasons if it decides not to co-operate.

Recommendation 72: The right to advocacy contained in the Disabled Persons (Services, Consultation and Representation) Act 1986 should be retained in the statute, with a power for the Secretary of State and Welsh Ministers to implement the right and modify it to bring it into line with modern understandings.

Recommendation 73: Local authorities should be required to establish and maintain a register of blind and partially sighted people. In all other cases, local

authorities should be given a power to establish and maintain registers.

The code of practice should maintain the existing requirements for local authorities to analyse data on a number of issues including which groups are referred for assessment and receive services; and identify, make contact with and keep a record of deafblind people in their catchment area.

Recommendation 74: The statute should retain local authority powers to provide temporary urgent services before an assessment is carried out.

Recommendation 75: The statute should give the Secretary of State and Welsh Ministers a regulation-making power to prescribe whether Shared Lives schemes should be considered to be residential or non-residential services. This power should allow the regulations to apply differentially to specific Shared Lives schemes.

Recommendation 76: The Government and Welsh Assembly Government should consider reviewing the complaints and redress system and whether a community care tribunal should be established.

APPENDIX B

GLOSSARY

Community care services	Any service provided following a community care assessment. Currently, this term 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 Part 3 of the National Assistance Act 1948; section 45 of the Health Services and Public Health Act 1968; section 254 and Schedule 20 of the NHS Act 2006; section 192 and Schedule 15 of the NHS (Wales) Act 2006; and section 117 of the Mental Health Act 1983.
Decision maker	Any person or body charged with making decisions under our scheme. This could include social workers, other social care staff and health workers.
DHSS	Department of Health and Social Security
Directions and approvals	Directions can be issued by the Secretary of State or the Welsh Ministers in order to set out how local authorities shall exercise their social services functions. They can be issued under section 7A of the Local Authority Social Services Act 1970 or under powers contained in other legislation. Legislation can also give the Secretary of State or the Welsh Ministers the power to issue approvals. These give local authorities a power but not a duty to do certain things. Under our scheme directions and approvals would be abolished.
Direct payments	Monetary payments made by local authorities directly to individuals who have been assessed as needing certain services, so that they can buy their own services directly.
ECHR	European Convention on Human Rights
Eligible need	A need that has been assessed as falling within the local authority's eligibility criteria.
<i>Fair Access to Care Services</i> statutory guidance	The now repealed statutory guidance on eligibility criteria in England, which applied to local authorities until February 2010. Full title: LAC(2002)13, <i>Fair Access to Care Services: Guidance on Eligibility Criteria for Adult Social Care</i> . It has been superseded by the <i>Prioritising Need</i> statutory guidance.
HSC	Health Services Circular
Independent living	The concept that all disabled people should have the same choice, control and freedom as any other citizen.

LAC	Local Authority Circular
LAC(93)10	The local authority circular which includes the approvals and directions issued under the National Assistance Act 1948 and NHS Act 1977 (now the NHS Act 2006 and NHS (Wales) Act 2006). Full title: <i>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.</i>
NAFWC	National Assembly for Wales Circular
NASS	National Asylum Support Service
Non-registered housing	Housing in England and Wales that is not required to be registered with the Care Quality Commission or Care and Social Services Inspectorate Wales.
Non-residential services	Community and home-based services, such as day centres, workshops and recreational facilities, home care, meals, disability equipment and home adaptations.
Ordinary residence	The settled place of residence for a person. In current community care law this concept applies only for the purposes of services provided under the National Assistance Act 1948 and certain other legislation.
Ordinary residence rules	The rules used to establish which local authority is responsible for providing community care services to an individual.
Outcomes	What people want to achieve through the provision of services.
Personal budget	A sum of money allocated to a service user by the local social services authority in order to meet their assessed eligible needs.
Personalisation	The dominant policy approach to adult social care in England, as described in Part 1 of this report.
Portability	The ability of service users to ensure continuity of support when they change their place of residence from one area to another.
Practice guidance	Government guidance which is not issued under section 7(1) of the Local Authority Social Services Act 1970 or any other enactment. It is weaker in status than statutory guidance.

<i>Prioritising Need</i> statutory guidance	The statutory guidance on eligibility criteria in England. Full title: Department of Health, <i>Prioritising Need in the Context of Putting People First</i> (2010).
Registered housing	Housing in England and Wales that is required to be registered with the Care Quality Commission or the Care and Social Services Inspectorate Wales.
Residential care	Accommodation provided under section 21 of the National Assistance Act 1948 or certain other legislation. It can include ordinary housing as well as registered care homes and other forms of supported living.
Self-directed support	The idea that people should be able to choose and control, to the extent that they want, their care and support.
Statutory guidance	Guidance issued by the Secretary of State and the Welsh Ministers under section 7(1) of the Local Authority Social Services Act 1970. This guidance must be complied with unless there are good reasons for not doing so.
Statutory guidance on eligibility criteria in Wales	The Health and Social Care for Adults statutory guidance, which applies to local authorities in Wales. Full title: NAFWC 09A/2002, <i>Health and Social Care for Adults</i> .
Supported living	The provision of support to help a person live independently in their home (whether this be a care home, nursing home or any other form of accommodation).